United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

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I. Background

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

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

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

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

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

II. Methodology

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

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

III. Organization of Report

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

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

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

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

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

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

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

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

IV. Substantial Compliance Ratings and Progress

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

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

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

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

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

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

V. Executive Summary

As this report indicates, it was positive that Austin State Supported Living Center (AUSSLC) had moved forward in some areas, and that in a number of areas, Facility staff had developed plans to address areas in need of improvement. There clearly was a lot more work to be done. However, it appeared that Facility Administration was committed to taking a measured approach to making the necessary changes, and had developed a number of forums to obtain staff and individual input into the process. For example, some of these included:

- The System Committee Meeting, which was designed to address barriers to systems issues. This was an interdisciplinary group that identified issues and potential solutions to them. As necessary, it used a workgroup approach to further investigate needed changes or formulate solutions to identified barriers. The group, which the Facility Director led, had decision-making authority, so once solutions were agreed upon, they could be implemented swiftly;
- Town Hall meetings, which provided forums for sharing information, and responding to staff's questions or concerns. These meetings had begun to be held monthly, and were mandatory for all staff. Based on observation of a Town Hall meeting during the onsite review, the meetings provided a forum to ensure that a consistent message was provided to all staff regarding topics relevant to improving the protections, supports, and services to individuals, and offering staff across the Facility an opportunity to offer comments or ask questions; and
- Committees designed to address specific subjects, such as a committee designated to review the current work shifts for direct support professionals to determine if viable alternatives could be used to reduce overtime, turnover, and the use of pulled staff.

This collaborative approach in conjunction with increased accountability should assist the Facility to move forward in a number of areas in which concerns have existed for some time. The Monitoring Team encourages the Facility to continue its efforts to build a strong team with the ultimate goal of improving the outcomes for individuals AUSSLC supports.

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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

In particular, the Monitor would like to thank the Self-Advocacy group for inviting the Monitor to their meeting held during the week of the onsite review. It was wonderful to see real self-advocacy at work, and hear about some of the results of the self-advocacy activities on campus, ranging from the reintroduction of chicken wings at the Canteen to true involvement of self-advocates on the Human Rights Committee. These activities reflected positively on self-advocates with skills and a commitment to making their voices heard, as well as a the efforts of current and previous advisors to the Self-Advocacy group, the group's participation in conferences and training available to self-advocates, and the Facility Administration's recognition of and response to topics of concern for self-advocates.

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

Restraints

- Progress was noted in a number of areas regarding the use of restraint. Highlights of progress included:
  - A Restraint Review Board was in place and reviewing restraints on a regular basis, including screening videos of restraints. As the meeting during the Monitoring Team's onsite review demonstrated, this was a useful and necessary process that had the potential to teach everyone involved about the difficult issues associated with restraint. For example, during the meeting as a result of viewing a video of a restraint, staff appropriately identified and reported for investigation a potential use of prone restraint. This was an important finding and staff responded to it appropriately. As the Monitoring Team recommended while on site, given that two allegations existed regarding the potential use of prohibited restraints (i.e., this potential use of prone restraint and an allegation in an investigation of the use of supine restraint), a reminder to all staff about these prohibitions and what to do if an approved restraint could not be properly maintained would be prudent, until investigations were completed to determine if further action or training was needed.
  - The Facility was beginning to clear up confusion over counting restraints. More specifically, those which involved breaks out and re-restraint were logged as a single restraint; and those in which individuals were released, but the restraints were followed shortly by another restraint were treated as two restraints with full documentation packets for each restraint.
  - Rates of training on restraint use and Prevention and Management of Aggressive Behavior (PMAB) basic had improved considerably.
- Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with all of Section C of the Settlement Agreement included the need to:
  - Three individuals in the last six months had Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB). Clarification was needed regarding entry of PMR-SIB data into AVATAR. For example, each use needed to be entered at least once a day for a restraint that was in constant use during a 24-hour period.

- It is essential that Restraint Checklists, and Face-to-face and Debriefing sheets record what was happening before the behavior that caused the restraint. If the answer is that nothing was happening, then the record should show what was supposed to be happening to help determine if restraints were being used in lieu of active programming.
- The Restraint Monitor needs to review the Restraint Checklist for accuracy, identify missing information, and supplement it if necessary in the Face-to-face and Debriefing form. For example, if the Restraint Checklist does not include information about the preceding behavior, then the Face-to-face and Debriefing form should indicate the Restraint Checklist was incomplete, and the Restraint Monitor should attempt to discover and record the missing information.
- Restraint Monitors might need extended training in PMAB principles, and need to be careful to avoid becoming involved in the restraint they are monitoring, or if they do, they should call in another Restraint Monitor.
- When the Incident Management Review Team (IMRT) reviews the restraint, there should be documentation in the minutes of discussion related to the restraint and any follow-up that needs to be done.
- To achieve closure on the issue of orders for medical and dental restraints, the physicians' orders should include the schedule and type of monitoring, and monitoring according to the prescribed schedule needs to be present in the restraint documentation.

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

- Progress was noted in some areas in relation to abuse, neglect, and incident management. Highlights of progress included:
  - Several staff had been hired into the Incident Management Department, and at least two more were due to be hired.
  - The injury audit process has been restarted and injury trending has been started.
  - Information about reporting abuse was being provided to the Legally Authorized Representative (LAR) and individual at the Individual Support Plan (ISP) meeting and documented in the ISP.
- Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included:
  - The quality of Unusual Incident Reports (UIRs) that are Facility-only investigations needed improvement by including summaries of interviews, results of document reviews, and reconciliation of any conflicting information. Findings needed to be made in each review and recommendations where needed. When a UIR followed a return of an allegation from Department of Family and Protective Services (DFPS) as an information and referral, any issues involving serious incidents, such as sexual contact, needed to be investigated, or there needed to be a good explanation of why nothing further was needed.

- When the UIR followed a DPFS report, it needed to include an opinion as to the accuracy and comprehensiveness of the DFPS report, any questions raised, and a referral back to DFPS in the event there were unresolved issues.
- History of the alleged perpetrator with regard to allegations/findings of abuse, neglect, and exploitation (ANE) needed to be included in the UIR as well as the history of the alleged victim.
- A supervisor's review of the investigation needed to be completed and included in the file.
- UIRs needed to be completed within the required timeframes or a request for extension needed to be made and approved.
- UIRs needed to be signed and dated to establish the date of completion.
- Recommendations resulting from an investigation needed to be followed to conclusion and a check should be made to assure that the actions taken had the desired effect.

<u>Quality Assurance</u>

- Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including:
  - A data inventory was in place. It will need further work to assure it includes all relevant data, particularly with regard to key indicators, and is organized in a way that is useful to the Facility.
  - A Quality Assurance (QA) Plan was in place. Again, it requires some work to include information on key indicators, and to add a description of the purpose for the plan.
  - Thirteen Corrective Action Plans (CAPs) were in place. There was a format for developing plans to assure consistency, and a helpful chart to illustrate the difference between CAPs and other types of action plans. There was a tracking system, with numbered CAPs that appeared to be workable. In addition, there was a system for disseminating CAPs to persons responsible for them.
  - The Quality Assurance/Quality Improvement (QA/QI) Council meeting the Monitoring Team observed included some good exchanges of information and leadership from the Director to focus attention on resolving specific issues.

  In short, some solid groundwork had been to develop a QA system. The test will be how consistently it can be maintained and expanded.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - The QA Plan Matrix needed additional work to clarify exactly which monitoring tools were in use for each section of the Settlement Agreement. It might be useful to provide the actual name of the tool and the date modified in the matrix.
  - Monitoring tools need to be in place for any sections that do not have them, the tools need to be implemented consistently according to the matrix, and data needs to be gathered and tested for inter-

rater agreement. If there are sections for which a process other than a monitoring tool will be used, that process needs to be identified in the matrix.

- Monthly meetings between Program Compliance Monitors (PCMs) and disciplines need to include review and analysis of quality assurance data, and minutes should document discussion of issues identified through the monitoring process as well as ideas for resolution. The minutes also should document any resolution of differences in understanding regarding the monitoring tools to assist in reaching a satisfactory level of inter-rater agreement.
- The Facility should continue working on the key indicators and connect them to the sections of the Settlement Agreement.

Integrated Protections, Services, Treatments and Supports

- Based on information staff provided, in the six months prior to the Monitoring Team's onsite review, the Facility had a new Qualified Intellectual Disability Professional (QIDP) Director, and QIDP Educator, and over half the QIDPs were new. The Facility had switched from a model in which Unit QIDPs were responsible for developing and drafting ISPs to one of having Facilitator QIDPs primarily responsible for these tasks. Unit QIDPs were now responsible for day-to-day implementation and oversight of the ISPs. Although this new model was still in the early stages of implementation, it appeared to provide an opportunity to allow concentrated training and mentoring, as well as to use the various skills of QIDPs to the best advantage.
- Some of the improvements that were noted with the ISP process included:
  - A lot of work had been done to provide valuable training and resources to the new QIDPs on many of their duties and responsibilities, and to provide more specialized training to Unit and Facilitator QIDPs. Although the Facility recognized that additional focused training would be needed, hopefully, this comprehensive training effort had laid some important foundations.
  - ISP meetings were generally being held annually.
  - Some improvements were seen in the scope and detail included in ISP action plans, including Integrated Health Care Plans (IHCPs). Although more work was needed, it was clear that efforts had been made to improve the measurability as well as the content of the action steps.
  - Between November 2013 and February 2014, efforts have been made to review ISPs, and particularly Skill Acquisition Programs (SAPs) to make sure that there was agreement between what the team discussed, and the SAPs being implemented. A process had been put in place to assist in ensuring that ISPs accurately reflected the teams' agreements with regard to SAPs moving forward.
  - As of 2/14/14, an interdisciplinary process had been used to develop Active Treatment Daily Plans for all individuals or groups of individuals, and implementation of these plans was in the beginning stages. For staff responsible for ISP implementation, these plans provided information about individuals' schedules, including expected times for SAP implementation, as well as other opportunities for training or active

treatment, communication strategies, leisure interests, physical and nutritional management and mealtime needs, and behavioral strategies.

- Some of the areas in which the Facility needed to focus its efforts included:
  - Based on review of the sample of ISPs, attendance of necessary team members at ISP meetings and timely submission of needed assessments were areas requiring improvement. The quality of assessments also continued to need improvement.
  - For the sample of ISPs, monthly reviews had not been completed. In the weeks following the Monitoring Team's onsite review, training was scheduled for QIDPs on the completion of monthly reviews. Facility staff recognized that other disciplines also would need to contribute to the monthly review process.
  - Teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs.
  - Teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences.
  - ISPs generally continued to lack measurable goals/objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, behavior, skills, etc., or maintaining his/her current status).
  - The quality assurance efforts related to ISP development were under revision. Once finalized, monitoring data, as well as the other sources of data, should be utilized to identify and address problematic trends.

<u>Integrated Clinical Services</u>

- The Facility had made progress in the area of integrated clinical services. The look-back record review for hospitalized individuals had continued. Individual Support Plan Addendum (ISPA) templates had been implemented for post-hospital, post-Emergency Room (ER) visits, and Infirmary admissions. ISPA completion was tracked at the morning medical meeting.
- Areas needing focus were documentation of attendance at morning meetings. The morning meeting minutes did not include this information, and attendance at specific morning meetings could not be determined. The look-back record review process needed quality assurance (QA) monitoring. ISPA completion needed further interdisciplinary support to provide timely responses for those hospitalized, going to the ER, or admitted to the Infirmary. The Facility had identified the need for providing evidence of closure to other concerns assigned at the morning medical meeting, and a corrective action plan had been developed. This will need implementation.
- The morning medical meeting continued to be an important forum of interdisciplinary collaboration in responding to change of health status. The Medical Department had developed several tools to provide guidance and evidence of integrated clinical services. The Medical Department continued to make gains in this area.

Minimum Common Elements of Clinical Care

- Much effort had been directed to ensuring annual assessments were updated. Annual medical assessments were current in 97 percent of the records. Annual dental assessments were current in 91 percent of records. Quarterly Drug Regimen Reviews (QDRRs) were current in 100 percent of records.
- Based on a sample of records, the significant diagnoses on the Active Problem Lists were based on appropriate criteria (i.e., consultations, test results, physical examination) in all records the Monitoring Team audited.
- Areas needing improvement included ensuring the medical and dental assessments were submitted in a timely manner as part of the ISP process. Quarterly medical reviews will need a system for tracking to completion, with demonstration of analysis and corrective actions, if needed. Internal Medical Department QA monitoring needed to expand to other clinical areas not covered by the peer review audits. QA efforts need evidence of analysis of audit results, and action plan based on findings, along with follow-up audits to determine impact of corrective actions. In addition, teams needed to include individualized clinical indicators in IHCPs, and implement mechanisms to track determine the efficacy of treatments, and to make changes to individuals' plans as needed. Such data also needed to be analyzed and responded to on a systemic level.

At-Risk Individuals

- Since the last review, there continued to be a significant amount of work yet to be done regarding the At-Risk system and understanding what the system represented and what it entailed. The Facility continued to experience significant staffing challenging and changes, including complete turnover regarding the staff overseeing the At-Risk Individuals systems. Consequently, since the last review, the Facility had lost traction and momentum in some of its previous efforts regarding the development and implementation of the Facility's At-Risk system. In addition, it was clear to the Monitoring Team that there was a significant lack in the depth of understanding of the complexity and overall purpose regarding the At-Risk process and system. As a result, significant weaknesses were found in the existing pieces of the system, such as the Integrated Risk Rating forms (IRRFs), the Integrated Health Care Plans (IHCPs), the validity of the risk ratings, the implementation of action steps, and discipline-specific assessments necessary to ensure that individuals with elevated health/mental health risks were being consistently provided the care they required.
- Since the last review, the establishment of the Pneumonia Workgroup had been a positive step forward. However, efforts need to be directed at addressing the day-to-day clinical care of the individuals in addition to determining differential diagnoses. On another positive note, the Facility's review of data regarding Gastrostomy tubes (G-tubes) resulted in initiation of bedside competency training for all nurses involved in providing nutrition and medications by G-tube.
- From meetings observed the week of the Monitoring Team's onsite review, there was some good discussion of information, use of the Risk Guidelines, and some good clinical discussions regarding the risk indicators. Although some positive changes were noted during the ISPs observed, there continued to be significant issues regarding the accuracy and documentation of the risk levels, the reflection in the IHCPs of supports with the

necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process. Consequently, at the time of the review, the efforts the Facility put forth had not yet translated into any consistent measurable progress in this area.

Psychiatric Care and Services

- At AUSSLC, the current Psychiatrists were all Board Certified by the American Board of Psychiatry and Neurology, and the numbers appeared to be adequate for the individuals served at the Facility.
- During the visits to the vocational programs and the residences, direct observation of approximately 22 percent of the individuals prescribed psychiatric medication did not reveal individuals who appeared to be overly medicated, lethargic, or experiencing obvious side effects, such as impaired gait or abnormal movements. The use of chemical restraint frequently involved the Intramuscular (IM) injection of an antipsychotic or other medication to an individual against their will, and if administered improperly, could be considered to be punishment. Based on the Monitoring Team's review, there were deficiencies in the documentation for the episodes of chemical restraint reviewed, which made it impossible to determine if these interventions were used appropriately.
- Currently, AUSSLC had only developed a few of desensitization plans or other strategies to reduce the use of pre-treatment sedation to the extent possible. The rates of pre-treatment sedation for medical procedures were much greater than the corresponding rate for dental procedures, and had received less attention.
- The Psychiatry Department had made considerable progress with the Comprehensive Psychiatric Evaluations (CPEs). In addition, the criterion for each individual's psychiatric diagnosis was listed at the beginning of the psychiatric Quarterly Reviews and was carried forward in each review.
- Individuals who were discharged from the Psychiatric Clinic after their medications had been discontinued received a Reiss Screen a few months after discharge, as part of the follow-up procedure. There was also a protocol for the administration of the Reiss Screen to individuals who had a potential change in their psychiatric status. This review indicated that the Facility was performing a CPE for individuals who had elevated Reiss Scores, unless there were extenuating circumstances.
- The Psychiatric Quarterly Reviews, the CPEs, and the Psychiatric Treatment Plans the Monitoring Team reviewed all included extensive discussions of the risk-versus-benefit considerations, and verified that the consents were up-to-date for all of the prescribed psychotropic medications.
- The Facility had reduced their absolute rate of polypharmacy to 15.5 percent, and the adjusted rate (taking into account those for whom the medication had been justified) was 9.4 percent. Also, many of those in the "Active" category had tapering plans in place for their remaining medications. In addition, the Facility's data showed that from January 2012 to January 2014, 15 individuals had all psychotropic medication tapered and discontinued. This number did not include individuals discharged into the community. In addition, data from January 2012 to

January 2014 indicated that an additional 15 individuals were transitioned from polypharmacy status to regimens that did not meet the criteria for polypharmacy.

- The Facility had identified some difficulties in the timely completion of side effect monitoring assessments, and the Monitoring Team's review of a sample of individuals prescribed psychotropic medication confirmed that there were deficiencies.
- The Facility tracked the occurrence of the Quarterly Reviews, and they had occurred as scheduled. In addition, the Psychiatrists often did follow-up or urgent consults in between the Quarterly Reviews.
- The Psychiatrists routinely attended all Neurology Clinics, and this was documented in both the psychiatric section of the record, as well as in the Neurology Consultation Note.

Psychological Care and Services

- Several positive changes were observed within the Behavioral Health Services Department. Although no Board Certified Behavior Analysts (BCBAs) were currently on staff, the majority of the Behavioral Health Specialists were pursuing certification. The Department had initiated a contract with a local BCBA to ensure that supervision requirements could be met.
- Staff attendance at the Behavior Therapy Committee (BTC) was quite good, which was a promising practice because this internal peer review offered an excellent opportunity for increased training and development of skills. The primary focus of the meeting a member of the Monitoring Team observed was protective mechanical restraint for self-injurious behavior (PMR-SIB). The discussion regarding its use, fading strategies, risks, and continued oversight reflected a very caring and thoughtful approach to treatment. This Committee was well established to provide internal peer review. Documentation showed that external peer review had occurred in five of the six previous months through phone conferencing with staff from three other State Supported Living Centers, but follow-up to recommendations made was not consistently documented. Plans had been developed to introduce a third tier of peer review to address particularly challenging cases, which would be a positive addition.
- Staff also had focused their attention on addressing many of the problems observed with data collection. Suggestions for improving data accuracy and reliability were being considered. Weekly review of data within the Behavioral Health Services Department had been initiated with plans to begin monthly review with supervisory staff from the homes. One suggestion would be to include key direct support professionals in this meeting.
- Other promising practices included regular scheduling of professional staff in the homes and day programs, clear expectations for timely completion of all paperwork, and staff training that included role-play and on-the-job performance checks and feedback.
- Although there were many positive changes presented and discussed, the Facility will need to ensure consistent implementation of plans for improvement. A number of the issues that existed during previous reviews continued to exist, and focus on these efforts to improve them was positive and necessary.

Medical Care

- Under the leadership of the Medical Director, the medical team of Primary Care Practitioners (PCPs) provided quality care in a number of areas, as well as quality documentation of clinical care. Critical clinical discussions occurred at each morning medical meeting, and included participation from a variety of other disciplines. The morning meeting had an appropriate structure/format and was efficiently run. Minutes reflected the critical discussions. ISPAs were tracked to closure.
- Annual medical assessments had been behind schedule in completion, and a corrective action plan was implemented with rapid improvement in this area. Caseloads were of an appropriate size per PCP. PCPs had in-depth knowledge of the individuals on their clinical caseloads.
- Tracking of on-site and off-campus appointments appeared thorough.
- A task force on aspiration pneumonia had had significant impact on several clinical departments. Clinically, the significant potential contribution of gastroesophageal reflux disease (GERD) to aspiration pneumonia appeared to be identified in the template used to review each instance of pneumonia. Evaluations of acute respiratory distress often included evaluations of GERD, and GERD diagnoses were appropriately evaluated and treated.
- Areas needing improvement included the many databases on which the Medical Department relied for information to make continued advances in health care. Some preventive care databases appeared out-of-date and unhelpful, and might not have accurately reflected the clinical care at the Facility. Facility computer/information technology support/database entry and management support might be needed to address the issues.
- The lack of QA Department follow-through in monitoring results of external and internal peer review corrective action plans needed focus. Although the formal process set forth expectations for a strong component of QA monitoring to ensure follow-up on the results of these peer review audits, at AUSSLC, no monitoring had occurred in the prior six months.
- The annual medical assessments were now up-to-date, but the content varied across PCPs, and this needed review. The quality of the quarterly medical reviews was exemplary, but there was no information available to provide evidence of timely completion via an information management system.
- Ethics Committee closure items needed documentation of follow-through to completion.
- The Medical Department had not begun to develop a policy and procedure manual.
- Components of quality medical care were reflected in the discussions of the morning medical meetings, and in the improved documentation in the active records, concerning acute changes in health status and chronic care. Continued progress will require strengthening of other clinical and nonclinical departments critical to the services the Medical Department provided.

Nursing Care

- Since the last review, nursing staffing continued to be a significant challenge for the Facility, with turnover in a number of staff nursing positions as well as some turnover in the key leadership nursing positions. Due to these

staffing issues, the Facility had to continue to use Agency nurses to cover positions, and continued to do so at the time of the review. Some of the changes regarding the Nursing Department and nursing positions since the last review included the following:

- In October 2013, the Chief Nurse Executive (CNE) position was vacated and in November 2013, a nurse from a private consulting firm became the Acting CNE;
- In January 2014, the Program Compliance Nurse position was vacated, and reportedly was filled in March 2014;
- In January 2014, the Case Manager Supervisor position was vacated;
- In December 2013, the Infection Control Nurse position was vacated;
- Since January 2014, the current Nurse Operations Officer (NOO) had been on leave; and
- In January 2014, one Nurse Educator position was vacated, and a new Nurse Educator was hired in January 2014.

- At the time of the review, the information the Facility provided indicated that the Nursing Department had a total of 136 allotted positions with 19 vacancies. The nursing vacancies included seven Registered Nurse (RN) positions and 12 Licensed Vocational Nurse (LVN) positions.
- Interviews with the Acting CNE indicated that since the last review, due to staffing issues, there had been significant periods of time where very few monitoring activities had been conducted resulting in little to no data generated. Consequently, due to the significant lack of data contained in the Facility's Self-Assessment as well as available during the review, the Monitoring Team was not able to accurately ascertain what specific activities the Facility was conducting to address most areas of Section M of the Settlement Agreement.
- Overall, the numerous and 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 vacated, had resulted in a Nursing Department that was not functioning in a manner that supported individuals' nursing needs, including the needs of individuals most at-risk for health and mental health issues. The Monitoring Team continued to identify significant concerns with regard to nursing supports provided to individuals with acute changes in status, as well as individuals with chronic health conditions, and also identified numerous problems with the documentation of nursing supports. Consequently, the Facility essentially had made no progress regarding the overall requirements of the Settlement Agreement for Section M.
- However, based on interviews with State Office staff and the Facility Director during the review, there appeared to be some aggressive and very promising strategies in development to address the structure of the Nursing Department and the responsibilities that had been assigned to the different nursing positions. Hopefully, these efforts will ultimately address the problematic issues that have existed and currently existed in the Nursing Department.

Pharmacy Services and Safe Medication Practices

- Several processes central to Pharmacy services demonstrated quality, and the numerous monitoring tools implemented to assure quality and identify problems at their inception further demonstrated this. Quality processes included new order processing, completion of Quarterly Drug Regimen Reviews (QDRRs), quality of recommendations based on these QDRRs, the process to identify and address adverse drug reactions (ADRs), and the thoroughness of the drug utilization reviews (DUEs). In the area of medication variances, the Pharmacy Department had implemented numerous steps to identify causes and provide systems approaches, as well as put a process in place to attempt to address concerns unique to an individual building.
- The challenge ahead was the continued search for causes of medication variances and development of a systems approach to reduce these events. This will require ongoing collaboration with the Nursing Department. The Pharmacy Department appeared to take every opportunity to provide additional training to nurses and other appropriate staff as the need arose.

Physical and Nutritional Supports

- At the time of the Monitoring Team's onsite review, the Facility Physical and Nutritional Management Team (PNMT) was functioning with the disciplines defined in the Settlement Agreement. However, the PNMT membership had not been consistently staffed with the required disciplines throughout the past six months. Consequently, required PNMT members were not in attendance at a significant number of meetings. The Facility's evidence showed that medical providers were not routinely participating in PNMT meetings. The Facility did not have a comprehensive physical and nutritional management (PNM) policy. On a very positive note, the PNMT was identifying and resolving system issues.
- The Facility PNMT Guidelines had been updated to define the PNMT referral process. However, the Facility's IDTs had not been trained on the revised PNMT Guidelines. Some individuals who had experienced a change in status had been referred to the PNMT, but other individuals who should have been referred had not been referred. The PNMT was not completing assessments per established timelines. PNMT assessments were missing many necessary assessment elements. PNMT assessment recommendations had not been integrated into individuals' IHCPs.
- Individuals' Physical and Nutritional Management Plans (PNMPs) were missing necessary components. Teams had not met to approve individuals' PNMPs that had been revised after the annual ISP meeting.
- There had been some improvement in staff compliance with dining plan implementation since the last review, when compliance was zero percent, to this review, when compliance was 26 percent. On a positive note, during dinner mealtime observations in the dining room for Hummingbird and Roadrunner, there were no mealtime errors observed. However, during observations in multiple other dining rooms, staff were not following dining plan instructions. The Facility had implemented the Mealtime Management System campus-wide, but additional work needed to be done to ensure Mealtime Coordinators (MTCs) and Table Captains performed their duties as defined.

- In addition, although there had been some improvement in staff implementation of other components of PNMPs from the last review, additional work needed to be done.
- The Facility therapists had revised the New Employee Orientation (NEO) and annual refresher PNM foundational competency-based training to place more emphasis on staff's understanding of the implementation of PNMPs and dining plans. The Facility therapists had identified individuals whose staff would require individual-specific training, had developed individual-specific performance check-offs, and had provided some training. The therapists were in the process of finalizing the system for the provision of individual-specific training.
- Since the last review, the Facility had reinitiated PNMP monitoring. PNMP monitoring was being completed for meals, positioning, lifting/transfers, and communication. The Monitoring Team questioned the reliability and validity of the cumulative scores from this monitoring. The Monitoring Team's direct observations did not find the same level of compliance with positioning in wheelchairs and/or alternate positioning.

Physical and Occupational Therapy

- The Facility therapists collaborated with the State Office and Facility Administration to add four additional Orientation and Mobility Specialists. This expanded capacity to provide services such as assessments, training, and active treatment for individuals who were visually impaired and/or hearing impaired. A training curriculum was developed and implemented to provide training to clinical staff and direct support professionals in Sighted Guide and Hand-Under-Hand techniques. Staff from numerous departments worked together to develop a work/day program center to meet the unique needs of individuals with visual and hearing impairments.
- Individuals' OT/PT assessments included 17 of 22 assessment elements. However, essential elements were missing. Individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements.
- None of the five individuals reviewed who were receiving direct OT and/or PT interventions had therapy plans. Monthly progress notes had not been completed that included the necessary elements. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs.
- The Facility did not have OT/PT policies/protocols that included the necessary elements.

Dental Services

- The Dental Department provided a broad spectrum of clinical dental services. The annual dental assessments were timely. The refusal rate for dental appointments was low, and each individual was tracked. The annual dental assessments and summaries provided considerable detail of information. Emergencies were tracked to completion. Additional training was provided to nurses concerning nothing by mouth (NPO) status for individuals scheduled for general anesthesia to minimize intra- and post-op complications.
- Areas of concern included the lack of transition information and the lack of ISP risk rating in the dental summary, which was forwarded to the Interdisciplinary Team (IDT). Oral hygiene scores across campus

remained a challenge. Desensitization or other strategies to reduce the need for sedation did not appear to include those undergoing general anesthesia. There appeared to be little focus on proactive approaches to reducing the rate of tooth loss.

Communication

- The Facility had established a protocol describing the process for determining Speech Language Pathologist (SLP) caseloads. However, additional work was needed to determine what an appropriate caseload would be for SLPs at AUSSLC. The five allocated SLP positions at the Facility were filled. The SLPs were licensed to practice in the state of Texas and provided evidence of current American Speech-Language-Hearing Association (ASHA) certification.
- The Facility had not developed policies and/or procedures to define the provision of communication services and supports, including the necessary elements.
- The small sample of the most recently completed Speech Language (SL) assessments showed notable improvements. In addition to continuing to address the areas of the assessments still needing work, the Facility is encouraged to continue the use of the improved practices as additional individuals' SL assessments are completed. Although the Facility remained in noncompliance with this provision, significant progress had been made.
- ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' alternative or augmentative communication (AAC) systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs and/or ISPAs to structure skill acquisition, and provide a mechanism to measure progress.
- The Facility did not have policies/procedures to define the monitoring process for communication supports provided to individuals.

Habilitation, Training, Education, and Skill Acquisition Programs

- The Facility clearly had initiated changes to ensure that the majority of individuals were leaving their homes to attend day habilitation or vocational programs. This was the Monitoring Team's first visit during which observations on the Castner Unit revealed very few individuals gathered in large groups in their shared living area. Changes had been introduced not only in the programs offered, but also in the scheduled transportation times. Transitions to program sites were occurring earlier and throughout the day to best meet the needs of the individuals served. Hybrid programs had been created to allow individuals to switch between day habilitation and work programs as appropriate. Further, a specialized program for individuals with visual impairment had been developed. With the addition of professional staff trained in orientation and mobility, direct support professionals had received specialized training to work with this population. Although only a small number of individuals were affected, the opportunities for community-based employment also had been expanded.

- Key staff had been trained in writing SAPs, and there was a renewed focus on scheduling activities throughout the day and on weekends. Active Treatment Daily Plans were being introduced to replace individual daily schedules. These offered more in-depth information regarding both formal training and incidental teaching opportunities. Tracking of off-campus activities also was being introduced to ensure that individuals were accessing scheduled events, and if not, that problems and accompanying solutions were identified early.
- In spite of these changes, many of the problems identified in the past remained present. Activities were very limited, refusals to participate in daily activities persisted, and individualized habilitation planning remained compromised.

Most Integrated Setting

- Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community, but some did not. In addition, individuals' ISPs generally included a recommendation from the Facility's team members with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. When team members modified the opinions they had included in their assessments, generally no explanation was provided.
- Systemic issues that negatively impacted referrals and had not been addressed were gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs. At the time of the onsite review, the State Office had not yet provided its annual report on obstacles to referral and transition, including explanations of how it was working to overcome systemic obstacles.
- Although obstacles to referral were being identified on an individual basis, they were not consistently accurate, and more work was needed to determine the specific concerns of individuals and their guardians when their choice was the reason for a referral not being made. Individuals frequently did not have plans to address the specific obstacles identified, and the quality of the plans teams had developed to overcome such obstacles remained inadequate. Although plans were measurable, they continued to lack individualization. In addition, although teams were identifying obstacles to transition once individuals' referrals exceeded the 180-day mark, teams were not collecting and reporting information on obstacles to transition throughout the transition process. Anecdotally, issues such as a lack of day/vocational program capacity to support individuals with pica behavior were resulting in teams considering more restrictive options, such as in-home day programs, but this obstacle to transition to the most integrated setting was not captured in the data on obstacles, because individuals' referrals had not exceeded 180 days.
- In general, Admissions Placement staff reported increased collaboration with the Local Authorities (LAs) over the last several months. One Local Authority was developing a crisis intervention team, and becoming more involved with individuals at AUSSLC with complex behavioral needs in the transition process. The Director of Consumer and Family Relations reported that she met quarterly with State Office Staff and the Local Authorities

to discuss obstacles to transition. The Facility was developing a new module on the most integrated setting for New Employee Orientation, and it was anticipated that in April 2014, one of the Local Authorities would participate in providing the training to new employees. In addition, the Local Authority staff reportedly were collaborating more with the Post-Move Monitors in conducting monitoring activities, and follow-up needed.

- Although most individuals had plans in their ISPs related to educational opportunities on community options, the plans generally were not individualized. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Efforts to share success stories were needed, particularly for individuals and guardians who were reluctant.
- On a positive note, for individuals in the process of transition, the Facility was often using a provider interview format. Admissions Placement staff worked with the IDT, including the individual and guardian, and developed questions to ask the community providers. In addition, the Local Authority that was developing a crisis intervention team recently had been involved with facilitating these provider interviews for individuals with complex behavioral needs. The provider interviews and LA's involvement in this process were positive additions to the community provider selection process.
- The Facility had made some good improvements in the Community Living Discharge Plans (CLDPs), particularly in developing more comprehensive and detailed pre- and post-move supports. However, this was an area that required continued focus, because some key supports continued to be missing. The Facility's review of an individual's death after transitioning to the community had identified some, but not all missing supports from her CLDP.
- Post-move monitoring documentation did not consistently show that findings were well supported. It is important that clear evidence be provided to support the findings and to increase the likelihood that community providers will respond to them. In addition, action plans should clearly set forth the steps planned for follow-up, and documentation should be maintained to confirm the necessary actions took place.

<u>Consent</u>

- For individuals for whom guardianship appeared necessary, with the leadership of the Human Rights Officers, teams had begun to complete the Facility's prioritization tool again. It was good that this tool would now be reviewed annually, because as Facility staff recognized individuals' needs change, and, to the extent possible, the limited guardianship resources need to be targeted to the individuals with the highest priority need.
- The Facility had a Guardianship Committee that began functioning again within the last few months. It played an important role in reviewing and further prioritizing the need for guardianships.

- The Facility continued to have a strong relationship with the probate court, and this had a number of benefits to assist in obtaining and maintaining guardians for individuals that need them. The recent addition of a certified guardian to the pool of potential guardianship resources also is helpful.
- A significant remaining issue was that the list of individuals requiring guardians was not based on a valid process for determining individuals' functional decision-making capacity. As Facility staff recognize, guardianship is an extremely restrictive practice. A draft assessment process had been shared with the Facility. Once such a process is finalized, individuals' teams will need to assess individual's capacity, and this should include identification of less restrictive supports that might assist some individuals to make decisions.

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

- The Records Department had reviewed all of the Individual Notebooks to ensure they were current and organized.
- In addition, the Records Department had continued to audit active records, and had focused on making sure necessary documents were present in the records. When issues were found, a process was in place to request corrective action, and to follow-up with supervisory staff, if corrections were not made. This data also was now being looked at on an aggregate level, with some Corrective Action Plans developed and underway, and some others slated for development.
- A pilot project had proved successful in increasing staff's compliance with signing in and out records, and returning them at the end of the day.
- Facility staff self-identified that the next area of focus for audits would be on correcting some of the quality components of the records, such as legibility.
- The Facility recognized the need to continue efforts to localize State Office policies, and revise older policies. Although this has been somewhat slow, progress was made since the last review, and a plan is in place to move forward with this process.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

Presentation Book for Section C;
Presentation at the entrance meeting;
State Supported Living Centers: Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, dated December 2013;
Restraint Reduction Committee Meeting Notes, for 8/8/13, 9/12/13, and 10/10/13;
Restraint Reduction Review Board meeting notes: 2/6/14, and 2/20/14;
Materials from the Restraint Reduction Review Board, on 2/26/14;
Incident Management Review Team (IMRT) Agenda, for 2/25/14;
Section C - Protection from Harm - Restraints monitoring tool, revised 9/16/13;
DADTX Course Delinquency List AUSSLC: PMAB Basic, RES0100, dated 2/26/14;
DADS MHMR102: Percent of All Employees Completing Courses of Training Program, dated 2/26/14;
Training Curricula used to train Restraint Monitors as of 2/11/14;
Restraint and Peer-to-Peer Trend Report, dated 9/20/13 and 10/25/13;
Materials from IMRT meeting on 2/25/14;
Sample #C.1: Chosen from list individuals restrained between July and December 2013 per II.5 of document request. The list included 133 incidents of crisis restraint. A sample of 20 (15%) of the restraint episodes was drawn. Since the sample was reduced for all but Section C.2, a full sample of 20 was drawn for Sections C.2 and C.3, and a reduced sample of 10 was drawn for Sections C.1, C.4, C.5, C.6, and C.8.
REDUCED SAMPLE #C.1: for Sections: C.1, C.4, C.5, C.6 and C.8: the following documents were requested:

Restraint checklist form;
Face-to-face/debriefing form;
The individual's Crisis Intervention Plan, if applicable;
Positive Behavior Support Plan;
ISP;
Any and all reviews of this use of restraint; and
Any addenda or changes to the ISP or Safety Plan that resulted.

<table>
<tr><th>Sample #</th><th>Name</th><th>Date and time</th><th>Type</th></tr>
<tr><td>C1.1</td><td>Individual #421</td><td>10/13/13 at 7:10 a.m.</td><td>Physical</td></tr>
<tr><td>C1.2</td><td>Individual #421</td><td>10/13/13 at 7:15 a.m.</td><td>Physical</td></tr>
<tr><td>C1.3</td><td>Individual #421</td><td>9/6/13 at 3:17 p.m.</td><td>Chemical</td></tr>
<tr><td>C1.4</td><td>Individual #30</td><td>10/19/13 at 4:10 p.m.</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

C1.5	Individual #406	12/2/13 at 6:55 p.m.	Physical
C1.6	Individual #246	10/11/13 at 11:35 p.m.	Chemical
C1.7	Individual #56	12/20/13 at 12:08 p.m.	Physical
C1.8	Individual #374	9/1/13 at 9:50 p.m.	Physical
C1.9	Individual #333	12/15/13 at 3:12 p.m.	Physical
C1.10	Individual #273	9/8/13 at 5:35 p.m.	Physical

- **#C.1 FULL SAMPLE**: for Sections C.2 and C.3 only (these were added to records C.1 through C1.10 to create a sample of 20.) For Section C.2 and C.3, the following documents were requested:
  - The Restraint Checklist;
  - The face to face/debriefing report; and
  - The crisis intervention plan.

Sample #	Name	Date and time	Type
C1.11	Individual #421	10/7/13 at 3:53 p.m.	Physical
C1.12	Individual #421	9/7/13 at 3:29 p.m.	Physical
C1.13	Individual #30	10/19/13 at 4:52 p.m.	Physical
C1.14	Individual #30	11/20/13 at 6:50 p.m.	Physical
C1.15	Individual #406	9/1/13 at 1:40 p.m.	Physical
C1.16	Individual #4	12/12/13 at 7:56 a.m.	Physical
C1.17	Individual #56	8/19/13 at 3:28 p.m.	Physical
C1.18	Individual #56	10/13/13 at 3:55 p.m.	Physical
C1.19	Individual #193	9/18/13 at 10:48 a.m.	Chemical
C1.20	Individual #98	12/4/13 at 5:38 p.m.	Physical

- A subsample of three records for use in Section C.4 (metrics e and f) was drawn from the #C.1 sample list and the following documents were requested:
  - Annual Medical Summary Active Problems list;
  - The form used by the Facility to document restraint considerations/restrictions; and
  - ISPs/ISPAs indicating that restraint considerations that have been identified by any member of the IDT have been addressed and documented.

Sample #	Name	Date and time	Type
C1.4	Individual #30	10/19/13 at 4:10 p.m.	Physical
C1.7	Individual #56	12/20/13 at 12:08 p.m.	Physical
C1.9	Individual #333	12/15/13 at 3:12 p.m.	Physical

- **Sample #C.2**: The following documentation for a selected random sample of 24 staff:

- Their start dates;
- The dates they were assigned to work with individuals;
- Their training transcripts showing date of most recent:
  - PMAB training;
  - Training on use of restraints; and
  - Training on abuse/neglect/exploitation; and
- The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

o **Sample #C.3:** a reduced sample of 10 records of medical/dental restraint including:
- The physicians' orders for the restraint, including the monitoring schedule;
- The medical restraint plan;
- The restraint checklist;
- The documentation of the monitoring that occurred;
- Any reviews of this use of restraint;
- The consent/authorization for the restraint; and
- Any applicable desensitization plan.

Sample #	Name	Date	Type
C3.1	Individual #246	11/13/13 at 7:59 p.m.	Chemical
C3.2	Individual #4	12/13/13 at 8:58 a.m.	Physical
C3.3	Individual #45	8/30/13 at 8:00 p.m.	Mechanical
C3.4	Individual #13	12/11/13 at 8:00 a.m.	Chemical
C3.5	Individual #375	11/5/13 at 11:40 a.m.	Chemical
C3.6	Individual #123	9/10/13 at 6:30 a.m.	Chemical
C3.7	Individual #180	12/17/13 at 11:00 a.m.	Chemical
C3.8	Individual #210	12/12/13 at 3:29 a.m.	Chemical
C3.9	Individual #88	9/20/13 at 8:30 a.m.	Chemical
C3.10	Individual #8	10/22/13 at 5:05 p.m.	Chemical

o For Section C.4:
- Medical Desensitization Report, dated 1/27/14;
- Dental Desensitization Report, dated 1/27/14;
- Dental Desensitization SAPs for: Individual #204, Individual #34, Individual #102, Individual #319, Individual #299, and Individual #18;
- Individual Support Plans for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425;
- AUSSLC Rights Assessment for Individual #98;

o **Sample #C.4:** Chosen from the list provided in II.7a in response to the document request. The total number of chemical restraints for crisis intervention was 24. Sample size was two or 10%. Note that these are the same chemical restraints included in Sample #C.1

above. Documentation requested included:

- The restraint checklist;
- Face-to-face and debriefing reports;
- Any reviews of the use of restraint;
- Documentation of contact between the psychologist and physician prior to the use of the restraint; and
- Any changes to the ISP or Safety Plan as a result of the restraint.

Sample #	Name	Date and Time	Type
C1.3	Individual #421	9/6/13 at 3:17 p.m.	Chemical
C1.6	Individual #246	10/11/13 at 11:35 p.m.	Chemical

- **Sample #C.5:** the records of restraint used off-grounds: The response to Document Request #11 indicated there were no restraints off-grounds. However, the restraint Sample #C.1 included an off-grounds restraint (i.e., C1.9) which was used for the metric related to off-grounds restraint.
- **Sample #C.6 for Section C.7**:
  - List of restraints, 7/13 to 12/13;
  - Description of Restraint Reduction Board, dated 2/13/14;
  - Minutes from Restraint Review Board meeting, dated 2/6/14;
  - Crisis Restraint Checklist, Restraint Face-to-Face Assessment, and where appropriate, Pre- and/or Post-Chemical Restraint Review (an asterisk indicates that either the pre- or post-chemical restraint review was provided, but not both) for the following restraints:

Individual	Date	Time(s)
Individual #30	8/6/13	11:15 p.m.
	8/11/13	5:03 p.m.
	8/12/13	2:13 p.m.
	8/17/13	4:39 p.m.
	8/27/13	6:58 p.m.
	9/3/13	3:50 p.m., 4:05 p.m.
	9/15/13	2:25 p.m.
	9/16/13	5:47 p.m., 5:49 p.m., 6:05 p.m.
	9/30/13	1:55 p.m., 7:50 p.m., 7:58 p.m.
	10/19/13	4:10 p.m., 4:20 p.m., 4:52 p.m.
Individual #202	10/22/13	12:18 p.m.
	10/23/13	4:45 p.m.
	10/27/13	1:14 p.m.
	10/28/13	11:31 a.m.
Individual #109	12/11/13	6:14 a.m., 8:49 a.m.

	12/12/13	2:26 p.m., 11:20 p.m.
	12/13/13*	4:28 p.m.
	12/15/13*	12:49 a.m.

- Individual Support Plans for: Individual #30, Individual #202, and Individual #109;
- Psychological Evaluations for: Individual #30, Individual #202, and Individual #109;
- Positive Behavior Support Plans for: Individual #30, Individual #202, and Individual #109;
- Individual Support Plan Addenda minutes for: Individual #30 (9/17/13, 9/30/13, 10/1/13, and 10/4/13) and Individual #109 (12/19/13 and 12/20/13);
- Psychology Monthly Progress Notes for: Individual #30 (8/13 to 9/13), Individual #202 (10/13 to 12/13), and Individual #109 (10/13 to 12/13);
- Crisis Intervention Restraint Instructions (draft) for Individual #30;

o **Sample #C.7**: There were no Protective Mechanical Restraints for Self-Injurious Behavior (PMR-SIB) listed in the pre-visit list of all restraints, and as a result, no sample was requested. On-site discussion revealed that there were three PMR-SIBs, and that there was some confusion about how often these restraints were entered into the database. A list was requested and provided on site, and one individual's record (i.e., Individual #389) was selected for this sample. The record included the following for the month of December 2013:

- The Restraint Checklist; and
- Related ISPA; and

o Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals:

- Individual #421 on 10/7/13 at 3:53 p.m.;
- Individual #30 on 10/19/13 at 4:10 p.m.;
- Individual #406 on 12/2/13 at 6:55 p.m.;
- Individual #56 on 12/20/13 at 12:08 p.m.;
- Individual #374 on 9/1/13 at 9:50 p.m.;
- Individual #333 on 12/15/13 at 3:12 p.m.; and
- Individual #273 on 9/8/13 at 5:35 p.m.

▪ **Interviews with**:

o Laura Cazabon-Braly, Facility Director;
o Mike Fitch, Assistant Director of Programs;
o George Schock, Interim Director of Incident Review and Management (DIRM);
o Stacey Thompson, Director of Behavioral Health Services;
o Kimberly Testa, Assistant Director of Behavioral Health Services;
o George Zukotynski, State Coordinator for Behavioral Health Services;
o Holly Lindsey, Director of Quality Assurance; and
o Informal interviews/conversations with staff and individuals.

	▪ **Observations of**: o The Quality Assurance/Quality Improvement Council, on 2/25/14; o Unit I Meeting, on 2/25/14; o Incident Management Meeting, on 2/25/14; o Pre-treatment Sedation Committee meeting, on 2/25/14; o Restraint Reduction Board, on 2/26/14; o Visits to Residences #782, #784, #786, and #787; and o Visits to day and vocational programs in buildings #527, #532, #533, and #544.
	Facility Self-Assessment: The Austin State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance with two of the 14 provisions in Section C of the Settlement Agreement. The Monitoring Team found the Facility to be in substantial compliance with two of the 14 provisions. In its Self-Assessment, dated 2/4/14 for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, and interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled: "Section C-Protection from Harm-Restraints," revised 9/16/13. ▪ This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. For example: for Section C.8, the only questions on the tool inquired as to whether the Unit Team and IMRT reviewed the restraint, but did not include information about the circumstances of the restraint or whether review by the IDT was needed and addressed. While the language in some portions of the monitoring tool was consistent with the provisions of the Settlement Agreement, further work was needed to assure the tool is comprehensive enough to provide the Facility with an indication of compliance. ▪ The monitoring tool included some adequate methodologies, such as the review of documentation. ▪ It was not clear if the Self-Assessment was based primarily on results of the quality assurance monitoring tool. The Self –Assessment needed to indicate how data was collected, if not through the use of the monitoring tool, who collected it, and what provisions were in place to assure inter-rater consistency. ▪ The Self-Assessment identified some of the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. ▪ The monitoring/audit tool included instructions/guidelines, which were not generally adequate to ensure consistency in monitoring. ▪ The following staff/positions were responsible for completing the audit tools: Program Compliance Monitors, the Director of Behavioral Services, and Behavioral Health Specialists. ▪ There did not appear to be a formal process in place to train or to determine whether the staff persons responsible for conducting the audits were competent in the use of the tools, and that they were clinically/programmatically competent in the relevant area(s). For Section C, no information

	was provided regarding inter-rater reliability. ▪ The Facility used some relevant data sources and was beginning use of some key indicators/outcome measures. For example, in addition to conducting audits, the Facility used data sources such as its training database and trend analysis reports, and data from other sections, such as Section J. Work had been done to develop key indicators (performance indicators) as explained in more detail with regard to Section E of this report. ▪ The Facility presented some of the data in a meaningful/useful way, but more work was needed. Specifically, the Facility: o Presented findings based on specific, measurable indicators rather than on overall composite scores. o Did not present data in charts and tables across six months to allow for easy comparisons. o Included comments and examples to explain differences or irregularities in data. o Did not include reviews of quality as well as presence of items. For example, the Facility did not include comments on the quality of IMRT reviews and the actions taken to improve quality. ▪ When the Facility data identified some areas in need of improvement, it provided analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in substantial compliance with two out of 14 provisions of Section C, as opposed to no provisions that were in substantial compliance during the last full compliance review (i.e., November 2012). Progress was noted in a number of areas. Highlights of progress included: ▪ A Restraint Review Board was in place and reviewing restraints on a regular basis, including screening videos of those restraints. As the meeting during the Monitoring Team's onsite review demonstrated, this was a useful and necessary process that had the potential to teach everyone involved about the difficult issues associated with restraint. For example, during the meeting as a result of viewing a video of a restraint, staff appropriately identified and reported for an investigation a potential use of prone restraint. This was an important finding and staff responded to it appropriately. As the Monitoring Team recommended while on site, given that two allegations existed regarding the potential use of prohibited restraints (i.e., this potential use of prone restraint and an allegation in an investigation of the use of supine restraint), a reminder to all staff about these prohibitions and what to do if an approved restraint could not be properly maintained would be prudent, until investigations were completed to determine if further action or training was needed. ▪ The Facility was beginning to clear up confusion over counting restraints. More specifically, those which involved breaks out and re-restraint were logged as a single restraint; and those in which individuals were released, but the restraints were followed shortly by another restraint were treated as two restraints with full documentation packets for each restraint. ▪ Rates of training on restraint use and Prevention and Management of Aggressive Behavior basic had improved considerably.

Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with all of Section C of the Settlement Agreement included the need to:

- Three individuals in the last six months had Protective Mechanical Restraint for Self-Injurious Behavior. Clarification was needed regarding entry of PMR-SIB data into AVATAR. For example, each use needed to be entered at least once a day for a restraint that was in constant use during a 24-hour period.
- It is essential that Restraint Checklists, and Face-to-face and Debriefing sheets record what was happening before the behavior that caused the restraint. If the answer is that nothing was happening, then the record should show what was supposed to be happening to help determine if restraints were being used in lieu of active programming.
- The Restraint Monitor needs to review the Restraint Checklist for accuracy, identify missing information, and supplement it if necessary in the Face-to-face and Debriefing form. For example, if the Restraint Checklist does not include information about the preceding behavior, then the Face-to-face and Debriefing form should indicate the Restraint Checklist was incomplete, and the Restraint Monitor should attempt to discover and record the missing information.
- Restraint Monitors might need extended training in PMAB principles, and need to be careful to avoid becoming involved in the restraint they are monitoring, or if they do, they should call in another Restraint Monitor.
- When the Incident Management Review Team reviews the restraint, there should be documentation in the minutes of discussion related to the restraint and any follow-up that needs to be done.
- To achieve closure on the issue of orders for medical and dental restraints, the physicians' orders should include the schedule and type of monitoring, and monitoring according to the prescribed schedule needs to be present in the restraint documentation.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment,</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.

Data supplied by the Facility for an eight-month and a sixth-month period showed:

<table>
<tr><th>Type of Restraint</th><th>12/1/12-7/31/13 (8 months)</th><th>8/1/13-1/31/14 (6 months)</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>178</td><td>61</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>22</td><td>22</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>3</td><td>3</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.

TOTAL restraints used in behavioral crisis	203	86
TOTAL individuals restrained in behavioral crisis	24	17
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	8	7
Medical/dental restraints	58/7	68/14
TOTAL individuals restrained for medical/dental reasons	7	14
TOTAL protective mechanical restraints for SIB	636	552
TOTAL Individuals restraint per PMR-SIB	3	3

Prone Restraint

a. Based on Facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (e.g., trend reports and lists of restraints) and observations, the use prone restraint was potentially identified, although the Facility needed to further investigate to determine if it had occurred. Specifically, in reviewing the sample for Section D of this report, Sample #D1.6, involved Individual #409 who was described as being restrained while lying on the floor by a staff member who held the individual's hands while seated in a chair above the individual and while another staff held his legs. Per this description, it would appear that the individual was in a supine restraint, which was prohibited by Facility policy. In addition, a member of the Monitoring Team viewed a video, during the meeting of the Restraint Reduction Board, of a restraint that appeared as though it might have been a prone restraint. A member of the Restraint Reduction Board appropriately reported the observation for investigation. As the Monitoring Team recommended while on site, given that two allegations existed regarding the potential use of prohibited restraints (i.e., prone and supine), a reminder to all staff about these prohibitions and what to do if an approved restraint could not be properly maintained would be prudent, until investigations were completed to determine if further action or training was needed.

A sample, referred to as Sample #C.1 (Reduced Sample), was selected. (A list is provided in the Documents Reviewed Section above.)

c. Based on a review of the 10 restraint records for eight individuals in Reduced Sample #C.1, none (0%) showed use of prone restraint.

d. Based on questions with 10 direct support professionals, all were aware of the prohibition on prone/supine restraint.

#	Provision	Assessment of Status	Compliance
		Other Restraint Requirements e. Based on document review, the Facility and State policies indicated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 (Reduced Sample) that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ f. In 10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. ▪ g. For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that seven (70%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. Those that did not included: Samples #C1.1, #C1.2, and #C1.3 where there was no clear description of what was happening prior to the behaviors that occasioned the restraints and no description of what was supposed to be happening. ▪ h. In eight of the records (80%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. The two that did not have such evidence were samples #C1.1 and #C1.2, where the only indication of less restrictive measures was in the debriefing, and then only "verbal and physical prompts," with no other indications, such as whether these were part of a positive behavior support plan or a crisis intervention plan or the use of PMAB techniques. ▪ i. Facility policies do identify a list of approved restraints. That list was included on the Crisis Intervention Restraint Checklist under "Method of Restraint," dated February 2013. Similar lists were included on the checklists for PMR-SIB and Medical/Dental restraints. ▪ j. Based on the review of ten restraints, involving ten individuals, ten (100%) were approved restraints. However, as discussed above, incidents of the Facility's processes had identified the potential use of unapproved restraints, but further investigation was needed.	

#	Provision	Assessment of Status	Compliance
		k. In seven of these records (70%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Examples where this was not the case included: ▪ Sample #C1.1 and #C1.2, where it was not clear what was going on prior to the behavior that caused the restraint or what was supposed to be going on. ▪ Sample #C1.3, where the individual was described as "walking around" prior to the aggressive behavior that caused the restraint, but it was not clear why she was walking around and not engaged in some productive activity. l. Of the three restraints reviewed that the Facility considered to be PMR-SIB, the Monitoring Team reviewed one (Sample C.7). Of these, none (0%) followed state policy regarding the use, management, and review of PMR-SIB. Based on a review of the record of the one individual in the sample: ▪ The required nurse, Behavioral Health Services staff, and Restraint Monitor did not check the restraints to assure the restraints were in good condition, properly applied, and not creating any medical concerns on a daily basis. ▪ Not all records included indications of meal time release or release other than for circulation checks. As indicated at the beginning of this subsection, the Facility remained in noncompliance with this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Twenty restraint records involving 11 individuals in Sample #C.1 (Full Sample) were reviewed. Of these, three were removed from review for this provision including: #C1.6 and #C1.19 (chemical restraints), and C.16, which was a dental restraint. Five of the restraints ended when the individual escaped restraint including: #C1.1, #C1.3, #C1.7, #C1.14, and #C1.20. Of the remaining 12 restraints, for six of the records, the individuals had Crisis Intervention Plans (CIP) that defined the use of restraint. a. For six restraints for individuals with Crisis Intervention Plans, five (83%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. The one that did not was: ▪ #C1.2, the CIP required holding the individual for five minutes without struggling,. There was not sufficient documentation to determine if she was held for the five minutes without struggling, or whether she was released as soon as she calmed. When CIPs include requirements for a delayed release, it means that the individual continues to present danger to herself or others for a time after she stops struggling. It is important to follow such instructions to avoid multiple restraints in rapid succession, which can increase the risk of injury to both the individual and the staff members involved.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In #C1.11 and #C1.12, the CIP was not clear about when or how to release. However the individual was released when no longer a danger and therefore met the basic release requirement. b. For six restraints for individuals that did not have Crisis Intervention Plans, six (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review the Facility was in substantial compliance with this provision. Only one of twelve releases were not according to the CIP or released when not a danger. Efforts should be made however, to assure that CIPs are clear about when and how to release restraints.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. b. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ 23 of the 24 had current training in RES0105 Restraint Prevention and Rules. The Behavioral Health Services employee had training in RES115 Supporting the Prevention and Safe Use of Restraint. Therefore 24 of 24 (100%) staff had the required training. ▪ 19 of the 19 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. ▪ 24 of the 24 (100%) had completed PMAB training within the past 12 months. ▪ 19 of the 19 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint? (100%);	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques (100%); and ▪ How would you supervise an individual in restraint? (100%). d. In two of the 20 records, restraints were applied immediately due to the imminent danger to peers (i.e., #C1.15 and #C1.16). In the remaining 16 records, there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Thus, 18 of 20 (90%) were applied as required. The two records that did not show evidence of use of a graduated range of less restrictive measures were #C1.1 and C1.2, where the only indication of less restrictive measures was in the debriefing, and then only "verbal and physical prompts," with no other indications, such as whether these were part of a positive behavior support plan or a crisis intervention plan or the use of PMAB techniques. Based on this review the Facility was in substantial compliance with this provision.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a reduced sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. a. Based on a review of 10 restraint records (Reduced Sample #C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. In review of 12 Positive Behavior Support Plans, in 11 (92%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). The exception was the PBSP for Individual #159. While not indicated as a consequence for problem behavior, it was noted that the application of mechanical restraints could serve as an antecedent for challenging behavior. There was no rationale or explanation for the use of restraints. c. In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. d. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list the Facility maintained. e. In three of three restraint records reviewed (i.e., the subsample of Sample #C.1)	Noncompliance

#	Provision	Assessment of Status	Compliance
		(100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form the Facility used to document restraint considerations/restrictions. f. In three of three restraint records reviewed (i.e., the subsample of Sample #C.1) (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing the sample of individuals for whom restraint had been used for the completion of medical or dental work (i.e., Sample #C.3): ▪ g. Three (30%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). Those that had signed forms in the restraint record were: sample #C3.1, #C3.2 and #C3.3. During the presentation at the entrance meeting, the Facility reported that 18 dental desensitization plans and three medical desensitization plans had been developed. This also was noted on the Medical Desensitization Report and the Dental Desensitization Report, both dated 1/27/14. The Monitoring Team requested six dental plans and one medical plan. In response to this request, the Facility reported that the Medical Department had not yet implemented any desensitization plans. A review of the dental plans is provided below. ▪ The six plans (100%) all involved the individual learning to allow staff to brush his/her teeth or learning to brush his/her teeth. ▪ The schedule of training was identified as daily in all of the plans (100%). More than one daily training session was clearly identified in only two plans (33%). It is suggested that frequent training opportunities be provided each day to ensure that learning occurs. ▪ Three of the six plans (50%) indicated that a musical toothbrush and flavored toothpaste should be used to enhance individual cooperation. ▪ Five of the six plans (83%) noted that data should be recorded on three specified days each week. The sixth plan indicated that data should be recorded daily. ▪ None of the plans (0%) provided to the Monitoring Team involved visits to the dentist or medical doctor. The Facility was commended for ensuring that the need for pre-treatment sedation was discussed and approved or disapproved at the annual ISP meeting. Of the 12 individuals whose ISPs were reviewed for Section S.1, 10 individuals (83%) had been approved for pre-treatment sedation for dental procedures and 11 individuals (92%) had been approved for pretreatment sedation for medical procedures. For all but one of these individuals (i.e., Individual #153), this was clearly outlined in the rights restriction	

#	Provision	Assessment of Status	Compliance
		section of the ISP. (In the ISP for Individual #406, it was noted that he did well with medical exams and procedures on campus, yet he was approved for sedation without restrictions). Three of these 10 individuals (30%) had a skill acquisition plan included in their ISP for tooth brushing. The Integrated Health Care Plan suggested that encouragement or assistance should be provided to address adequate tooth brushing for five individuals (50%). One individual (10%) was to begin a desensitization plan that involved his visiting the dentist or clinic once each month, one (10%) was to start a desensitization plan that was not described, and one (10%) was to be assessed for a desensitization plan. For three individuals (30%), there was nothing in the ISP to address improved tooth brushing or desensitization planning. Of the 10 individuals who had been approved for pre-treatment sedation for dental procedures, seven had a high dental risk identified in their Integrated Risk Rating Form. Individual #448 had an identified medium risk rating, because she only occasionally required pre-treatment sedation. The ISPs for two individuals did not include their IRRFs. During future review, the following metrics will be used to assess compliance: ▪ h. ___ (___%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and ▪ i. ___ (___%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. While evidence of Human Rights Committee consent was not provided for the 12 individuals in the sample or the six individuals for whom a plan was reviewed, there was evidence of review of pre-treatment sedation at the HRC meeting held the week of the visit. Following a presentation of the rights assessment packet for Individual #98, there was a thoughtful discussion regarding plans to address his pre-treatment sedation. Individual #291, who is a member of the committee, presented some of the best comments and questions. When Individual #291 asked whether Individual #98 could visit the dentist just to reduce his anxiety, the QIDP responded that due to his autism diagnosis, he did not like change. He also noted that Individual #98 did not like to be touched. In response, Individual #291 asked why both issues could not be addressed. It was heartening to see these challenging questions, because the individual's reliance on routines and aversion to touch could both be addressed with gradual shaping programs. It was discouraging to hear that the team for this 21-year-old man "…has determined that he will most likely always need sedation." It is suggested that there should be some attempt to eliminate pre-treatment sedation through careful planning and program implementation. When summarizing the necessary changes to the request to the HRC for consent, it was positive to note that the HRC chair indicated that objective criteria was necessary to determine the efficacy of any plan. Individual #291 also questioned the continued inclusion of TIVA in rights assessment	

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		packets. He suggested that staff should know that intravenous sedation had been discontinued. The HRC chair responded that although TIVA had been discontinued several months ago, there might be some QIDP staff who were not aware of this change. It would appear that this significant change should have been clearly communicated. Although the Facility had initiated a careful review of all individuals regarding their need for pre-treatment sedation for dental and/or medical work, there remained very little evidence of comprehensive planning to address this very restrictive practice. For this reason, the Facility remained out of compliance with this provision of the Settlement Agreement.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a reduced sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. a. Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. However, based on the tape reviewed in the Restraint Reduction Board meeting, it appeared as though the Restraint Monitor was becoming involved in restraining the individual. The Facility must guard against the involvement of the Restraint Monitor in the restraints, and train the Restraint Monitors to call for another monitor if their involvement becomes unavoidable. c. Based on review of training records, of the four staff at the Facility who performed the duties of a Restraint Monitor in the sampled records, three (75%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. In sample #C1.7, the name of the Restraint Monitor was not found on the list of trained monitors provided in response to the document request. Based on a review of ten restraint records, including eight physical and two chemical restraints (Reduced Sample #C.1), a face-to-face assessment was conducted: ▪ d. In nine out of ten incidents of restraint (90%) by an adequately trained staff member. Records that did not contain documentation of this included: sample #C1.7. ▪ e. In eight out of ten instances (80%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: Sample #C1.8, where the time the Restraint Monitor arrived was not listed, and #C1.9, where it was not clear when the individual returned from the Emergency Room. ▪ f. In four of the eight instances of physical restraint (50%), the documentation	Noncompliance

#	Provision	Assessment of Status	Compliance
	return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: o Sample # C1.1 and #C1.2, where the Restraint Checklists did not provide information of the behavior prior to the behavior that occasioned the restraint, and where actions used to prevent the use of restraint were unclear and the Face-to-face assessment did not clarify; o Sample #C1.9, where the Restraint Checklist did not indicate when the individual returned from the Emergency Room and included a nursing monitoring checklist that was dated hours before the restraint, and the Face-to-face assessment did not provide clarification; and o Sample #C1.10, where the Restraint Checklist indicated the environment had been changed, but the restraint started and ended in the dining room, and the prior behavior involved the individual requesting seconds, but none were available, but the Face-to-face did not question or clarify how the environment was changed or whether the individual was entitled to seconds. ▪ g. In nine instances (90%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: Sample #C1.6, where a chemical restraint was used, but the Face-to-face did not include an assessment of the consequences. There were no records for which physicians had ordered alternative monitoring schedules. Had there been, the following metrics would have been assessed. ▪ h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of six restraint records for six individuals for restraints that occurred at the Facility (i.e., Individual #421, Individual #30, Individual #406, Individual #56, Individual #374, and Individual #273), there was documentation that a licensed health care professional: ▪ j. Initiated monitoring at least every 30 minutes from the initiation of the restraint in four (67%) of the instance of restraint. Records that did not contain documentation of this included: Individual #406 on 12/2/13 at 6:55 p.m., and Individual #56 on 12/20/13 at 12:08 p.m. ▪ k. Monitored and documented vital signs in four (67%) episodes. Records that did not contain appropriate documentation of this included: Individual #56 on 12/20/13 at 12:08 p.m., and Individual #374 on 9/1/13 at 9:50 p.m. Problematic issues that resulted in noncompliance included vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required.	

#	Provision	Assessment of Status	Compliance
		▪ l. Monitored and documented mental status in three (50%) episodes. Records that did not contain appropriate documentation of this included: Individual #56 on 12/20/13 at 12:08 p.m., Individual #374 on 9/1/13 at 9:50 p.m., and Individual #273 on 9/8/13 at 5:35 p.m. Problematic issues that resulted in noncompliance included either the mental status was not recorded, or was generic such as "alert, awake, responsive" without a specific description of the behavior included to support the generic documentation. Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. A sample of one was reviewed (Individual #333). A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in one out of one (100%). ▪ n. Monitored and documented vital signs in one (100%). ▪ o. Monitored and documented mental status in one (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. (Sample C.3 is defined above in the Documents Reviewed section.) However, upon review, it was apparent that sample #C3.1 was a crisis intervention restraint where a chemical restraint was ordered to induce the individual to leave her mother's car. This was clearly not a medical restraint and should not have been coded as such. For purposes of the following, #C3.1 was eliminated from the data. For the remaining nine individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In one out of nine (11%), the physician specified the schedule of monitoring required or specified Facility policy regarding this was to be followed. That one was Sample #C3.2, where a physical restraint was ordered. ▪ q. In one out of nine (11%), the physician specified the type of monitoring required if it was different than the Facility policy. That one was #C3.2. ▪ r. In one out of nine of the medical restraints (11%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. That one was #C3.2 (physical restraint). Sample #C3.4 was monitored appropriately according to the Nursing Protocol: Pre-treatment and Post-Sedation Monitoring for the first 12 hours, but nursing staff did not proceed to monitor every four hours for the remaining of 24 hours. For the rest, the physician did not specify the schedule or type of monitoring, and did not reference the nursing protocol as the appropriate type and schedule of monitoring. Nurses did not follow the protocol consistently with regard to the intervals between monitoring that the protocol required. Based on this review, the Facility was not in substantial compliance. More work was needed to assure that Restraint Monitors accurately assessed the application of restraints	

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		and questioned staff about behaviors prior to the ones that necessitated the restraint, documented the results, and refrained from designating the Restraint checklist as correct, if it failed to document this important information. It will be important to resolve how physicians document the schedule and type of monitoring in their orders, and for nurses to follow the ordered schedules or at least follow the nursing protocol when the order does not specify.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a reduced sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A sample (Reduced Sample #C.1) of ten Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In ten (100%), continuous one-to-one supervision was provided; ▪ b. In ten (100%), the date and time restraint was begun; ▪ c. In ten (100%), the location of the restraint; ▪ d. In seven (70%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. The three that did not were Sample #C1.1, #C1.2, and #C1.3 (as discussed above with regard to Section C.1). ▪ e. In eight (80%), the actions staff took prior to the use of restraint to permit adequate review per Section C.8. Those that did not were #C.1.1 and C.1.2. The information provided in the record about steps to avoid restraint should include the order of the activities and the amount of time involved in pursuing them. However, from a practical perspective, it is not realistic to expect direct support professionals to accurately recall the order and time involved in often rapidly progressing events. Therefore, if staff had at least recorded the types of actions taken, and did not list actions that could not have been done (such as following an individual's PBSP when he did not have one), a listing was rated as acceptable. However, whenever it is possible to document the order and the time involved in trying to prevent the restraint, this should be documented, since it will provide better information on which to determine future actions. ▪ f. In ten (100%), the specific reasons for the use of the restraint ▪ g. In ten (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In ten (100%), the names of staff involved in the restraint episode; ▪ Observations of the individual and actions taken by staff while the individual was in physical restraint (i.e., eight episodes in the sample), including: o i. In eight (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any	Noncompliance

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		duration); o j. In one of one (100%) restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint were recorded; and o k. There were no restraints in the sample that lasted more than 30 minutes, so the following metric was not rated: In ___ (___%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. o l. In eight (100%), the level of supervision provided during the restraint episode; and o m. In eight (100%), the date and time the individual was released from restraint. Based on a review of seven restraint records for seven individuals for restraints that occurred at the Facility (i.e., Individual #421, Individual #30, Individual #406, Individual #56, Individual #374, Individual #333, and Individual #273): ▪ n. In all seven episodes (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were appropriately documented. o. In a sample of ten records (Reduced Sample #C.1), restraint debriefing forms had been completed for nine of the nine for which this was possible (100%). The one that did not was sample #C1.10, where an allegation prevented the completion of the debriefing form, since staff were not allowed to pursue any investigations pending the outcome of the DFPS case. p. A sample of nine individuals subject to medical restraint was reviewed (Sample #C.3 minus #C3.1, which was a crisis restraint), and in one (11%), there was evidence that the monitoring had been completed as required by the physician's order. This resulted from the lack of information in the orders about what schedule and type of monitoring was required, and from lack of monitoring according to the nursing protocol (as discussed in further detail with regard to Section C.5). The one that was completed was a physical restraint, Sample #C3.2. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. This sample of two individuals who were the subject of a chemical restraint was reviewed (i.e., #C1.3 and #C1.6). q. In one (50%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who	

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		assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The one that was not was sample #C1.3, where the contact with the psychologist was after the administration of Ativan. Based on this review, the Facility was not in substantial compliance with the provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Prior to assessing the Facility's response to individuals who were placed in restraint more than three times in a rolling 30-day period, it is important to note changes that the Facility had initiated. At weekly meetings of the Restraint Review Board, members were reviewing videotaped recordings of all restraints that had occurred in the previous seven days. This review included an assessment of the seriousness of the events leading to restraint, whether a graduated range of less restrictive measures had been employed, whether the restraint was terminated as soon as appropriate, whether an appropriate technique had been employed, and the identification of contributing environmental factors. Recommendations and plans of action followed with responsible parties and due dates identified. This was a very promising practice that will hopefully result in improved supports and reduced restraint. According to the Facility's documentation, between 7/13 and 12/13, crisis intervention restraint was utilized more than three times in a rolling 30-day period for seven individuals. Three of these individuals were selected for review. For Individual #30, Individual #202, and Individual #109, four or more restraints that met this criterion were identified and reviewed. Documents reviewed for these specific incidents included: Crisis Restraint Checklists, Restraint Face-to-Face Assessment, Pre- and Post-Chemical Restraint Review (when appropriate), Individual Support Plan, Psychological Evaluation, Positive Behavior Support Plan, Crisis Intervention Plan, ISP Addenda, and Psychology Monthly Progress Note. For two of the five instances (40%) of more than three restraints in 30 days, the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The following are examples where teams met and utilized the Individual Support Plan addendum to guide the discussion: ▪ On 9/17/13, the team for Individual #30 met in response to restraints that had	Noncompliance

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		occurred between 9/3/13 and 9/16/13. Follow-up ISPAs were held on 9/30/13, 10/1/13, and 10/4/13, but these were not held to specifically address repeated restraints. ▪ On 12/19/13, the team for Individual #109 met with a follow-up meeting held on 12/20/13. For three of the five instances (60%) of more than three restraints in 30 days, the team failed to meet within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The following are examples where teams failed to meet: ▪ Individual #30 had been restrained five times between 8/6/13 and 8/27/13. There was no evidence that his team had met to review these restraints. ▪ Similarly, Individual #30 had been restrained six times between 9/30/13 and 10/19/13. His team failed to meet regarding these restraints. ▪ There was no ISP addendum reflecting a meeting of the team for Individual #202. However, psychology progress notes referenced an Administrative Review Team (ART) meeting held on 10/31/13, which would have met the criterion for meeting with 10 business days. The minutes from this meeting were not provided to the Monitoring Team, therefore, an analysis of the review cannot be provided. When the individuals' teams met to discuss repeated restraint, it was evident that a discussion had taken place regarding the individuals' adaptive skills, as well as biological, medical, and psychosocial factors. For two individuals (67%), there was evidence that the team hypothesized that one or more factors that affected the behavior that resulted in restraint. Recommended action plans were identified in each case. As a result, of these two, there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint in <u>two</u> of the cases (100%). Examples included the following: ▪ The team for Individual #30 reviewed two factors that may have contributed to his repeated restraint. These are summarized below: o The team noted that due to a diagnosis of obesity, Individual #30 was on a low calorie diet. His meant intake was also restricted due to his diagnosis of hypertriglyceridemia. It was recognized that these restrictions might contribute to some of his difficulties. The team was working with a dietician and his physician to develop possible alternatives to these restrictions. o At repeated ISPAs, the team for Individual #30 reviewed his medication and appropriate dosing. ▪ The team for Individual #109 reviewed factors that may have contributed to the use of restraint. These are summarized below:	

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		o The team noted a recent increase in psychiatric symptoms. Before adjusting or changing her medication and in response to an increased heart rate, her physician wanted her seen at the local emergency room to rule out any heart issues. An EKG and laboratory analyses were requested. There were several concerns regarding treatment planning for Individual #202: ▪ The Psychological Evaluation for Individual #202 dated 10/3/13, provided a review of an ART meeting held on 10/31/13. One of the recommendations was to conduct a medical exam to rule out medical causes or complications related to his enuresis and encopresis. At that time, it was noted that these were planned and still pending. It was of concern that this exam had still not taken place by the end of December as noted in the Psychology Progress Note. ▪ This individual was very resistant to bathing. All of the restraints resulted from his becoming aggressive when staff prompted him to bathe following a toilet accident. Although it appeared that a sponge bath had been recommended, there was no evidence of a carefully designed program to increase his compliance with hygiene tasks. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely reviews of more than three restraints in a 30-day period, a comprehensive analysis of adaptive skills, along with biological, medical, and psychosocial factors is required.	
	(b) review possibly contributing environmental conditions;	For two of the five instances of more than three restraints in 30 days (40%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. When the individuals' teams met to discuss repeated restraint, it was evident that a discussion had taken place regarding environmental conditions. For two individuals (67%), there was evidence that the team hypothesized that one or more factors that affected the behavior that resulted in restraint. Examples included the following: ▪ The team for Individual #30 noted that a preferred staff member had moved out of the home recently. They also noted that increased supervision might have contributed to an increase in aggression towards staff members. Lastly, it was noted that staff were having difficulty implementing a daily schedule. It was agreed that members of the team would monitor the effectiveness of the daily schedule. ▪ The team for Individual #109 had discussed plans for her return from the hospital. As loud and busy environments can be unpleasant for her, it was agreed that the staff would plan for a quiet environment with limited contact with her	Noncompliance

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		peers. It was also agreed that sharp objects would be removed from her room to ensure her safety. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two of the cases (100%). The Facility remained in noncompliance with this provision due to teams not consistently meeting to discuss and address potential environmental conditions.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For two of the five instances of more than three restraints in 30 days (40%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. For two of the individuals (67%), there was evidence of discussion of potential environmental and psychosocial antecedents to problem behaviors that may lead to restraint. Further, it was clear that the teams were addressing at least one antecedent variable for each individual. The team for Individual #30 was working with the dietician and physician to address his restricted diet, and the team for Individual #109 was trying to ensure a quiet environment upon her return from the hospital. As a result, Of these two individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in <u>two</u> of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two of the cases (100%). For Individual #202, there was no evidence of any action plans to address his poor sleeping patterns or lack of engagement, both of which were identified as antecedent variables in his Psychological Evaluation. While a review of the outcome of a structural assessment of problem behavior was included in the Psychological Evaluation for all three individuals (100%), there were several problems identified: ▪ The most recent Psychological Evaluation for Individual #30 was completed on 1/18/12. Information regarding setting events and antecedent conditions contributing to problem behavior had been gathered in 2011. Both the Psychological Evaluation and a structural assessment should have been updated. ▪ The Psychological Evaluations for Individual #202 and Individual #109 identified both setting events and antecedent conditions, but in neither report were the activities involved or the date of completion of the structural assessment identified.	Noncompliance

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		Although not discussed in an ISPA meeting, there was a review of the symptoms of autism included in the Psychological Evaluation for Individual #30. It is recommended that staff reference DSM-V when reviewing characteristics. In this report, it was suggested that Individual #30 displayed a "poker face," was not "chatty," was "self-centered," had "odd habits," and was "obsessed" with activities. Each of these terms has a negative connotation and does not clearly or thoughtfully identify the difficulties this young man might experience. This did not contribute to thoughtful planning to address his needs. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely and comprehensive reviews of more than three restraints in a 30-day period, structural assessments should be updated annually or more frequently in response to worsening behavior.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For two of the five instances of more than three restraints in 30 days (40%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. For two of the individuals (67%), there was evidence of discussion of potential factors that were maintaining problem behaviors that may lead to restraint. While a review of the outcome of a functional assessment of problem behavior was included in the Psychological Evaluation for all three individuals (100%), there were several problems identified: ▪ The most recent Psychological Evaluation for Individual #30 was completed on 1/18/12. Information regarding variables that were potentially maintaining problem behavior had been gathered in 2011. Both the Psychological Evaluation and a functional assessment should have been updated. ▪ The Psychological Evaluations for Individual #202 and Individual #109 identified variables that were potentially maintaining problem behavior, however in neither report were the activities involved or the date of completion of the functional assessment identified. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely and comprehensive reviews of more than three restraints in a 30-day period, functional assessments should be updated annually or more frequently in response to worsening behavior.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the	Each of the three individuals reviewed (100%) had a Positive Behavior Support Plan (PBSP) in place at the time of repeated restraint. The review of these PBSPs is summarized below: ▪ In the PBSPs provided for three individuals (100%), there was evidence of	Noncompliance

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	objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	operationally defined problem behaviors. ▪ In the PBSPs for two of the three individuals (67%), there was evidence of functionally equivalent and operationally defined replacement and/or alternative behaviors. o Individual #30 was learning to wait for desired items, he was learning to request and wait for desired items, he was learning to ask for a break when prompted by staff, he was learning to use a picture schedule to structure his day, and he was learning to display appropriate social interactions when greeting others. One suggestion would be to eliminate hugs or "fist bumps," as these may encourage inappropriate forms of physical contact. o Individual #109 was learning to tell staff that she wanted to leave an activity or setting, and she was learning to transition to a "safe" location identified as either her room or the back porch. ▪ In the PBSPs for three individuals (100%), there was evidence of other programs designed to reduce or eliminate the problem behaviors that led to restraint. o Individual #30 was to be provided warnings prior to changes in his routine, offered choices, encouraged to engage in daily exercise, and engage in a quiet and "calming" activity prior to bed. o Individual #202 was to receive approximately five minutes of individualized attention every half hour. He also was to access some preferred activity every hour contingent upon the absence of targeted problem behavior. He was also to receive edible reinforcement following appropriate use of the toilet. o Individual #109 was to be prepared for novel and possibly loud/crowded environments by identifying a "safe" place for her to transition to, and by offering her the opportunity to remain on the perimeter of the activity. One concern was raised as the ISP noted that she was involved in counseling. There was no evidence of her participation in this therapeutic support at the time of her repeated restraints. ▪ In the PBSPs for three individuals (100%), there were clearly specified interventions designed to reduce or eliminate the behaviors that led to restraint. Only one of the three individuals in the sample (33%) had Crisis Intervention Restraint Instructions (draft). On 9/17/13, the IDT had approved the plan, but according to notes included in the ISPAs, the guardian's consent had not yet been obtained, nor had this gone through Human Rights Committee for approval. Minutes from the 9/23/13 meeting of the Behavior Therapy Committee indicated this had been reviewed internally. A summary of the review of this document is provided below: ▪ None of the one plans (0%) delineated the type of restraint authorized. The	

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		types of approved physical intervention were described as "…up to a PMAB two-person horizontal (side-lying) restraint." Staff should specifically identify each of the approved forms of restraint. It was appropriate that the plan clearly identified the exclusion of mechanical restraints. ▪ One of the one plans (100%) specified the maximum duration of restraint authorized. The maximum duration of the restraint prior to an attempted release was 15 minutes. ▪ For one of one plan (100%), the observed behaviors that constituted a crisis situation was clearly described. ▪ None of the one crisis intervention plans (0%) specified the criteria for terminating the use of the restraint in a sufficient manner. The criterion for release from restraint was identified as when the individual was "…no longer a danger to himself or others (i.e., no struggling, yelling, attempting to injure staff, etc. for 5 consecutive minutes)." It is suggested that there should be a clear rationale provided for this long duration of "quiet" or "calm" behavior. It would be possible for the individual to meet the criterion for four and one-half minutes, but then yell for 30 seconds. This could result in continued restraint. Administrative review may be required at some point in the restraint to ensure that the hold is not unnecessarily prolonged. ▪ It should be noted that a Safety Plan for Crisis Intervention had been developed one to two years earlier. (The plan was not dated, although the service objectives covered the period of time between 12/11 an 12/12.) It is unclear whether this had ever been implemented or whether it had been discontinued. It is noteworthy that in the face-to-face assessment following a restraint on 9/16/13, staff were quoted as saying: "Restraint instructions might be needed." The Facility remained out of compliance with this provision of the Settlement Agreement. Positive Behavior Support Plans will need to be developed and implemented in a timely manner and will need to include comprehensive prevention strategies, functionally equivalent replacement behaviors with adequate training guidelines, and enriched schedules of reinforcement for appropriate behavior. Crisis Intervention Plans should be developed in response to repeated restraints and should clearly outline approved forms of restraint with clear and appropriate guidelines for release.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written	As reported by the Facility, there was no assessment of treatment integrity for any of the individuals in this sample during the period of repeated restraints. The Facility remained out of compliance with this provision of the Settlement Agreement. Improved staff training and supervision will be necessary to ensure a high level of treatment integrity for all plans.	Noncompliance

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	upon each occurrence of a targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	As noted above, each of the three individuals in the sample had a PBSP in place at the time of repeated restraint. Specific dates of review and/or revision are addressed below. ▪ On 9/30/13, the PBSP for Individual #30 was revised. The primary changes were to the replacement behaviors. These were clarified and addressed a variety of communication and social skills. ▪ The most recent revision to the PBSP for Individual #202 had occurred two months before he experienced repeated restraints. It should be noted that his Psychology Progress Notes from 10/13 through 12/13 included the same recommendations to "complete the PBSP revision and CPA updates." It is suggested that these should have been addressed in a timely manner. On a positive note, on 1/17/14, his case was presented before the External Peer Review Committee. The Facility reported that follow-up review occurred at the Behavior Therapy Committee on 1/29/14, but the meeting minutes were not available. ▪ Individual #109 had experienced repeated restraints the month before her scheduled annual ISP meeting. It was suggested that the PBSP would be reviewed at that time. In summary, in three of the cases (100%), changes to the PBSP were necessary. Of these, there was evidence of a revision to the PBSP in a timely manner in one of the cases (33%). The Facility remained out of compliance with this provision of the Settlement Agreement. When the team identifies necessary changes to programming and/or suggests revisions to the PBSP, these should occur as soon as possible.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a reduced sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A sample of documentation related to three incidents of crisis intervention restraint was reviewed, including: Sample #C1.4, #C1.5, and #C1.8. Documents reviewed included documents provided for Sample C1. This documentation showed that: ▪ a. In three (100%), the review by the Unit IDT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. ▪ b. In three (100%), the review by the IMRT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist.	Noncompliance

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		▪ c. In three (100%), the circumstances under which the restraint was used was determined, and was documented on the Face-to-Face Assessment and/or Debriefing form, including the signature of the staff responsible for the review. ▪ d. In none (0%), was the review conducted by the Unit IDT and the IMRT sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. o Sample #C1.4: No unit minutes were provided. The IMRT minutes consisted of entries on a chart to indicate when the restraint happened. The circumstances of the restraint started with his unwillingness to leave NEOS at closing time and escalated into attacks on staff when he reached his home. However, there was no record of any discussion of the restraint, such as what the individual was supposed to be doing when the behaviors occurred that necessitated restraint or whether staff were following his PBSP correctly. There was no discussion of what steps should be taken if this individual reacted similarly to the ending of a favored activity in the future. o Sample #C1.5: There were no unit minutes, and IMRT minutes consisted of dates on a chart with no record of discussion, recommendations, questions or any indication of a thorough review of the restraint, such as whether his daily schedule had been followed, whether sign language had been used during efforts to deescalate his behavior, etc. o Sample #C1.8: There were no unit minutes, and IMRT minutes consisted of a chart with numbers filled in and no record of discussion, such as why the Face-to-face assessment did not include the time the monitor arrived or whether there was an adequate routine for getting this individual to bed and whether the routine had been followed. ▪ e. In none (0%), referrals were made to the team, as appropriate. Had there been discussions as indicated in C.8.d above, referrals to IDTs might have been made to assure that schedules for these individuals were being followed or were adjusted if needed. ▪ f. None were referred to the team. If they had been, the following metric would have been rated: Of the ___ referred to the team, ____ appropriate changes were made to the individuals' ISPs and/or PBSPs. The Facility remained in noncompliance with this provision.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC Policy #II.B.13: Protection From Harm – Abuse, Neglect and Exploitation (ANE), dated November 2013; o AUSSLC Policy #II.B.4: Incident Management, dated November 2013; o AUSSLC Policy #II.B.7: Client Injury, dated November 2013; o Staff Reassignment Log in response to Document Request TX-AU-1402-III.22, undated; o Presentation Book for Section D; o AUSSLC Self-Assessment for Section D, dated 2/4/14; o AUSSLC Action Plan for Section D, dated 2/7/14; o Facility Investigator Training Chart, undated; o Adult Protective Services (APS) Training Transcript Crosswalk – Austin, undated; o List of ANE Investigations for six months, date range unspecified; o List of Investigations by the Facility Only for six months, date range unspecified; o Log of Employees Reassigned Due to ANE for a six-month period, date range unspecified; o Section D – Injury Audit Review (Under Reporting) tool, revised April 2013; o Section D – Settlement Agreement Cross-Referenced with ICF/ID Standards: Protection from Harm – Abuse, Neglect and Incident Management tool, revised February 2013; o Section D – Rights, Zero Tolerance for Abuse, Zero Tolerance for Retaliation Posters, dated April 2013; o Injury Trending Report with data through 11/30/13, undated; o Abuse/Neglect/Exploitation Trending with data through 9/30/13, undated; o Unusual Incidents Trending For All Types with data through 9/30/13, undated (included restraint and peer-to-peer aggression data); o **Sample #D.1 (Reduced Sample)**: was drawn from the list the Facility provided in response to Document Request TX-AU-1402-III.18. The following documents were requested for nine investigation records in the Reduced Sample, as well as the additional eight in the Full Sample: • The Unusual Incident Report (UIR); • The record of the call; • The final Department of Family and Protective Services (DFPS) investigation report; • Any extension approval; • The documentation of any disciplinary action; • Documentation that any recommendations were implemented; • Any correspondence/notification from Office of Inspector General (OIG) or law enforcement agencies;

- Documentation of supervisory review of the investigative report; and
- Any checklist maintained by the Facility or DFPS.

Sample ID#	Date Notified	Facility #	DFPS #
D1.1	12/17/13	14-090	42967112
D1.2	10/31/13	14-062	42919703
D1.3	9/18/13	14-017	42871666
D1.4	12/3/13	14-083	42952060
D1.5	12/8/13	14-087	42957843
D1.6	11/14/13	14-071	42934762
D1.7	9/14/13	14-013	42867632
D1.8	10/19/13	14-052	42906355
D1.9	9/30/13	14-031	42885358

- **Sample #D.1 (Full Sample)**: The full sample includes 18 investigation records. The following were added to the nine in the Reduced Sample above:

Sample ID#	Date Notified	Facility #	DFPS #
D1.10	10/15/13	14-045	None indicated
D1.11	10/14/13	14-041	42823654
D1.12	8/28/13	13-234	42848812
D1.13	9/9/13	14-008	42861004
D1.14	9/11/13	14-010	42863600
D1.15	10/29/13	14-060	42917241
D1.16	11/2/13	14-065	None indicated
D1.17	8/2/13	13-224	42824306
D1.18	11/20/13	14-075	42941976

- **Sample #D.2:** was drawn from a list the Facility provided in response to Document Request TX-AU-1402-III.19. The full sample included five records. One was eliminated because it was not a Facility-only investigation. The records requested were to include:
  - The Unusual Incident Report;
  - The record of the call;
  - Any extension approval;
  - The documentation of any disciplinary action;
  - Documentation that any recommendations were implemented;

- Any correspondence/notification from OIG or law enforcement agencies;
- Documentation of supervisory review of the investigative report; and
- Any checklist maintained by the Facility.

Sample #	Date	Facility #
D2.1 *	10/18/13	14-051
D2.2	10/21/13	14-055
D2.3	11/1/13	14-064
D2.4	12/7/13	14-086
D2.5	12/28/13	14-099

* Removed: not "Facility Only."

- **Sample #D.3**: none chosen;
- **Sample #D.4**: the sample of 13 Individual Support Plans drawn from those ISPs provided in Section C and Section F records, including ISPs for Individual #421 (11/28/13), Individual #30 (3/5/13), Individual #406 (1/29/13), Individual #246 (9/12/13), Individual #56 (5/24/13), Individual #374 (4/11/13), Individual #333 (8/23/13), Individual #273 (3/27/13), Individual #153 (9/18/13), Individual #133 (11/8/13), Individual #405 (11/13/13), Individual #307 (11/29/13), and Individual #390 (11/1/13);
- **Sample #D.5**: a subsample of the investigations included in Samples #D.1 and #D.2. This included investigation reports in which programmatic recommendations were made and/or the IMRT made recommendations. The normal minimum is five, but three were selected, because this was a reduced sample. Documentation was requested and reviewed to show whether or not follow-up had been completed to address the recommendations resulting from these investigations. The sample included:

Sample ID#	Name	Date Notified	Facility #	DFPS #	Type	Outcome
D1.1	Individual #109	12/17/13	14-090	42967112	Neglect	Confirmed
D1.3	Individual #421	9/18/13	14-017	42871666	Verbal	Inconclusive
D2.2	Individual #60	10/21/13	14-055	----------	Serious injury	----------

- **Sample #D.6**: a sample of audits not drawn, since the parties agreed to "update only." Audit samples included in the Presentation Book were reviewed; and
- **Sample #D.7**: sample of action plans developed as a result of trend analysis was not selected, since this related to an "update only" section of the report.

- **Interviews with**:
  - Laura Cazabon-Braly, Facility Director;

- Mike Fitch, Assistant Director of Programs;
- George Schock, Interim Director of Incident Review and Management;
- Holly Lindsey, Director of Quality Assurance; and
- Informal interviews/conversations with staff and individuals.

- **Observations of**:
  - The Quality Assurance/Quality Improvement Council, on 2/25/14;
  - Sunrise Unit Meeting (building #790), on 2/25/14;
  - Incident Management Meeting, on 2/25/14;
  - Visits to Residences #782, #784, #786, and #787;
  - Visits to day and vocational programs in buildings #527, #532, #533, and #544.

Facility Self-Assessment: The AUSSLC Self-Assessment indicated the Facility was in substantial compliance with 15 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with ten of the 22.

It was not clear that the conclusions the Facility drew were based on sufficient or objective data. The provisions of Section D for which there were differences between the Monitoring Team's and the Facility's findings are described in the following chart:

Provision	Facility Self-Assessment	Monitoring Team's Finding	Comment
D.2.b	Substantial Compliance	Noncompliance	Reduced sample
D.2.c	Noncompliance	Substantial Compliance	Full sample
D.2.e	Substantial Compliance	Noncompliance	Full sample
D.3.a	Substantial Compliance	Noncompliance	Full sample
D.3.b	Substantial Compliance	Noncompliance	Full sample
D.3.f	Substantial Compliance	Noncompliance	Reduced sample
D.3.h	Substantial Compliance	Noncompliance	Reduced sample

The Facility submitted a Self-Assessment for Section D, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

For Section D, in conducting its self-assessment:

- The Facility used monitoring/auditing tools: Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:
  - The monitoring/audit tools the Facility used to conduct its self-assessment consisted of:
    - A template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management;"
    - Section D – Rights, Zero Tolerance for Abuse, Zero Tolerance for Retaliation

	Posters, dated April 2013; and ▪ Section D – Injury Audit Record Review (Under-Reporting). o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement. o The monitoring tools included some adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed. Interviews and observation were to be conducted as appropriate. However, "appropriate" was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist of documentation review alone. o The Self-Assessment identified the sample(s) sizes, but did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Per the Quality Assurance Matrix, sample sizes for monthly monitoring were set at 50% of a month's actual cases. Some samples in the Self-Assessment appeared larger, such as auditing of staff acknowledgement of obligations to report ANE. o According to the information provided, inter-rater reliability was not regularly reviewed and had not been consistently established between the various Facility staff responsible for the completion of the tools. o The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitors from the Quality Assurance Department worked collaboratively with Department staff to conduct the audits. (Department staff positions were identified in the QA Matrix as the Director of Incident Review Management, investigator, Program Compliance Staff, and Campus Administrators (i.e., for under-reporting audits). o It could not be determined from the information provided whether the staff persons responsible for conducting the audits were competent in the use of the tools, and whether they were clinically/programmatically competent in the relevant area(s). ▪ The Facility used some relevant data sources: In addition to data from the audits of investigation files, the Facility also cited some other data in its Self-Assessment. For example, it used data from the Competency and Training Department database on ANE training. The Facility did not present data on key indicators or outcome measures in its Self-Assessment, since those appeared to be in early stages of development. ▪ The Facility consistently presented some data in a meaningful/useful way. Specifically, in the Facility's Self Assessment: o Many of the findings were presented as specific, measurable indicators. However, many indicators were missing. As one example, Section D.3.e included a number of requirements related to investigation reports. However, the Facility only addressed two. o The Facility did not consistently measure the quality as well as presence of items. o The Facility did not distinguish data collected by the QA Department versus the program/discipline.

	▪ The Facility rated itself as being in compliance with 15 subsections of Section D. This was not consistent with the Monitoring Team's findings that showed ten subsections in compliance. The differences were noted in a table, earlier in this report. ▪ The Facility data did not identify in sufficient detail the areas in need of improvement. There was scant analysis of the information, such as identifying potential causes for the issues leading to the issues or connecting the findings to the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance ten out of 22 provisions of Section D, as opposed to 15 provisions that were in compliance during the last review. Progress was noted in some areas. Highlights of progress included: ▪ Several staff had been hired into the Incident Management Department, and at least two more were due to be hired. ▪ The injury audit process has been restarted and injury trending has been started. ▪ Information about reporting abuse was being provided to the Legally Authorized Representative and individual at the Individual Support Plan meeting and documented in the ISP. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included: ▪ The quality of Unusual Incident Reports that are Facility-only investigations needed improvement by including summaries of interviews, results of document reviews, and reconciliation of any conflicting information. Findings needed to be made in each review and recommendations where needed. When a UIR followed a return of an allegation from DFPS as an information and referral, any issues involving serious incidents, such as sexual contact, needed to be investigated, or there needed to be a good explanation of why nothing further was needed. ▪ When the UIR followed a DPFS report, it needed to include an opinion as to the accuracy and comprehensiveness of the DFPS report, any questions raised, and a referral back to DFPS in the event there were unresolved issues. ▪ History of the alleged perpetrator with regard to allegations/findings of abuse, neglect, and exploitation needed to be included in the UIR as well as the history of the alleged victim. ▪ A supervisor's review of the investigation needed to be completed and included in the file. ▪ UIRs needed to be completed within the required timeframes or a request for extension needed to be made and approved. ▪ UIRs needed to be signed and dated to establish the date of completion. ▪ Recommendations resulting from an investigation needed to be followed to conclusion and a check should be made to assure that the actions taken had the desired effect.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Based on an agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. AUSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result, the Facility was found to be in substantial compliance with this provision.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement. According to data the Facility provided in a document entitled Austin Data Charts: Incidents, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were:	Noncompliance

#	Provision	Assessment of Status	Compliance

	2/1/13 to 7/31/13 (6 months)	8/1/13 to 1/31/14 (6 months)
Total abuse allegations	79	65
Physical	61	44
Verbal/Emotional	9	16
Sexual	9	5
Abuse substantiated	11	10
Physical	10	9
Verbal/Emotional	1	1
Sexual	0	0
Total neglect allegations	135	98
Neglect substantiated	30	22
Total exploitation allegations	1	0
Exploitation substantiated	0	0

According to Facility data provided in a document entitled Austin Data Charts: Incidents, the numbers of Unusual Incidents investigated over the past two six-month periods included:

	2/1/13 to 7/31/13	8/1/13 to 1/31/14
Deaths	6	1
Serious Injuries	20	17
Sexual Incidents	11	4
Suicide Threat (credible)	0	2
Unauthorized Departure	2	2
Choking	2	0
Other	1	5
TOTAL	42	31

Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

Metric 2.a.2: According to AUSSLC Policy number II.B.4 revised November 2013, staff were required to report abuse, neglect, and exploitation within one hour by phone to the DFPS number, and to the Facility Director or Designee via the AUSSLC switchboard or the

#	Provision	Assessment of Status	Compliance
		Campus Administrator between 10 p.m. and 6 a.m. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the Facility policy number II.B.4, revised November 2013, required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to notify the Facility Director or Designee via the AUSSLC switchboard or the Campus Administrator between 10 p.m. and 6 a.m. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Although not used in the assessment of compliance, based on responses to questions about reporting, ten of ten (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Although not used in the assessment of compliance, based on responses to questions about reporting, ten of ten (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the nine investigation reports included in Sample #D.1 (Reduced Sample): ▪ Metric 2.a.6: Four (44%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. Those that did included: Sample #D1.4 and #D1.9. Sample #D1.5 recorded the time of the incident as unknown, and therefore, it was counted as reported on discovery. #D1.8 was unfounded and there was nothing for staff to report, and it was counted as within the timeframe. The remaining five were confirmed, or inconclusive and could have been reported timely. ▪ Metric 2.a.7: nine (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.8: For the three allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures and for which abuse or neglect was confirmed, none of the UIRs/investigation folders (0%) included recommendations for corrective actions. The three confirmed allegations with late reporting were sample #D1.1, #D1.6, and #D1.7. Based on a review of four investigation reports included in Sample #D.2: ▪ Metric 2.a.9: Four (100%) showed evidence that unusual/serious incidents were	

#	Provision	Assessment of Status	Compliance
		reported within the timeframes required by DADS/Facility policy. ▪ Metric 2.a.10: Three (75%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The one that did not was sample #D2.4, where the duty officer was not notified for almost three hours after the incident occurred. ▪ Metric 2.a.11: For the one unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folder did not (0%) include recommendations for corrective actions to help assure that future incidents would be reported according to procedures. Metric 2.a.12: The Facility did have a standardized reporting format. Metric 2.a.13: Based on a review of 13 investigation reports included in Samples #D.1 (Reduced Sample) and #D.2, 11 (85%) contained a copy of the report utilizing the required standardized format and were completed fully. The two that were not completed fully were: ▪ Sample #D2.3: An individual had received medication at the Infirmary at four times the normal dosage. The error was discovered when he returned to his home and the nurse noticed the missing medications. There was no evidence of interviews of staff at the Infirmary, no examination of documents, and no evidence of a clinical review of the error, no reconciliation of any conflicting evidence, and no clear picture of what transpired. ▪ Sample #D2.4: An individual was reported to have made a credible suicide threat due to not being able to call her daughter. There was a statement that the individual did not have a phone number to call her daughter, but were no interviews of staff or the individual to determine why she did not have a number to call her daughter, no examination of records to determine whether she was not permitted to use a phone for a programmatic reason, whether she had a human rights approval for such a restriction, or any other information other than what was done to protect and continue to evaluate her. Based on the agreement between the parties, this provision was reviewed in a shortened sample and remains in noncompliance. As illustrated by the findings from this abbreviated review, the Facility should focus on improving the timely reporting of incidents, including allegations; ensuring when investigations identify concerns related to reporting incidents, they include recommendations to address the issue; and ensuring the thorough completion of UIRs.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect,	According to AUSSLC Policy #II.B.13 the Facility required staff to take immediate action to stop abuse, neglect, or exploitation upon discovery. The person discovering the ANE was required to arrange for medical assistance, provide comfort to the victim, preserve	Noncompliance

#	Provision	Assessment of Status	Compliance
	exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	evidence, and report immediately to DFPS and to the Facility Director. Based on a review of 18 investigation reports included in Sample D.1, alleged perpetrators (16) were removed from direct contact with individuals immediately following the Facility being informed of the allegation, or the identities of the alleged perpetrators were unknown (2). However, the Staff Reassignment Log did not substantiate the removal of staff as reported in the UIRs in ten of these cases including: ▪ Samples #D1.1, #D1.2, #D1.3, #D1.4, #D1.5, #D1.6, #D1.7, D1.10, and #D1.11, where the Staff Reassignment Log did not include any information on the investigations; ▪ Sample #D1.9, where one staff member was removed according to the Staff Reassignment Log, but none of the remaining three alleged perpetrators. As a result, six of the 16 applicable records (38%) included evidence that the staff were removed promptly, and for the remaining two, the alleged perpetrators were unknown. In the four investigation reports in Sample D.2, one case involved an individual who allegedly received four times the normal dosage of medication at the Infirmary (Sample #D2.3). The investigation record reported removal of the staff member. However, this was not confirmed by an entry in the Staff Reassignment Log. The remaining three cases did not involve any suspicion necessitating staff removal. Therefore, none of the one case that needed staff removal (0%) did so. Based on a review of seven investigation files included in Sample #D.1 (six) and Sample #D.2 (1) where staff had been removed and the Staff Reassignment Log included an entry, a total of seven (100%) showed that staff that had been removed from direct contact were reinstated only after the conclusion of the investigation allowed their return to direct contact duties or the log showed they had been terminated or resigned. However, as noted above, information that should have been available for an additional 11 staff was not. This was of significant concern. Based on a review of 22 of the above documents, adequate additional action was taken to protect individuals in all cases (100%). For example: ▪ In Sample #D2.2, where the individual sustained a cut above his eyebrow after a fall, the nurse in the home, the campus nurse, and the physician all saw the individual; he received an emotional assessment; and staff were in-serviced on gait belt use as a precaution. In addition, the IDT tested the gait belt and found it was in good working order. ▪ In Sample #D1.3, where there was an inconclusive finding of verbal abuse, the individual received an emotional assessment. ▪ In most cases, the individual received a nursing assessment and an emotional assessment, regardless of the allegation. Where alleged perpetrators were not	

#	Provision	Assessment of Status	Compliance
		known, extra monitoring was provided for the home. The key issue for this provision was the Staff Reassignment Log. It did not include entries for many of the records where the UIRs indicated staff had been reassigned, and it was not possible to confirm either that the reassignment had happened or when the staff member was returned to duty. The Staff Reassignment Log is a key document in tracking staff reassignments and should be accurate and up-to-date. The Facility Self Assessment did not include a review of the reassignment log and it will be important to include such review going forward. The Facility was found to be in noncompliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to AUSSLC policy, during new employee orientation and every 12 months thereafter, all staff were obligated to attend competency-based training on preventing abuse and neglect. All required training must be appropriately documented by certification and by date of completion. Supervisors were to periodically assess employee knowledge, and provide additional training as needed. This was consistent with the requirements of the Settlement Agreement. A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ The training was competency-based; and ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 22 staff records (Sample #C.2), showed that 22 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) and incident management (UNU0100) prior to working directly with individuals, or had completed refresher training within the last year. Review of a list of staff who were delinquent in training (i.e., the course delinquency list for ABU0100, dated 2/3/14), showed that 25 staff were delinquent in training, or 1081 of 1106 active staff (98%) as listed in the "Active Employee list," dated 2/18/14, had been trained as required. This number compared favorably with the Facility's determination that the percentage trained reached a high of 96% in December 2013. While the Facility's calculation of percentage was 88% in September 2013, it was in the 90s for five of the six months since the Monitoring Team's last review. This positive direction indicated that the Facility was substantially compliant with the requirements of the Settlement Agreement. Likewise, the Facility data for course UNU0100 showed 95% or higher compliance since	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		September 2013. Based on interviews with ten staff: ▪ Ten (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on the sample drawn during the site visit, the review of delinquency reports and the corroboration of the Facility's own data, the Facility was found to be in substantial compliance with this provision. The Facility had found noncompliance based on their data that fell below the 90% range during July and August 2013. For purposes of the Monitoring Team's report, July was outside the scope of this review and the trend in compliance was decidedly positive.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	As described in earlier reports, the Facility's policy and practice required that all employees sign a statement confirming the obligation to report abuse, neglect, and exploitation. The statement was first signed at new employee orientation and, then, annually thereafter. Copies were requested of the forms for three staff hired during the two full months prior to the onsite review. Based on a review of those forms, three (100%) of staff hired during this time period had signed the acknowledgement form. A sample of 22 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 22, all (100%) had signed annual acknowledgments. A sample of five volunteers was selected at random from the list of volunteers the Facility provided. In all five (100%), there was evidence that the volunteer had signed the acknowledgement and had been trained in ANE. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of five staff that failed to report an allegation of physical abuse – no injury. Personnel actions related to these failures revealed the following: ▪ Four staff were issued first level personnel actions (the lowest level); and ▪ One staff was issued second level personnel action. In addition, the Facility provided a systemic response by conducting campus-wide retraining on ANE, placing stickers on phones, and issuing reporting cards to accompany employee IDs. Several staff that were interviewed for this report, reached for those cards	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		when questioned about how to report abuse. It was clear that in the reported case, the Facility had taken appropriate action on both the individual and systemic level, and that interviewed staff demonstrated at least some of the elements of the topics included in the retraining. The Facility was found to be in substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	As noted in previous reports, the interdisciplinary teams (IDTs) were to review injuries, ANE allegations, and other incidents at the annual Individual Support Plan meetings. Individuals, LARs, and primary correspondents were to be given a copy of the Resource Guide, and mechanisms for reporting abuse were to be discussed. A review was conducted of the materials to be used educate individuals, LARs, or others significantly involved in the individual's life for the Monitoring Team's previous reports. It was found to include sufficient information. Based on a review of 13 individuals' ISPs (Sample #D.4), 11 (85%) individuals, or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation, as documented in their annual ISPs. The two that were not were the ISPs for Individual #406 and Individual #273. In interviewing/observing a sample of 10 individuals, four were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. The remainder were either not willing to communicate about this, or did not have the communication skills to do so. A review was conducted of one allegation of abuse known to have been reported by individuals, their LARs, or others who were significantly involved in their lives. In that one (100%), there was evidence Facility staff provided adequate support to the reporter. The Facility was not in substantial compliance with this provision because less than 90% of the sample individuals had information about reporting abuse provided and documented in the minutes of their ISP meeting.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to	Facility policy #II.B.13 required posters regarding individual rights and reporting of violations. A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	report violations of such rights.	In interview, the Acting DIRM reported that posters were being checked at least monthly and replaced as needed. Observations by the Monitoring Team of eight of eight living units and day programs on campus showed that eight (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. Posters were also in evidence in common buildings such as the administration building. The Facility was in substantial compliance with this provision.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to Facility Policy: Protection From Harm – Abuse, Neglect and Exploitation, #II.B.13, any allegation that the individual might have been the victim of a crime must be reported to appropriate law enforcement. Based on a review of 18 DFPS investigations (Sample #D.1), in 11 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 11 (100%). Based on a review of four investigations completed by the Facility (Sample #D.2), in one for which a referral to law enforcement was appropriate, the Facility had made a referral in one (100%). The Facility was in substantial compliance with this provision.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	As indicated in previous reports, according to AUSSLC's policy, retaliation against a person for reporting abuse, neglect, or exploitation was prohibited. Any person, who believed he or she was being subjected to retaliatory action upon reporting an allegation, or who believed an allegation had been ignored, was directed to immediately, within one hour, contact the Director or her designee. The Office of the Attorney General, the Office of the Inspector General, and DFPS also could be contacted. Based on interviews with the Interim Director of Incident Review Management, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ Posters were distributed widely warning against retaliation; and ▪ ANE training included information about actions to take if retaliation was suspected. Based on interviews with 10 staff, 10 (100%) reported they were confident that retaliation would not be tolerated and did not voice concerns about possible retaliation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on interviews/observation of 10 individuals served by the Facility, four of the four who could communicate about such matters (100%) reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were no concerns noted related to potential retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. None had been reported in the last six month. In conversation with the Facility Director, it was clear that OIG would be contacted immediately if anyone reported an instance of retaliation. Based on this review, the Facility was found to be in substantial compliance with this provision.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Since this was an "update only," this review follows the outline of the requirements for this section, but does not determine whether the Facility was in compliance with all of the metrics. Rather, this review indicates where there might have been progress or need for further attention, and some of the metrics for which sufficient information was provided have been completed. <u>Metric 2.i.1:</u> The Facility policy and/or procedures: The procedures for audits were included in Facility Policy #II.B.7 Client Injury, dated November 2013. The audit procedure included information about: ▪ Personnel who would conduct the audit (Incident Management Personnel). A list of eight staff that had been trained by the DIRM was included in the Presentation Book; ▪ The time frame for review: a six-month look-back period for each audit; ▪ The documents to be reviewed; ▪ A requirement to initiate an injury report for any discovery of a "recent" injury that had not been reported, but did not define what would be considered "recent;" ▪ A requirement to notify the Director and DFPS immediately if suspicions of abuse/neglect arose during the course of the audit. A similar requirement to report to the Director should apply if a serious injury, subject to investigation by	Noncompliance

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		the Facility was discovered and had not been reported for investigation. Likewise, suspicious patterns of injuries or repeated peer-to-peer altercations should be reported for investigation as possible abuse or neglect. ▪ A definition of the sample as 20% of the census every six months and either random or focused; ▪ The results of audits would be shared with "leadership," without specifying exactly which positions in leadership, such as the Facility Director, the Quality Assurance Director, etc., or sharing with the QA/QI Council or some other specific committee which would be empowered to act on the findings as needed; ▪ Reference was made to the Executive Trending Committee without further specification or definition of that committee, its composition, purpose, and frequency of meeting; and ▪ Injury trends would be shared with the individual's IDT for review and action directed toward prevention of future occurrences. Metric 2.i.2: The Facility had made some progress in conducting audits at least semi-annually and produced nine reports (the number specified in the procedure) completed in January 2014 in a format adopted in April 2013. Metric 2.i.3: The audits conducted appeared to contain information about unreported incidents and about missing entries in IPNs or other reviewed documents. The following metric was not completed, though: The audits conducted **were/were not** sufficient to determine whether significant resident injuries had been reported for investigation. Metric 2.i.4: The January 2014 audits did identify significant injuries that had not previously been investigated, and only some of these were reported to the Facility Director, and/or DFPS, as appropriate. For example: ▪ On 1/10/14, records for Individual #168 were audited and the auditor noted that it appeared the individual had multiple bruises and injuries due to SIB that were unreported. The auditor initiated a UIR, notified DFPS, and referred the identified trends to the individual's IDT for programmatic review. There were some injuries that appeared suspicious and might have warranted further investigation. For example: ▪ On 1/9/14, records for Individual #32 were audited. Information was included in the audit about two non-serious, discovered injuries one of which was a bruise to the upper back. Injury reports had been filed and the conclusion reached that the bruise was probably the result of bumping up against furniture. However, bruises to the back can also result from being hit, and it was not clear that possibility had been ruled out through investigation.	

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		In the Facility Self-Assessment, the DIRM noted that his review of audits in December indicated some inadequacies with regard to identifying trends and proceeded to retrain the auditors, resulting in some trend identification as noted for Individual #168 above. This was a demonstration of good practice and if the process of reviewing and retraining is carried forward, it should produce positive future results. The results of the Executive Trending Committee in reviewing and analyzing trends would be a good addition to the work of the auditors.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy Number 002.4: Incident Management, dated 11/20/12, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 021.2: Protection from Harm - Abuse, Neglect and Exploitation, dated 12/4/12, established procedures for the identification, reporting, trending, analysis of incidents, and prevention of abuse, neglect, and exploitation at State Supported Living Centers. DADS Policy Number 002.4 specified the training required for investigators, and the expectation that they not be in the direct line of supervision of an alleged perpetrator. According to Facility Policy #II.B.13: Protection from Harm – Abuse, Neglect and Exploitation, dated November 2013 and Facility Policy #II.B.4: Incident Management, dated November 2013, the Facility policies: ▪ Described in a comprehensive fashion of the conduct of all such investigations; ▪ Required that investigators be qualified by taking courses: Comprehensive Investigator Training (CIT0100) and People with Mental Retardation (MEN0300), Conducting Serious Incident Investigations or Fundamentals of Investigation (INV0100) and Root Cause Analysis (RCA); ▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Required that investigators be outside of the direct line of supervision of the alleged perpetrator.	Noncompliance

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		Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. This review was described in detail in previous monitoring reports. The curricula for the Facility and the DFPS investigators were generally determined to be adequate. The Adult Protective Services) APS Facility Instructor Led Skills Development (ILSD) curriculum contained excellent information regarding aspects of the investigation process as well as competency-based tests and quizzes. A list of DFPS investigators with their hire dates and training was provided. All thirteen listed had completed the required training. The training records for investigators who conducted investigations in Sample #D1 were reviewed with the following results: ▪ Seven out of eight DFPS investigators (88%) had completed the requirements for investigations training. The one that had no listing and no training record was the investigator in sample #D1.5. (It was noted that there were two investigators on the list with the same first name. It was possible that the one listed in #D1.5 had changed her last name, but there was no such indication in the documents provided.) ▪ Seven out of eight DFPS investigators (88%) had completed the requirements for training regarding individuals with developmental disabilities. The documents the Facility provided were not responsive to the document request with regard to training records of Facility investigators. The records submitted did not contain a complete record of training in the required courses for each investigator. The Facility did provide a table with staff listed and an indication of whether or not each course had been taken. However, the chart did not list Comprehensive Investigator Training for any of the investigators. As a result, the Monitoring Team was unable to substantiate whether Facility investigators had completed the necessary training. As a result, the Facility was found to be in noncompliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on State Policy and Facility Policy #II.B.4, Facility staff were required to cooperate with outside entities conducting investigations of abuse and neglect. This included DFPS and any outside law enforcement agencies. Generally, Facility practice was to cooperate with DFPS in the collection of evidence once those agencies became involved. As described above with regard to Section D.2.a of the Settlement Agreement, a sample of investigation files were selected for review (Sample #D1) that consisted of DFPS investigations. ▪ Review of the investigation files in Sample #D.1 showed that in 15 out of 18 investigations (83%), Facility staff cooperated with DFPS investigators. In three cases, Facility staff was not readily available for interview: o Sample #D1.8: DFPS requested a staff member for interview and was told she had not appeared for work on 10/21/13. The Facility had	Noncompliance

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		called, but she was not answering the calls. The Facility sent a letter on 10/30/13 requesting that she appear for an interview by 11/4/13. The record shows that she did appear, was interviewed, and the investigation resulted in a finding of "unfounded." While, the Facility did produce this witness, it was not clear why she could not be interviewed while at work, whether there was a reason for her apparent reluctance to be interviewed, and why there was no comment on that reluctance either from the DFPS or the Facility investigator. In addition the Facility did not send a letter for nine days from the initial request for interview by DFPS, and it was not clear why a letter was not sent sooner. o Sample #D1.13: DFPS requested to interview the two alleged perpetrators in the investigation. DFPS sent letters requesting their cooperation to which they responded and presented themselves for interviews. Abuse was confirmed against one of the two alleged perpetrators. While recommendations were made, neither DFPS nor the Facility recommended retraining on the need to participate promptly in interviews following reports of abuse. o A related incident occurred in Sample #D1.17: A staff member left work and her one-to-one assignment before being relieved. She refused to cooperate with a DFPS request for an interview, and in spite of phone calls and letters, did not appear. Neglect was confirmed against her and the Facility terminated her employment. In their report, DFPS recommended training for that staff member on the need for cooperation in the investigative process. While it appeared that the Facility cooperated in trying to secure the staff member's participation, no recommendations were made to address such situations in the future. Cooperating with DFPS requires the cooperation of staff in the investigatory process. Given the number of issues with cooperation noted (i.e., a total of four staff in the sample of investigations), at a minimum, additional efforts were needed to inform staff of their responsibilities to cooperate in future investigations. The Facility was found to be in noncompliance with this provision.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services,	Substantial Compliance

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		the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 18 the investigation records from DFPS (Sample #D.1), 11 had been referred to law enforcement agencies. For 11 of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. However, while the Facility appeared to be cooperative with law enforcement, in one record, Sample #D1.16, where possible sexual abuse by an unknown perpetrator was alleged based on bruising found on the individual's genitals, the Facility physician sent the individual to the Emergency Room for "sexual evaluation." The results of that evaluation had not been received by the Facility or DFPS at the time of the Monitoring Team's visit (i.e., February 24-28, 2014), while the allegation was entered on November 2, 2013. It is inconceivable why there was such a delay, and why the Facility, the State Office and the police did not get involved and secure the response. Neither the DFPS report nor the UIR could be completed without this information, and the investigation remained open at the time of the Monitoring Team's visit. ▪ Of the four investigation records from the Facility (Sample #D.2), one had been referred to law enforcement agencies (Sample #D2.5). For that one (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. The Facility was found to be in substantial compliance as evidenced by the information in the samples. However, the Facility should resolve the delay in obtaining information in the case cited, and determine a plan for addressing such delays in the future.	
	(d) Provide for the safeguarding of evidence.	As reported previously, the AUSSLC policy on Incident Management provided instruction on the safeguarding of physical evidence. It required that the evidence be handled as little as possible to prevent destruction, labeled clearly, and secured in the Incident Management Offices. Documentary evidence (i.e., copies of individuals' records, photographs, etc.) was stored in locked cabinets in the Incident Management Offices. Only the Director of Risk Management/Incident Management and the Lead Investigator had keys to these cabinets. While on site, the Monitoring Team observed the area the Facility used for safeguarding evidence. Evidence was safeguarded in a locked space on the second floor of the administration building, near the office of the Director of Investigations and Risk	Substantial Compliance

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		Management. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2): ▪ Evidence that needed to be safeguarded was in 17 out of 18 (94%) DFPS investigations. The investigation for sample #D1.16 had not been completed so it was not possible to be sure whether physical evidence was collected or should have been collected. In cases of possible sexual assault, it is common to collect underwear, bedding, or other clothing to be tested for signs of assault. Based on the preliminary UIR, it did not appear that any physical evidence had been collected; and ▪ Evidence that needed to be safeguarded was in none out of none Facility investigations. Based on this review, the Facility was in substantial compliance with this provision.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on Facility Policy #II.B.4, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Did require a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To monitor this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Reduced Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of nine DFPS investigations: ▪ Nine out of nine (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24	Noncompliance

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		hours of DFPS being notified of the allegation. ▪ Four out of nine (44%) were completed within 10 calendar days of the incident, including sign-off by the supervisor: o For the five that were not completed within 10 days, five (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ Nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In four of the investigations reviewed, recommendations for corrective action were included. In seven of the investigations, the related UIR added to the recommendations of the DFPS investigator. In nine (100%), the recommendations (DFPS and added Facility recommendations) were adequate to address the findings of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of the four Facility investigations: ▪ Four out of four (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ One out of four (25%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one that was completed within 10 days was Sample #D2.5. o For the three that were not completed within 10 days, none (0%) had documentation of a written extension request that had been approved by the Facility Director, with documentation of the extraordinary circumstances that necessitated the extension. ▪ Two (50%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. The two that did not appear to have summaries of findings were Samples #D2.3 and #D2.4. ▪ In two of the investigations reviewed, recommendations for corrective action were included. In two of the investigations (50%), the recommendations were adequate to address the findings of the investigation. The following were the investigations for which concerns were noted with regard to the adequacy of	

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		the recommendations: o Sample #D2.3 was incomplete. There were no recommendations and no signatures of investigators. o Sample #D2.4 was also incomplete. The investigation involved a suicide threat. No witness statements were taken, and it was difficult to understand whether any attempt was made to understand the threat and what the circumstances were. As noted above, the finding of noncompliance stands. The Facility needed to work on the timeliness of investigations or documentation of extensions; thorough recommendations, including, as appropriate, recommendations for DFPS to reconsider its findings; and ensuring written reports include summaries of findings.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. This provision was reviewed based on the reduced sample of DFPS investigations. The number of Facility Only investigations was set at five and constituted a full sample. Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. Metric 3.f.2: The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ Metric 3.f.3: In seven out of nine investigations reviewed (78%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The ones that did not were: o Sample #D1.2, where it was alleged that a staff member slapped the individual in the face while in the medication room. The nurse witnessed the slap and the video surveillance tape showed the individual exiting the medication room holding her face. The finding was "inconclusive." Since the tape appeared to provide reasonable confirmation that a slap took place and there was a witness, it was not clear why the decision of "inconclusive" was reached, and the investigation report did not reconcile this evidence in a way that explained the conclusion.	Noncompliance

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	perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	o Sample #D1.3 involved an allegation of verbal abuse to the same individual and another finding of inconclusive. While a number of statements were obtained and videotapes were reviewed, some re-interviews might have helped clarify what went on and enabled a definitive finding. For example, the UIR noted that two witnesses had said that they heard the individual state that she did not want to get off the bus and did not want to go to the workshop. Further inquiry might have established whether her reluctance was based at all on a fear of verbal abuse. ▪ The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.4: In nine (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.5: In nine (100%), the name(s) of all witnesses; o Metric 3.f.6: In nine (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.7: In nine (100%), the names of all persons interviewed during the investigation; o Metric 3.f.8: In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o Metric 3.f.9: In nine (100%), all documents reviewed during the investigation; o Metric 3.f.10: In nine (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o Metric 3.f.11: In nine (100%), the investigator's findings; and o Metric 3.f.12: In eight (89%), the investigator's reasons for his/her conclusions. That one was Sample #D1.2 as noted above. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Metric 3.f.13: In one out of four investigations reviewed (25%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The contents were not sufficient for the following investigations: o Sample #D2.3: The investigation involved an individual allegedly receiving four times the normal dosage of his medication by an Infirmary nurse. It was not clear that witnesses had been interviewed, documents reviewed, and a reenactment of the medication administration practice conducted to determine how the error occurred. o Sample #D2.4: The investigation involved a credible suicide threat by a	

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		woman who was upset because she had not been visited by her daughter and did not have a number to reach her daughter. It was not clear why no witnesses were interviewed, why there had been no effort to determine if the individual's daughter had not provided a contact number, or whether the individual could not find the number, and what the nature of the suicide threat had been. o Sample #D2.5: Involved two individuals observed to be naked in the hallway of the Infirmary and engaged in some sexual contact. No staff were interviewed, and there was no information about how two individuals would have had access to the space without anyone being aware. ▪ The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.14: In four (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.15: In four (100%), the name(s) of all potential witnesses, but in three cases noted in Metric 3.f.13, no or not all witnesses were interviewed. o Metric 3.f.16: In four (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In one (25%), the names of all persons interviewed during the investigation. In samples #D2.3, #D2.4, and #D2.5, it did not appear that the Facility investigator interviewed any witnesses. However, in #D2.5, the two alleged victims had been interviewed by DFPS before the case was referred back to the Facility. o Metric 3.f.18: In one (25%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. As noted, above the Facility investigator did not interview anyone in three cases. o Metric 3.f.19: In four (100%), all documents reviewed during the investigation; o Metric 3.f.20: In three (75%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. In Sample #D2.3, the list of relevant history included the notation "AP history is currently pending" without further explanation. o Metric 3.f.21: In (100%), the investigator's findings. o Metric 3.f.22: In one (25%), the investigator's reasons for his/her conclusions. ▪ Sample #D2.5: there was a brief summary of the incident with no reasons for accepting the facts as stated.	

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		▪ Samples #D2.4 and #D2.3: there was a recitation of the chronology of events with no conclusions and no reasons for conclusions. Based on this review, the Facility was not in substantial compliance with this provision. Based on the full sample of Facility-only reviews, they were not complete investigations with interviews, reconciliation of documentary and testimonial evidence, and contents that supported the conclusions. While it is possible that a full sample of DFPS investigations would have resulted in ratings commensurate with a substantial compliance finding, the issues with the Facility-only investigations would still have prevented the Facility from achieving a substantial compliance with this provision.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, and a finding of noncompliance would be entered. Metric 3.g.1: The Facility policy and procedures did require that staff supervising the investigations review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. Facility policy #II.B.4 did not state these two requirements precisely as written, but it did require the DIRM to "oversee and ensure quality control of the investigative process." Metric 3.g.2: The Facility policy did not require that any further inquiries or deficiencies be addressed promptly. However, the requirement for supervision could reasonably be seen as being encompassed in the quoted language described with regard to Metric 3.g.1 above. If that was not the intent of the quoted language, the policy should be modified to describe the responsibilities for supervision. DFPS Investigations The parties have agreed that due to concerns related to the confidentiality of the DFPS supervisory process, the Monitoring Teams will not review it. As a result, the Monitoring Teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: One of four (25%) was reviewed by the DIRM within five working days of receipt of the completed investigation. ▪ Metric 3.g.9: In one out of four investigation files reviewed (25%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. That one was Sample	Noncompliance

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		#D2.5. ▪ Metric 3.g.10: For none, the supervisor had identified concerns. As a result, the following metric was not applicable: For these investigations, for ___ (___%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ Metric 3.g.11: For the three investigations noted above for which the Monitoring Team identified deficiencies, the supervisory review did not appear to address these deficiencies. The Facility Self-Assessment agreed that this provision would not be in substantial compliance due to the lack of supervisory reviews. In the Presentation Book, copies of recent supervisory reviews were included, however, without copies of the investigations, it was not possible to gauge how accurate they were. The Facility was not in substantial compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Metric 3.h.1: The Facility-only investigations did not meet the requirements outlined in Section D.3.f.	Noncompliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a reduced sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Metric D.3.i.1: The Facility policy and procedures did not require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. The language in Facility Policy II.B.4 required the supervisor of the designated department to send any documentation related to completing or complying with corrective action plans to the DIRM. However, the policy did not specify an outside timeline for completing such activity. Metric D.3.i.2: In addition, the policy and procedures did not specify the Facility system for tracking and documenting such actions and the corresponding outcomes. Facility Policy II.B.13 specified use of the Incident Management Recommendation Tracking Log to track all ANE conclusions, recommendations and corrective actions, but there was no such provision in the Incident Management Policy (II.B.4) for tracking serious incidents that were not classified as ANE. Metric D.3.i.3: For one out of one of the investigations reviewed in Sample #D5 in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented.	Noncompliance

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		Based on a review of Sample #D5 investigations the following was found: ▪ Metric D.3.i.4: For none of the three investigations reviewed (0%), prompt and thorough programmatic action had been taken and documented. o Sample #D1.1 included recommendations: ▪ To in-service staff in the home on the Facility Rover Policy. While there was no evidence to indicate this had been done, on interview with the DIRM, it was clear that the Facility had suspended the rover program where an extra staff person was assigned to some Level of Supervision (LOS) one-to-one (1:1) to facilitate coverage in the event of a behavioral episode. ▪ To secure all buildings no longer in use and routinely check them to assure security devices were intact. There was no evidence to support that this had happened. o Sample #D1.3 included recommendations: ▪ Hands-on training for one staff member on an individual's PBSP. There was no evidence that this training took place. ▪ Training for the staff member using the I-Learn course on the Rights of people with developmental disabilities. There was evidence this course had been completed. ▪ A review of the individual's vocational placement was recommended and completed at her ISP. o Sample #D2.2 included recommendations: ▪ To consider amending the PBSP to deal with loosening his gait belt. The IDT met and recommended the update. ▪ To update the Special Considerations to include the most current information. The form was changed to add a caution on checking his gait belt, but it was not listed under mobility, leaving the reader who might quickly look to check on his mobility status with the understanding that he walked and transferred independently. ▪ Metric D.3.i.5: For none of the three investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. o Sample #D1.1 did not offer evidence the two programmatic recommendations had been completed or the outcomes achieved. o Sample #D1.3: While there was evidence that a review of the individual's vocational program was completed, there was no evidence of changes having been made. While a staff member received some training, there was no evidence of any checks to see whether she had	

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		retained the training. o Sample #D2.2: While the IDT supported changes to the PBSP it was not clear that the changes were made and how they would be monitored to assure they were being followed. The Facility was not in substantial compliance with this provision. The Facility Self-Assessment found the same.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Based on review of Facility policies, records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, records were filed in the office of the Administrative Assistant to the DIRM in a locked room. This staff member provided access. Both the Facility and DFPS maintained electronic records with restrictions to prevent unauthorized access. The Facility was in substantial compliance with this provision.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Since this review was an "update only," it follows the outline of the requirements for this section, but does not determine whether the Facility was in compliance with all of the metrics. Rather, this review indicates where there might have been progress or need for further attention. Where the Monitoring Team had enough information to complete the metrics, they have been completed. Metric D.4.1: For all categories of unusual incident categories and investigations, the Facility did not have a system that allowed tracking and trending by: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Some tracking was being done on injuries, peer-to-peer contact, ANE, and unusual incidents. However, it did not appear that the tracking and trending was ongoing. The ANE trending report, found in the 10/28/13 QA/QI minutes, was dated 9/1/13, based on	Noncompliance

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		data from June, July, and August 2013. That report included most of the above designated data. However, reports were not available for October, November, and December 2013. Over the past two quarters, the Facility's trend analyses: ▪ Metric D.4.2: Were not conducted at least quarterly; ▪ Metric D.4.3: Did not address the minimum data elements; ▪ Metric D.4.4: Did not use appropriate trend analysis procedures; ▪ Metric D.4.5: Did not provide a narrative description/explanation of the results and conclusions; and ▪ Metric D.4.6: Did not, as appropriate, contain recommendations for corrective actions. Again, the tracking and trend analysis that had been done for injuries as in the 9/1/13 – 11/31/13 period did address the above requirements, including narrative descriptions and recommendations. Likewise, tracking and trending data on ANE, but without narrative analysis was produced for a September report. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed. While this was sometimes done, notably with trends uncovered in injuries, there was no clear systemic approach. Metric D.4.8: Corrective action plans were not consistently developed both for specific individuals and at a systemic-level based on identified trends. However, with the injury trending, individual and systemic plans had been developed. Metric D.4.9: The trend reports and/or minutes did not show that corrective action plans were implemented and tracked to completion. While there were some, again, notably with injuries, this appeared to be a practice under development rather than an established practice. Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective action plans. At least there was no evidence of this, perhaps due to the limited number of preceding corrective action plans. In a full review of this section, the following metrics will be rated, based on a review of action plans, resulting from trend analysis, and documentation related to implementation, such as what the Facility did with injury trends: ▪ Metric D.4.11: ___ out of ___ action plans (__%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ Metric D.4.12: For ___ out of ___ of the action plans reviewed (___%), the plan had	

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		been timely and thoroughly implemented. ▪ Metric D.4.13: For ___ out of ___ action plans (___%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. While there were examples of progress in trending and analysis, notably with injuries and to some degree with ANE and peer-to-peer contacts, there was no evidence of a clear system for trending and analyzing ANE and unusual incidents, or evidence that analysis routinely resulted in corrective action plans. According to the Facility's Self-Assessment and action plan, as of 1/2/14, steps to produce such reports and evidence were getting underway. As the Facility noted in the Self-Assessment, significant work was needed to gain substantial compliance with this provision.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2013. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information and discussion with the Facility Director indicated that three people had	Substantial Compliance

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		been terminated based on background checks. In an interview with the Facility Director, her decisions regarding the employment of applicants with any criminal history were discussed. Her decisions were based on the facts, and were mindful of her responsibility to safeguard the individuals and staff of the Facility. The Facility was in substantial compliance with this provision.	

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003.1: Quality Assurance (QA), dated 1/26/12; o AUSSLC Policy #I.A.5: Quality Assurance, dated October 2012; o AUSSLC Policy #I.A.10: Policy and Procedure Overview, revised December 2013; o AUSSLC – Quality Assurance Plan (including matrix and key indicators), revised 2/6/14; o AUSSLC Correction Action Plan Tracking, undated; o Key Indicators Under Review: January 2014; o AUSSLC Self-Assessment Section E, dated 2/4/14; o AUSSLC Action Plans Section E, dated 2/7/14; o Quality Assurance/Quality Improvement (QA/QI) Council Meetings, dated 9/24/13, 10/28/13, 11/12/13, 11/25/13, and 12/9/13; o Monitoring tools associated with the Quality Assurance Plan; o Breakdown of QA Duties, dated January 2014; o Types of Action Plans, dated 11/12/13; o AUSSLC Corrective Action Plan (form), undated; o AUSSLC Corrective Action Reporting Document, undated; o Training material for corrective action plans, undated; o Client Protections Trend Analysis, undated; o Injury Trending 11/30/12 to 11/30/13; and o STRAW Quarterly Analysis (Dental Services), dated 9/23/13. ▪ **Interviews with**: o Laura Cazabon-Braly, Facility Director; o Mike Fitch, Assistant Director of Programs; o George Schock, Interim Director of Incident Review and Management (DIRM); o Holly Lindsey Director of Quality Assurance; o Program Compliance Monitors and QA Nurses; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o Quality Assurance/Quality Improvement Council, on 2/25/14; o Sunrise Unit Meeting (Building #790), on 2/25/14; o Incident Management Meeting, on 2/25/14; o Visits to Residences #782, #784, #786, and #787; and o Visits to day and vocational programs in buildings #527, #532, #533, and #544.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment:

	▪ The Facility did not use a monitoring/auditing tool. This report and the Monitoring Teams' protocol for this section provide information about what the Facility should include in its monitoring tool to accurately assess the status of compliance. ▪ The Facility did present data employing charts or graphs to show progress toward compliance for Section E. Much of the data provided were dates of meetings and narrative descriptions of information provided in those meetings. There were also lists of CAPs assigned, based on data, and lists of tools and the number of audits completed monthly. ▪ The Facility did not consistently present data in a meaningful/useful way for Section E. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators, such as monitoring tool results for Section E. The Facility did report on examples of committee work, such as the Pneumonia Committee, which produced graphs, illustrating the decline in cases of pneumonia after action by the committee. o Did not consistently measure the quality as well as presence of items. For example, a table was included that showed the dates Settlement Agreement sections were reviewed by the QA/QI Council. This helped to establish which sections were being reviewed, but did not provide any information about the quality of the reviews. ▪ The Facility rated itself as being in substantial compliance with one of the sub-sections of Section E, specifically, Section E.3. This was consistent with the Monitoring Team's findings. ▪ The Facility data did identify areas in need of improvement. For example, the need for the key indicators to be refined and finalized and the resulting data tracked with sufficient particularity to identify trends across a variety of areas; the need for a consistent system to monitor, track, trend and implement essential elements of the quality assurance process; the need to improve data analysis; and the need to create ownership and accountability in the CAP process.
	Summary of Monitor's Assessment: Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including: ▪ A data inventory was in place. It will need further work to assure it includes all relevant data, particularly with regard to key indicators, and is organized in a way that is useful to the Facility. ▪ A Quality Assurance Plan was in place. Again, it requires some work to include information on key indicators, and to add a description of the purpose for the plan. ▪ Thirteen Corrective Action Plans were in place. There was a format for developing plans to assure consistency, and a helpful chart to illustrate the difference between CAPs and other types of action plans. There was a tracking system, with numbered CAPs that appeared to be workable. In addition, there was a system for disseminating CAPs to persons responsible for them. ▪ The Quality Assurance/Quality Improvement Council meeting the Monitoring Team observed included some good exchanges of information and leadership from the Director to focus attention on resolving specific issues. In short, some solid groundwork had been done for a QA system. The test will be how consistently it can be maintained and expanded. Some of the areas that will need to continue to improve for the Facility to progress toward substantial

	compliance with the Settlement Agreement included: ▪ The QA Plan Matrix needed additional work to clarify exactly which monitoring tools were in use for each section of the Settlement Agreement. It might be useful to provide the actual name of the tool and the date modified in the matrix. ▪ Monitoring tools need to be in place for any sections that do not have them, the tools need to be implemented consistently according to the matrix, and data needs to be gathered and tested for inter-rater agreement. If there are sections for which a process other than a monitoring tool will be used, that process needs to be identified in the matrix. ▪ Monthly meetings between Program Compliance Monitors and disciplines need to include review and analysis of quality assurance data, and minutes should document discussion of issues identified through the monitoring process as well as ideas for resolution. The minutes also should document any resolution of differences in understanding regarding the monitoring tools to assist in reaching a satisfactory level of inter-rater agreement. ▪ The Facility should continue working on the key indicators and connect them to the sections of the Settlement Agreement.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>State QA policy</u> There was a State policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the State policy, entitled #003.1: Quality Assurance, dated 1/26/12. The Monitoring Teams' comments on the State Office policy have been provided in other monitoring reports and are not repeated here. Given that the statewide policy was disseminated almost two years ago, edits may be needed. State Office should consider this. <u>Facility QA policies</u> Facility policies and procedures related to quality assurance (as listed in Documents Reviewed) were examined and found to support/implement the State QA Policies. The Facility Quality Assurance Policy had not been updated since October 2012, and might need updates to assure congruence with the recently updated QA Plan. <u>QA data list/inventory of data</u> The Facility had developed a data inventory that included data relevant to sections of the Settlement Agreement. However, the format of the inventory did not connect the data directly to the sections of the Settlement Agreement and had not completed the portion of the inventory designed to record why each description of data was being tracked. As a result, it could not be determined if there was data available for use in identifying trends related to the requirements of all provisions of the Settlement Agreement sections.	Noncompliance

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		The data inventory might have included data on key indicators (outcome and process) of performance, selected by the QA/QI Council to track priorities. However the inventory did not directly reference key indicators, making it difficult to determine if all key indicators had data sources in the inventory. It could not be determined if the data inventory included data from: ▪ Settlement Agreement self-monitoring tools; ▪ Disciplines/departments; ▪ Areas of Care; ▪ Protections; ▪ Supports; and ▪ Services. Or whether data on the data list/inventory included data recorded by: ▪ Program areas; ▪ Living units; ▪ Work shifts; and ▪ Individuals. The data inventory was designed to include a description of the data and the source of the data, as well as how the data was tracked, the reason for tracking it, who did the entry, who owned the database, and whether the data were used to generate reports. This design appeared to be useful, although it was incomplete for some of the entries. If this format included a column to connect the data to Settlement Agreement sections/requirements and it was complete, it would provide a good means of determining location and usefulness of data for purposes of compliance with the Settlement Agreement as well as other Facility purposes. The data inventory was current. However, the Facility policy had not been updated to include a data inventory or regular updating of the inventory. The QA Plan did address data collection as one of the QA functions and listed a "data map" as something to be maintained. The QA Plan did not specify the maintenance and periodic updating of a data inventory or data map. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was current. The QA plan narrative was not complete. The QA plan narrative had been reviewed and revised, as appropriate, within the last 12 months. The following describes the components of what the QA Plan should include to describe the QA program, at a minimum, and a status of the Facility's QA Plan with regard to these components:	

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		▪ A description of the purpose of the QA program was not included; ▪ The organizational structure of the QA process was included, but there was no table of organization to clearly identify roles and responsibilities; ▪ The data inventory was not described and its function was not specified; ▪ QA matrix was part of the QA Plan; ▪ Key indicators of performance were present, but indicated to be in development; ▪ A description of how data are summarized and analyzed: a summary of the data functions of the QA Department was included. The QA Plan did not include detail on how the trend reports were produced or how QA data from monitoring was summarized and analyzed; ▪ The role of other departments in QA was described, but there was no mention of QA Department and discipline department collaboration/meetings; ▪ Workgroups or quality assurance related committees were addressed; ▪ The QA report: there was no indication of how or how often the QA Department would issue reports on progress throughout the system; ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process was included; and ▪ A description of how corrective actions/CAPs were tracked was included. <u>QA Plan Matrix</u>: ▪ Key Indicators (process and outcome) for each Settlement Agreement section: The list presented with the QA Plan included 47 indicators, which appeared to link to Sections D, L, M, N, P, Q, R, and U of the Settlement Agreement. A more recent listing in the Facility Self-Assessment included more than 100 indicators, covering more, but not all, sections. ▪ For the 20 sections of the Settlement Agreement, a set of key indicators was available for eight of the 20 sections (40%). This was based on the January 2014 list. The list was not coded to the Settlement Agreement sections, making it difficult to determine which sections had indicators. ▪ Of these eight, both process and/or outcome indicators were identified for (100%) of the sections. There were both process and outcome indicators present, but with distinctly more outcome measures than process which suggested an attempt to focus on outcome measures. In order for the indicators to be effectively implemented, definitions for key terms and methodologies for collecting the data need to be established. Benchmarks and goals for key indicators need to be established, and steps need to be put in place to assure that the data collected are accurate and reliable measures of progress. Over time, additional key indicators will need to be added for a comprehensive list to exist. As the indicators are refined, the Facility should be sure to include enough process measures to provide guidance into the reasons some outcomes may not be achieved. ▪ Of these eight, in eight (100%) the indicators provided data that could be used to	

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		identify the information specified in E1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. Self-monitoring tools for all Settlement Agreement provisions: The QA plan matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the Settlement Agreement. Copies of tools were not provided for sections E, O, P, and R, and they were listed in the matrix as not having tools. Section L was listed as having a tool, though a copy was not provided. Appropriately, the matrix identified the frequency of monitoring, and the persons responsible for monitoring. All Data Collected by QA Department: All data that QA staff members collected were listed on the matrix. All Items in QA Plan Matrix Also Appear in the QA Data Inventory: Not all of the items in the QA plan matrix also appeared in the QA data inventory as far as could be determined. This would be easier to determine if the data inventory listings were coded to the matrix and the Settlement Agreement sections. All data in QA plan matrix were submitted and received: Data for the months of November and December 2013, or for the last quarter for those sections monitoring quarterly were reviewed. Data were reviewed by section rather than by tool, since the matrix was difficult to follow with regard to the number of tools for some sections and the correct names for the tools. However, considering data submitted related to each section in the QA plan matrix for the 20 sections of the Settlement Agreement, data were submitted/collected/received by the QA Department as listed in the Facility Self-Assessment for Section E, as follows: ▪ The six sections that did not appear to have provided data to the QA Department were Section E, I, J, K, L, and T, which might have had tools and might have collected data, but did not appear to have submitted them to Quality Assurance. ▪ The eleven sections that submitted data for both November and December were Sections C, D, F, G, H, M, N, Q, S, U, and V. However, not all of these sections submitted data from all of the tools listed in the matrix. ▪ The sections that submitted data for one of the two months were sections O, P, and R. However that submission was for only one record. Of the 20 sections in the QA Plan Matrix, eleven sections (55%) were submitted/collected/received by the QA Department for the November and December reporting periods, or for the quarter if scheduled for quarterly submissions.	

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		Reviewed/analyzed: Of the 20 sections in the QA plan matrix, there was no clear evidence to show that any of the sections had documentation to show review or analysis by the QA Department and/or the department section leaders for November and December for the listed tools. The QA Department was not documenting meetings with section leaders. There was documentation of limited analysis and review in quarterly summaries presented to the QA/QI Council for most sections, but the summary sheets in use did not generally provide evidence of analysis. Some sections such as J, K, and V provided reviews of matrix data by the department in quarterly summaries. Others provided data from monitoring, but without analysis, notably Section S where a printout of scores by item on the tool was provided, but without analysis. During September, STRAW (Summarize, Trend, Report, and Ask Why, What are we doing) analyses had been conducted for some sections. The STRAWs appeared to provide not only analysis, but some ideas for moving forward to address identified issues. However, that process did not appear to have extended beyond June and July 2013. Since there was no documentation of QA/discipline meetings and no other evidence of monthly review and analysis of QA monitoring data by the disciplines, the Monitoring Team could not verify that reviews/analysis was happening monthly. A large part of the problem was reported to be the turnover in QA staff and in the leadership of some of the disciplines. In future reviews the Monitoring Team will need to see evidence that data from each monitoring tool listed in the matrix has been reviewed/analyzed monthly. Implement the QA Plan as written: The Monitoring Team did not attempt to quantify the following metric for this report: Of the ___components of the QA plan narrative and QA plan matrix, the Facility implemented ___%. QA Staff Assist Disciplines/Departments in Analysis of Data Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, that there was documentation that it was not needed. For the 19 sections of the Settlement Agreement (Section E excluded), for none was there documentation indicating that QA staff had assisted the section leads with analysis in some respect. For those sections without documentation of assistance, there was no documentation of the reasons that assistance was not needed. There were no minutes of meetings between QA staff and discipline leads, so it was difficult to determine what, if any, assistance had been requested or provided. While many of the reviews summarized monitoring data, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed.	

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		Self-monitoring tools/activities for all section of the Settlement Agreement: At the next monitoring visit, the Facility (Quality Assurance Director) should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: ▪ Content/validity: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and evidence that each tool received a review by QA/QI Council at least twice within the past six months. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, (a) the content of ___ (%) appeared to be appropriate and (b) __ (%) were reviewed within the past six months, and revised as appropriate.) ▪ Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, ___ (%) had adequate instructions for the user.) ▪ Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. [Metric to be measured: Since the last onsite review, of the self-monitoring tools for the 20 sections of the Settlement Agreement, (%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement).] ▪ QA review: A report or summary showing that there was documentation of QA Department review of the results of the monitoring, at least once each quarter, for each of the 20 sections of the Settlement Agreement. (Metric to be measured: Since the last onsite review, of the 20 sections of the Settlement Agreement, there was documentation that the implementation (including inter-observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for ___ (%) of the 20 sections.) While the above four items were not rated, it was noted that there was evidence that the QA Director had been attending to them. ▪ A helpful chart was included in the Facility Self-Assessment that showed QA/QI review dates for all 20 sections, at least twice in the past six months. ▪ Most tools did have instructions, though it was not clear if they were adequate. ▪ A helpful table was included in the Facility Self-Assessment that indicated the number of tools completed by month for the tools that had been completed. There were not tools for all sections on the chart, and it was not clear if the tools had been implemented (e.g., I, J, L, and T). While there had been good progress in developing the foundation of the QA Department and its processes, including filling positions, modifying the QA Plan, working to establish key indicators, and drafting a data inventory, the Facility was not in substantial compliance with	

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		this provision. There was still much to do, including: meetings between QA staff and discipline heads need to be documented and there needs to be evidence of a summary and analysis of QA monitoring data, including assessment of inter-rater agreement.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As a result, this subsection of the report follows the outline of the requirements for this subsection, but does not determine whether the Facility was in compliance with the metrics. Rather this review indicates where there might have been progress or need for further attention. Data and QA Reports: **(Not Scored)** Data from the QA plan matrix for ___ of the 19 (%) sections of the Settlement Agreement (not section E) were: ▪ Summarized; ▪ Graphed showing trends over time; and ▪ Analyzed across: a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. **Comment**: Data must be presented over time for a long enough period to permit assessment of trends; graphs need to present data in ways that facilitate analysis; and the analysis that results in the identification of common issues and/or underlying causes of those trends or issues. There were some trend reports, notably on injuries that did provide trending over time, and graphed and analyzed data to identify common issues. The source of this data was the AVATAR system into which staff were required to log all injuries. While not a trending of QA monitoring data, this kind of reporting was an important contribution to overall assessment of quality in the system. Some trending was also available for incident management and peer-to-peer aggression, as well as for some health issues. Regular Meetings Between Discipline Department and QA Staff **(Not scored)** Based on a review of a sample of five (5) of the sections of the Settlement Agreement, the minutes of meetings between QA staff and discipline heads for the last two quarters: ▪ A meeting occurred at least twice for ___ of the sampled sections (____%) of the Settlement Agreement; ▪ The minutes of these meetings documented that the reviews that occurred in each meeting included the following: o In _____% review of the data listing/inventory and matrix; o In ____% discussion of the data and outcomes; o In ____% review of the conduct of the self-monitoring tools; o In ____% creation/proposal of corrective action plans; and	Noncompliance

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		o In ___% review of previous corrective action plans. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were available to facilitate department/discipline analysis of data. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were reviewed and analyzed. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. **Comment**: Minutes of meetings between QA staff and discipline heads were not available for the last two quarters. Such meetings were occurring for many of the sections according to interviews with PCMs. However, documentation was needed to provide a record of what sort of analysis was done to aid discipline heads in making quarterly reports, and to help to determine what CAPs might be needed, based on the analysis of data. At a minimum meetings should occur quarterly and: ▪ Review the data inventory and matrix for accuracy; ▪ Discuss current data and outcomes; ▪ Review the conduct of the self-monitoring tools; ▪ Consider corrective action plans; and ▪ Review previous corrective action plans. <u>QA Reports</u> **(Not scored)** Since the last onsite review, a Facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for ___ of the ___ (%) months. Of the 20 sections of the Settlement Agreement, ___ (%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the Settlement Agreement that were presented, ___ of ___ (%) contained the following components: a. Self-monitoring data i. Reported for a rolling 12 months or more ii. Broken down by program areas, living units, work shifts, etc., as appropriate b. Key indicators i. Reported for a rolling 12 months or more ii. Broken down by program areas, living units, work shifts, etc., as appropriate **Comment**: Quality Assurance needs to report on its analysis of data produced through quality monitoring, at least once each quarter for each of the 20 sections of the Settlement Agreement, and the report(s) should be shared with the QA/QI Council. These reports could be separate from or included in the discipline reports for each quarter. It is probably most helpful if the QA reports are presented to the QA/QI Council at the same time as the discipline reports.	

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		Facility QA/QI Council There was an adequate description of the QA/QI Council in the QA plan narrative. The narrative listed the Facility Director as chairing the QA/QI Council and listed the discipline heads and other key members, such as the Settlement Agreement Coordinator, as members. The narrative provided for additional department staff as necessary to attend or facilitate a discussion. Since the last onsite review, the QA/QI Council did not meet at least once each month. It appeared that there was no meeting in August 2013, or in January 2014. Minutes from five (September, October, two in November, and December) of the five (100%) QA/QI Council meetings since the last review indicated that: ▪ Meetings occurred according to schedule or reasons for changes were documented; ▪ Agendas included topics/presentations related to QA; and ▪ There was attendance/representation as per policy. Data and Analysis Presented: **(Not scored)** Minutes from of the (%) QA/QI Council meetings since the last review documented that: ▪ Data from QA plan matrix (self-monitoring, key indicators data) **were/were not** presented; ▪ The data presented **were/were not** trended over time; and ▪ Comments/interpretation/analysis of the data **were/were not** presented. **Comment**: Generally, there was data presented in conjunction with the presentations of section leads at the QA/QI Council meetings. Sometimes data were based on monitoring tools, and sometimes they were based on AVATAR entries such as unusual incident data and injury data. Most data had some analysis such as an indication of which homes or which individuals were experiencing the most difficulties. However, data was not consistently trended over time, and did not consistently include the interpretation and analysis needed to provide guidance to the QA/QI Council in making decisions about plans of correction or resource allocation. Recommendations and Corrective Action Plans: **(Not scored)** ▪ In ___ of the ___ meetings (%), recommendations and action plans selected when appropriate to do so, were based on the data presented. **Comment:** Fifteen corrective action plans (CAPs) were listed on the CAP tracking sheet. Three addressed data integrity (#2, #10, and #12). Five were related to monitoring data (#3, #6, #7, #14, and #15), though these involved meetings not being held, documents not	

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		being completed, or records not available. The remaining involved such issues as transitioning from paper to electronic record keeping for restraints, a prioritized list for guardianship, monthly monitoring of ISPs, timeliness of injury reports, and nursing quarterly reports. System for generating CAPs: A written description did exist that indicated how CAPs were generated in the QA Plan. The description included: ▪ Criteria for a CAP: there was no rule about when a CAP was required. The decision was left to the QA/QI Council to address problems identified through data analysis. This was appropriate, since there were a range of options for addressing identified problems as described in "Types of Action Plans," dated 11/12/13. This document described CAPs as "Actions to address systemic issues as identified through data, monitoring, external entities or departments; broken down into small steps with assigned due dates and persons responsible." The document described who developed a CAP, why it would be used, and the timeframes to be considered. **Comment**: This was an excellent attempt to clarify the confusion that surrounds the types of action plans. The Monitoring Team suggests that consideration be given to using a CAP to address an intractable issue or set of issues with an individual that may need organized assistance from the QA/QI Council. ▪ There was no description of how to evaluate indicators for criteria for CAPs. It appeared from discussions that the determination was made based on priorities (addressing data integrity might take precedence over addressing trends, if the analysis suggested the data was faulty or incomplete), whether the identified issue could be addressed by the discipline without the oversight of QA/QI, or by a committee that reported to the QA/QI, as described in the "Types of Action Plans" document. **Comment**: A form for developing a CAP had been used to capture the needed information, including how the need for the CAP was determined (type of data, survey, observation, etc.) This appeared to be an excellent way to guide the person writing the CAP to address the necessary components. In addition, a table had been developed for reviewing and organizing CAPs to be developed from trend analysis data (Actions Plans Prioritized from Trend Analysis – September/October 2013.) However it was not clear that the list of 12 proposed CAPs had been included in the CAP tracking sheet and whether their absence meant they were still in development. This table appeared to be a good way to track proposed CAPs, but the link to the CAPs tracking sheet should be made clear. CAP development: When considering the full set of 15 CAPs, 15 (100%) appeared to have been chosen following the written description policy or procedure. This may be because the	

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		written description was general and allowed for considerable discretion in the choice of CAPs. Content of each CAP: Of the 15 CAPs reviewed by the Monitoring Team, 15 (100%) appeared to address the specific problem for which they were created. **Comment**: This determination was based on the CAP Tracking sheet, rather than a review of each CAP with all of the steps outlined. Some recent CAPs were provided with the details included. For example a CAP for active treatment and client protections to be reviewed monthly (10/1/13) appeared to address issues of monthly monitoring. CAPs contain all necessary components: Based on a sample of 10 CAPs, which represented 100% of the total of 10 CAPs recorded on the CAPs Tracking sheet since August of 2013 (reviewing tracking sheet only): ▪ 10 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. ▪ 10 (100%) included the anticipated outcome of the CAP, (though outcomes for each step could not be determined without reviewing the entire CAP). ▪ 10 (100%) included the person(s) responsible. ▪ (__%) included the time frame in which each action step must occur. This could not be scored from the CAP tracking sheet since the due date was not on the tracking chart. **Comment**: CAP development should improve through use of the form for developing CAPs. At the next monitoring review, a sample of the CAPs will be examined. To achieve substantial compliance with this provision the Facility will need to assure that thorough data analyses are conducted; that there is clear linkage between data analysis and the corrective action plans; there is a clear description of what a CAP needs to include; that there are sufficient action steps in CAPs; that designations of responsibility are clear; and there are clear outcome measures to evaluate the success of the CAPs.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of 10 CAPs, which represented 100% of the total of 10 CAPs on the CAP Tracking sheet, since August 2013, there was documentation that indicated: ▪ How each CAP was disseminated; ▪ When each CAP was disseminated; ▪ The specific person(s) responsible; and ▪ To whom the CAP was disseminated. The Facility was found to be in substantial compliance with this provision since the CAPs were disseminated as required.	Substantial Compliance

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E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Implementation of CAPs: **(Not scored)** Based on a sample of ___ completed CAPs and ___ in process CAPs, ___ (%) were implemented and ___ (%) were implemented in a timely manner. **Comment**: It was not clear that CAPs on the tracking sheet were being implemented timely. The tracking sheet included a column for implementation date, but no column to record if the CAP had started on time or when it did start. Tracking CAP status: **(Not scored)** There **was/was not** a system for tracking the status of CAPs. Of the ___ CAPs being tracked by the Facility, ___ (%) the tracking sheet indicated the status of the CAP and any action taken if a CAP had not been implemented. **Comment**: Once the CAP was underway, there were no columns for tracking the proposed and actual completion dates. One way to do that would be to include a column for projected completion date and a comment column to enter progress as the CAP is reviewed at each QA/QI meeting (such as "step 2 completed, step 3 not started on time, etc.). The QA/QI meeting notes included a provision for discussing CAP Tracking and CAP Status. However, there was little information included other than reference to such activities as tips for writing CAPs (11/12/13), or a notation that "11 CAPs that have been requested and re delinquent in turning in," noting that the QA Director would meet with departments who had not completed CAPs. Presenting a tracking sheet that clearly shows what has been requested and not turned in, as well as CAPs underway, but with steps not meeting timelines would be a practical way to prompt action. It would also provide documentation of where the issues were with the status of CAPs. Management of CAPs: **(Not Scored)** The Facility QA Director: ▪ **Did/did not** maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review in the sample of CAPs; and ▪ **Did/did not** present this information to QA/QI Council at least quarterly. **Comment**: As noted above, it was not clear that the QA Director was sharing an updated tracking sheet with the QA/QI Council at its monthly meetings.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

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		Comment: The following metrics were not scored, since it was clear from interview and from the Facility Self-Assessment that the CAP process was in a developmental stage, and had not reached the point of regularly monitoring the CAPs for effectiveness and making changes to assure progress. To reach that point, the Facility will need to have tracking that allows for identification of lapses in timelines and the associated issues responsible for those lapses, review of that tracking at QA/QI meetings, and input from those responsible for the lapses. Where necessary to move a CAP forward, there may need to be direction from the QA/QI Council to modify the CAP. Once a system is developed, based on a review of a sample of CAPs, the following metrics will be used to assess the Facility's compliance: <u>Evaluate effectiveness of CAPs</u>: **(Not Scored)** For ___out of ___CAPs (%), documentation showed review of their effectiveness (i.e., outcomes). **(Not Scored)** For ___out of ___CAPs (%), documentation showed review of their timely completion and or timely completion of steps within the CAP. <u>CAPs are modified when needed</u>: **(Not Scored)** Of the ___ CAPs that appeared to need modification, ___ (%) had been modified. <u>Modifications/results are discussed at QA/QI Council</u>. **(Not scored)** Based on a sample of ___ completed CAPs and ___ in process CAPs, ___ (%) had been discussed at QA/QI Council. <u>Modifications are implemented as written</u>. **(Not scored)** For ___ out of ___ (%) modified CAPs, evidence was present to show the due dates had been met or an explanation was provided for any delays. **(Not scored)** For ___ out of the ___(%) modified CAPs, evidence was present to show that all the steps of the CAP had been implemented as written.	

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 004.2: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, 11/21/13; o AUSSLC Policy: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports), dated 4/4/11; o List of individuals with most recent ISP dates, previous ISP dates, and number of days in between, as of 1/24/14; o ISP Timeliness list, from 7/1/13 through 12/31/13; o Data on ISP timeliness, undated; o In response to request for list of individuals admitted over last six months, including date of admission and date of initial ISP meeting, the statement: "No new admissions in the past six months;" o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Integrated Risk Rating form, Integrated Health Care Plans, Rights Assessment, last three monthly reviews, ISP Preparation Meeting documentation, ISP Attendance Tracking, Active Treatment Daily Plan, and SAP Tracking Form/Post ISP Reports, as available for: Individual #153, Individual #307, Individual #390, Individual #133, and Individual #405; o ISPs in relation to Living Options Discussions for the following: Individual #417, Individual #195, Individual #160, Individual #403, and Individual #406; o In response to request for assessment tracking information for individuals for whom ISPs were submitted, a statement: "No assessment data for individuals for whom ISPs are provided…;" o Settlement Agreement Cross Referenced with ICF-MR Standards: Section F, revised March 2013; o Data from December 2013 resulting from implementation of monitoring tool; o In response to a request for a list of QIDPs who have been deemed competent in facilitation of ISP meetings, the following statement: "None;" o ISP Attendance Data, January to December 2013; o ISP Assessment Data, October 2013, and January/February/March 2014; o QIDP Assignments, as of 1/27/14; o QIDP Manual o Sample Community Preferences, Participation, and Training Records for Individual #425, and Individual #406; o Individual Support Plan Annual Assessments Spreadsheet, for January 2014; o Individual Support Plan Annual Assessments Spreadsheet, for January, February, and March 2014;

	○ Attendance Tracking, for ISP dates in December 2013 and January 2014; ○ Draft Section F monitoring tool, dated 11/7/13, and corresponding draft instructions; ○ Request for Staff training, dated 2/24/14; ○ Draft QIDP/F Monitoring; ○ QIDP Supervision System, dated 2/21/14; ○ Handouts from ISP meeting for Individual #40; ○ Provision Action Information, updated 2/5/14; ○ Self-Assessment for Section F, updated 2/4/14; ○ Action Plans: Section F, updated 2/7/14; and ○ Presentation Book for Section F. ▪ **Interviews/Meetings with**: ○ Tristan James, QIDP Director; Jamaun Willis, Director of Vocational, Recreational, and Day Programs; Jim Sibley, State Consultant; Heather Blackwell, State Office Program Coordinator; and Linda Lothringer, Director of Compliance, on 2/24/14; ○ Holly Lindsey, Director of Quality Assurance, on 2/26/14; and ○ Tristan James, QIDP Director; and Jim Sibley, State Consultant, on 2/27/14. ▪ **Observations of**: ○ ISP Meeting for Individual #40, on 2/27/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 2/4/14. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. However, for a number of the subsections of Section F, the Facility Self-Assessment stated: "Based on the findings from this self-assessment this provision is not in substantial compliance, because a system has not been implemented to track this provision. As discussed with regard to Section F.2.g that addresses quality assurance processes, based on discussions with the Director of QA and the QIDP Director, as well as review of documents, the Facility was in the process of revamping the monitoring tool used to assess the ISP development process and ISP documents. According to a document the Facility provided (i.e., TX-AU-1402-V.3), "The facility trialed the previous Section F tool in November and December of 2013. December results were entered into the database… Based on the trials and needs of the Systems Improvement Agreement, the tool is under revision and will be re-implemented by 3/1/2014." The Facility submitted a copy of the tool it had used in late 2013 to the Monitoring Team, as well as the draft instructions for this tool. However, as noted above, this tool was currently under revision. It was positive that the Facility was working to construct one tool that would provide staff with the information they needed with regard to the ISP requirements of the Settlement Agreement, as well as the Systems Improvement Agreement. It also was positive that the Facility was developing instructions for the draft ISP Monitoring Checklist. Based on discussions with staff, at the time of the review, a QA Department Program Compliance Monitor

	had just begun completing reviews of ISP meetings and documents, and the plan was for the QIDP Coordinator and another staff member to begin completing reviews in March 2014. The data from the monitoring tools was not yet being shared with the QA/QI Council. As a result, data was not yet being used to identify problematic trends and/or take actions to remediate such trends. The QA Department had assisted the QIDP Department in maintaining data with regard to team member attendance at ISP meetings, and timeliness of assessments for ISP meetings. This data was being shared with the QA/QI Council, and the Facility included this data in its Self-Assessment. However, as discussed with regard to Sections F.1.b and F.1.c, because teams were not yet accurately identifying the assessments needed for ISPs and required team attendance, the data being collected for these indicators could not be considered valid. The Facility's Self-Assessment for Section F reported noncompliance with all subsections. Although this was consistent with the Monitoring Team's findings, the Facility did not yet have reliable and valid mechanisms in place for determining compliance with Section F of the Settlement Agreement.
	Summary of Monitor's Assessment: Based on information staff provided, in the six months prior to the Monitoring Team's onsite review, the Facility had a new QIDP Director, and QIDP Educator, and over half the QIDPs were new. The Facility had switched from a model in which Unit QIDPs were responsible for developing and drafting ISPs to one of having Facilitator QIDPs primarily responsible for these tasks. Unit QIDPs were now responsible for day-to-day implementation and oversight of the ISPs. Although this new model was still in the early stages of implementation, it appeared to provide an opportunity to allow concentrated training and mentoring, as well as to use the various skills of QIDPs to the best advantage. Some of the improvements that were noted with the ISP process included: ▪ A lot of work had been done to provide training to the new QIDPs on many of their duties and responsibilities, and to provide more specialized training to Unit and Facilitator QIDPs. A number of valuable training sessions, as well as resources, such as a QIDP Manual, had been offered. Although the Facility recognized that additional focused training would be needed, hopefully, this comprehensive training effort had laid some important foundations. ▪ ISP meetings were generally being held annually. ▪ Some improvements were seen in the scope and detail included in ISP action plans, including IHCPs. Although more work was needed, it was clear that efforts had been made to improve the measurability as well as the content of the action steps. ▪ Between November 2013 and February 2014, efforts have been made to review ISPs, and particularly SAPs to make sure that there was agreement between what the team discussed, and the SAPs being implemented. A process had been put in place to assist in ensuring that ISPs accurately reflected the teams' agreements with regard to SAPs moving forward. ▪ As of 2/14/14, Active Treatment Daily Plans had been developed for all individuals or groups of individuals, and implementation of these plans was in the beginning stages. For staff responsible for ISP implementation, these plans provided information about individuals' schedules, including expected times for SAP implementation, as well as other opportunities for training or active

	treatment, communication strategies, leisure interests, physical and nutritional management and mealtime needs, and behavioral strategies. Staff reported that an interdisciplinary approach had been used in the development of these plans to ensure they included the various programs that staff needed to implement, as well as broad opportunities for habilitation. Based on review of the Active Treatment Daily Plans for the five individuals in the sample, they provided valuable information in user-friendly formats. Some of the areas in which the Facility needed to focus its efforts included: ▪ The Facility had developed a schedule to hold timely ISP Preparation Meetings, and was in the process of catching up on these meetings. However, many of the ISPs in the sample reviewed did not have the benefit of this pre-planning activity. As a result, the documentation for the sample reviewed generally did not show that prior to the ISP meeting, the teams had identified the individuals' preferences and strengths, proposed goals, required assessments in preparation for the ISP meeting, or required attendance at the ISP meeting. ▪ Based on review of the sample of ISPs, attendance of necessary team members at ISP meetings and timely submission of needed assessments were areas requiring improvement. The quality of assessments also continued to need improvement. ▪ For the sample of ISPs, monthly reviews had not been completed. In the weeks following the Monitoring Team's onsite review, training was scheduled for QIDPs on the completion of monthly reviews. Facility staff recognized that other disciplines also would need to contribute to the monthly review process. ▪ Teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. ▪ The Facility was using the IHCP format, which often expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences. ▪ ISPs generally continued to lack measurable goals/objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, behavior, skills, etc., or maintaining his/her current status). ▪ The quality assurance efforts related to ISP development were under revision. The Facility was working to develop a revised monitoring tool for ISP meetings and documents, including instructions. Progress had been made in developing other sources of data related to ISPs, such as timeliness of ISP document finalization, attendance at ISP meetings, and timeliness of assessments. As the monitoring tool is revised, it will be important for the Facility to ensure it is comprehensive, and that valid and reliable data are collected. Such data, as well as the other sources of data, should then be utilized to identify and address problematic trends.

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F1	**Interdisciplinary Teams -** Commencing within six months of	On November 21, 2013, DADS State Office issued Policy #004.2: Individual Support Plan Process. At the time of the Monitoring Team's onsite review, the Facility had not yet	

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	the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	localized the State Office ISP policy. The Facility included a draft policy in the Presentation Book, which was a replica of the State Office policy. Work will need to be done to develop a local policy and/or procedure that defines the specific procedures used at AUSSLC to implement a number of the broad requirements included in the State Office policy (e.g., training, quality assurance methodologies, tools or forms used to implement the ISP process, etc.). For most of the subsections of Section F, the parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample), because the Facility had made limited progress. A sample of five ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly reviews, the individuals' daily schedules, ISP Preparation Meeting documentation, ISP Attendance Tracking, Active Treatment Daily Plan, and SAP Tracking Form/Post ISP Reports, as available. The documents the Facility provided included the most recently developed ISPs for: Individual #153, Individual #307, Individual #390, Individual #133, and Individual #405.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ Policy #004.2 in Section II.F.1.b indicated that the QIDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. ▪ On September 1, 2013, the Facility had begun to use Facilitator QIDPs to facilitate ISP meetings, and Unit QIDPs for other duties related to the implementation and oversight of ISPs. The Facility submitted detailed draft listings of the duties of Facilitator QIDPs and Unit QIDPs. Observations of team meetings and reviews of ISPs illustrated that the QIDP Facilitators had been facilitating ISP meetings. Although the Facility was in the beginning stages of implementing this new system, it held promise for allowing QIDPs to develop and use specific skills, and to allow concentrated training and mentoring. The QIDP Director explained that cross-training was occurring, so that if a vacancy occurred or the model was not successful, there would be flexibility to revise job	Noncompliance

#	Provision	Assessment of Status	Compliance
		duties. ▪ With regard to staffing, a QIDP Coordinator oversaw the QIDP Department, and directly supervised the five Facilitator QIDPs, the QIDP Educator, three Lead QIDPs, and the Supervisor of Active Treatment. At the time of the Monitoring Team's onsite review, an Administrative Assistant position also recently had been filled. The three Lead QIDPs supervised 16 QIDP positions. Based on a list updated as of 1/27/14, there were 14 QIDPs and two vacant positions. When all 16 QIDPs were in place, one or two QIDPs generally would be assigned to each residence. Based on the current census of 280, this would be an average ratio of 1:18, with a range of 1:15 to 1:22. ▪ Since the Monitoring Team's last review, approximately half of the QIDPs were new, and since the last review, there had been 10 new QIDPs (i.e., approximately three QIDPs that had been hired had not stayed, and these positions had been refilled). This represented a turnover rate of over 50% for QIDPs assigned to the residences and/or as Facilitator QIDPs. As the Monitors recently discussed with State Office staff, the ongoing high turnover rates for QIDPs assigned to these positions makes it difficult to achieve the needed changes with ISPs due to the constant need to train new staff. Although it is positive that QIDPs sometimes move on to other positions within the Facility, it will be important to identify ways to extend the tenure of staff in the QIDP positions. ▪ As is discussed in further detail with regard to Section F.2.e, significant training had been done with QIDPs as well as other IDT members. Although the Facility recognized that additional training and mentoring would be needed, hopefully, this training had provided some QIDPs with some basic knowledge and skills. ▪ The QIDP Director also shared with the Monitoring Team an outline of the QIDP Supervision System, dated 2/21/14. It set forth the various regular meetings, as well as observations that supervisory staff in the QIDP Department were expected to hold. For example, Department meetings were to be held weekly, and Lead QIDPs were expected to meet individually with each QIDP he/she supervised at least monthly, and more often as needed. The QIDP Director and Lead QIDPs also were expected to observe a set number of ISP and ISP Preparation meetings per month. The document also listed the documentation that was expected for each of these activities. It was positive to see a structure that should improve oversight, and provide opportunities for information sharing, as well as mentoring and other supervisory activities. ▪ Similarly, the QIDP Educator shared a draft QIDP/F Monitoring document. This document outlined the various responsibilities for monitoring the completion of the various tasks related to ISP development and implementation, as well as monitoring the quality of the activities and documents. Although still in draft format, this appeared to be an important step in ensuring accountability, and creating a structure to assist in improvements in quality.	

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		▪ During the week of the review, the Monitoring Team observed two team meetings. Progress continued to occur with regard to the facilitation of meetings. Based on these limited observations, some of the areas in which progress had begun or been sustained included: o At annual ISP meetings, an agenda was clearly set forth, along with ground rules. QIDPs generally kept the teams focused on the agenda. o This was facilitated through the use of a draft ISP, IRRF, and IHCPs. These documents followed the formats that the State Consultants and State Office staff had developed. Although further improvement was needed, these documents helped to provide structure to the meetings, and synthesized some of the information in the assessments. ▪ The QIDPs had provided the teams with draft ISPs. This appeared to assist in facilitating the discussion. Recommendations from various assessments were included in the applicable sections of the draft. Although it had not completely resolved the problem, this seemed to help ensure teams discussed the various recommendations. It will be important to ensure that all recommendations are included, and when teams do not accept a recommendations or one recommendation contradicts another that the team discussion reconciling or justifying its decisions are included in the ISP document. o Efforts were made to include the individuals. o Teams listed the individuals' strengths and preferences, and this information was provided for the team to see. Although this was a positive practice, there was variability in the extent to which the QIDP referred the team back to this information during the course of the meetings. As a result, for the ISPs observed the week of the onsite review, little to no incorporation occurred of their preferences or strengths into the overall ISP. A positive example of the incorporation of preferences was seen for Individual #40: ▪ Individual #40 had refused nine gastrointestinal (GI) appointments, and the team was concerned due to his ongoing complaints of abdominal pain as well as unplanned weight loss. Although the work-ups that had been completed thus far were negative, the GI specialist had requested a CT scan. The team discussed creative and person-centered options for making an additional attempt to obtain Individual #40's cooperation to attend the needed appointments, including arranging the time of the appointments to suit his preferences, and building in incentives based on some of his specific preferences.	

#	Provision	Assessment of Status	Compliance
		o Efforts were made to elicit information from all team members. However, not all team members participated to the extent they should have. o During the ISP meetings on site, the teams had discussions about a variety of the protections, supports, and services. It appeared that the revised format of the ISP helped teams to more fully discuss non-risk items o Based on observations, it appeared that team members were coming more prepared to the meetings. o An area that continued to require attention was in expanding teams' expectations with regard to individuals' abilities to grow and develop, and for team members' responsibilities to facilitate this growth. However, based on observations, some good examples of IDT member advocacy in this regard were seen. For example: ▪ Individual #40 had hearing aids that he did not regularly use. The audiologist was present at his ISP meeting, and advocated for the team to put supports in place to try to increase his use of the devices. A member of the PNMT that was present at the meeting asked good follow-up questions regarding the impact of not using the hearing aids on Individual #40's ability to learn. Despite some initial reluctance from other team members, including the guardian from a private agency, the team eventually decided to implement some supports to encourage Individual #40's use of the devices. Evidently, these supports had been discussed in the past, but both residential and day service representatives indicated they had not been consistently implemented, and were not in place at the time of the ISP meeting. The re-initiation of these supports was a positive result of the advocacy of a couple of team members. Based on observations of meetings held the week of the onsite review and review of ISP documents, facilitation of team meetings was improving, but for none of the meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included: ▪ As indicated in previous reports, QIDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. According to documentation the Facility provided, none of the QIDPs had been deemed competent in Facilitation. ▪ Based on observations of meetings held the week of the onsite review and	

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		review of related documentation, facilitation of team meetings was continuing to improve. However, as is discussed in further detail below, areas in which QIDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o Expanding the list of individual preferences to include preferences related to work, relationships, past experiences, etc. and using the preferences to offer the individual new experiences. It will be important for QIDPs to ensure the full use of the information gained through the still developing Preferences and Strengths Inventory process. o Similarly, identifying a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. o Making sure decisions the teams make are data-based to the extent possible. A number of gaps continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and individuals' risks. Although teams were discussing some objective clinical data in relation to risks, this was an area that needed improvement, particularly with regard to comparing data from year to year to determine if the individual had improved, regressed, or remained stable. o Developing measurable objectives. This was an area in which improvement was seen from the last review. A number of the action steps included in the ISP action plans were measurable. However, goals and clinical indicators often were not developed, or when they were, they were not consistently measurable. This factored into the overall process of developing adequate action plans, including appropriate methodologies. o Articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., will participate in community trips twice monthly), rather than as a change in the individual's life (e.g., will pursue her interest in art by visiting two new art venues in the next six months, and making a ceramics piece at a local ceramics store at least once in the next three months). o To improve integration of supports, QIDPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain. Based on the Monitoring Team's review, some progress had been made. However, based on observations as well as review of ISPs, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of	

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		adequate treatments, supports, and services. In addition, the Facility was not yet using a valid process to determine QIDPs' competence in meeting facilitation skills. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. In Section II.A, DADS Policy #004.2 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. Teams were now supposed to determine attendance requirements at the ISP Preparation Meeting held 90 days prior to the annual meeting. The DADS November 2013 ISP policy had an attachment (Exhibit A) that included some guidance on when particular team members' attendance should be required. The document was entitled "Annual ISP Meeting IDT Attendance Indicators." At AUSSLC, these meetings were generally not occurring in a timely manner, and a Corrective Action Plan had been developed to improve timely completion of the ISP Preparation Meetings. Specifically, the QA Department worked with the QIDP Department and developed a schedule. The schedule required teams to conduct ISP Preparation Meetings in February 2014 for ISP meetings scheduled in March and April; in March 2014 for ISP meetings scheduled for May and June; and in April 2014 for ISP meetings scheduled for July. If this schedule was followed, Facility staff anticipated that the ISP Preparation Meeting schedule would be caught up and could be implemented on schedule moving forward. The QA Department had taken temporary responsibility for entering attendance data into a database to allow tracking of attendance at ISP meetings. The QIDP Department had resumed responsibility for this function now that an Administrative Assistant position had been filled. The Facility provided data on attendance for the one-year period from January 2013 through January 2014 with no data available for February 2013. According to the Facility's data, the average percentage of attendance by required team members was 68% in January 2013, and 76% in January 2014 (with a range of 68% to 92% during the year). In January 2014, the range per team member was 0% (i.e., behavior analyst, audiologist, family, and music therapy) to 100% (i.e., Designated Local Authority, clergy,	Noncompliance

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		and Placement Coordinator). This data was based on the "required attendance" in comparison to those that attended. However, as noted above and discussed below with regard to the sample of ISPs reviewed, teams were not conducting timely ISP Preparation Meetings and based on the sample, many meetings were not held. Therefore, it was unclear how the Facility was determining which team members were required to attend the ISPs. In addition, one of the concerns about the validity of the data stemmed from the fact that, even when ISP Preparation meetings were held, teams were not consistently identifying the appropriate members of the IDT that should be required to attend. Until this is corrected, it will be difficult for the Facility to interpret its data. Based on the sample of five ISPs the Monitoring Team reviewed: ▪ For the five individuals in the sample, one team (20%) (i.e., for Individual #405) defined the members of the team that should attend the annual meeting. Three individuals (i.e., Individual #307, Individual #390, and Individual #153) had no documentation of an ISP Preparation Meeting. One individual (i.e., Individual #133) had a meeting, but the sheet on which attendance was defined was not submitted to the Monitoring Team. ▪ One of the one individual had strengths, preferences, or needs that potentially required additional team member participation. For none of this one individual, (0%), the team had adequately justified why such team member's participation was not necessary. Specifically, although Individual #405's team identified most needed team members, the nutritionist was not identified despite the individual having needs in this area, and no justification was provided for not including the nutritionist. ▪ For none of five (0%), it appeared that a duly constituted team participated in the annual meetings. The Facility remained out of compliance with this provision. Teams were not yet consistently using the ISP Preparation Meeting to identify team members for participation in the ISP meetings. On a positive note, the Facility had a Corrective Action Plan in place to improve the timely completion of the ISP Preparation meetings. Although the Facility had a system to track data related to attendance, the data did not show when teams failed to identify an appropriate team member. Based on the Monitoring Team's review of ISPs, meetings occurred without the attendance of team members that it appeared should have been in attendance as dictated by the individuals' preferences and needs.	
F1c	Conduct comprehensive assessments, routinely and in	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The	Noncompliance

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	response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	noncompliance finding from the last review stands. Teams were now supposed to identify needed assessments at the ISP Preparation Meeting held 90 days prior to the annual meeting. As noted above with regard to Section F.1.b, at AUSSLC, these meetings were generally not occurring in a timely manner, and a Corrective Action Plan had been developed to improve timely completion of the ISP Preparation Meetings. As a result, in reviewing a sample of ISPs, individuals' teams generally had not identified the assessments that team members were required to prepare for the ISP meeting. In terms of quality of assessments, since the Monitoring Team's last review of AUSSLC, State Office had issued assessment formats to all disciplines, and these formats required the inclusion of the information related to individuals' preferences, strengths, and needs, as well as recommendations. Although a number of disciplines had begun to use the newest format, it had not yet resulted in the incorporation of individuals' preferences and strengths into recommendations, or the full delineation of recommended supports and services to meet the individuals' needs. In response to a request of assessment data for the last one-year period, the Facility submitted a statement that read: "No assessment data for January 2013 – September 2013 ISPs and November 2013 ISPs." Data on the timeliness of assessments was submitted for October 2013 and January 2014. The data was presented by discipline/type of assessment. For January 2014, the overall average for timeliness was 33%, with the range of timeliness from 4% to 77% per discipline. Similar to the data the Facility maintained on attendance at ISP meetings, this data related to timely assessments appeared to be based on the "required assessments" in comparison to those that were actually submitted 10 days prior to the ISP meeting (i.e., "N/A" was designated for some assessments). However, as noted above and discussed below with regard to the sample of ISPs reviewed, teams were not conducting timely ISP Preparation Meetings and based on the sample, many ISP Preparation meetings were not held. Therefore, it was unclear how the Facility was determining which assessments were required for the individuals' ISP meetings. Based on review of a sample of five ISPs, the following concerns were noted: ▪ The quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address clinical and therapy supports. ▪ As discussed in previous reports, assessments also frequently did not include adequate recommendations. Some of the issues noted included no or limited	

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		specific recommendations, or an incomplete list of recommendations; and recommendations not oriented to the development of action plans. Interestingly, some of the OT/PT (e.g., Individual #405) included a fairly extensive, although not exhaustive, list of supports the individual would require in the community. Presumably, the individual required these same or similar supports at AUSSLC, but the recommendations for what needed to be provided while the individual remained at the Facility did not include supports similar to what was identified as necessary should the individual transition to the community. ▪ Another issue identified was related to the listing of the individuals' strengths and needs in assessments. Although they were now more often listed in the new assessment formats from State Office, there was little evidence that assessors had incorporated them in meaningful ways in the resulting recommendations. Based on the sample of five ISPs: ▪ For these five individuals, at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for one (20%) (i.e., Individual #405). Three individuals (i.e., Individual #307, Individual #390, and Individual #153) had no documentation of an ISP Preparation Meeting. One individual (i.e., Individual #133) had a meeting, but the sheet on which assessments were identified was not submitted to the Monitoring Team. ▪ In reviewing the ISPs for five individuals, the teams for one individual (20%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. The team that had identified the necessary assessments was the team for Individual #405. ▪ For none of the five (0%) (i.e., Individual #97), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. In the past, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. For four of the five individuals included in this sample, the ISPs listed the individual's injuries and allegations over the previous year. For one (i.e., Individual #405), a list of incidents and injuries was not specifically included. Some teams documented discussion of incidents and allegations, but the level of analysis and planning to reduce future incidents, to the extent possible, varied. The following provide some examples of where further discussion was needed: ▪ The ISP indicated Individual #153's team identified a trend with regard to falls and that it was addressed in the IHCP. It was not clear from the discussions in the IRRF that the cause of the falls had been determined, and so it was unclear	

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		whether the action steps in the IHCP effectively addressed the issue(s). ▪ For Individual #133, a brief review of incidents was included, but no analysis. For example, he had had three falls, but no analysis was done to determine any potential for similar causes, etc. ▪ There was some detailed discussion of incidents, and the team looked at alternatives to the gait belt to address falls, because Individual #307 resisted the use of the gait belt. However, two injuries to her inner thigh were not connected as a potential trend in terms of location of injury on her body. ▪ For Individual #390, there was no documented review of the trend of self-inflicted bites or scratches. The Facility remained out of compliance with this provision. Efforts were needed to ensure teams were accurately identifying assessments that needed to prepare for individuals' annual ISP meetings, as well as to improve the timeliness and quality of assessments.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ Based on the Monitoring Team's review of five ISPs, none of the five teams (0%) addressed all recommendations in the assessments either by incorporation of the recommendation into the ISPs, or evidence that the team had considered the recommendation and justified not incorporating it. ▪ Some of the overall continuing concerns negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, an ISP that outlined the protections, services, and supports provided to the individual included: o As noted with regard to Section F.1.c, many assessments included minimal recommendations. As a result, it was not clear what protections, supports, and services, the assessors had determined the individual required. As noted above, some assessments included lists of supports individuals would require if they moved to the community, but corresponding recommendations for the supports the Facility would provide over the coming year did not include equivalent services and supports.	Noncompliance

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		o The assessment results were not translated into recommended action plans, including measurable, functional objectives. o Although some improvement was seen, based on review of documentation and observation of meetings, it was not clear that team members had read each other's assessments and identified questions and/or recommendations related to the integration of services and supports. This limited teams' ability to utilize assessment information to develop adequate protections, supports, and services. The Facility should address these issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans the Settlement Agreement requires. Based on the ISPs and related assessments submitted, assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them at the ISP meeting or in the ISP document. The Facility remained in noncompliance with the provision.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on information the Facility provided, the following activities had occurred to provide additional education to QIDPs regarding community living options and/or to facilitate teams' implementation of the requirements of this subsection: ▪ Admissions Placement staff reviewed the ISP schedule and made assignments for Transition Specialists as well as Placement Coordinators and other Department staff to attend ISP meetings. Based on the Monitoring Team's observation of the Department's meeting the week of the onsite review, for March 2014, it was anticipated that an Admissions Placement Department staff would be present at each ISP meeting. This was positive, and had the potential to assist in ensuring that teams, including individuals and their guardians make informed decisions regarding living options. ▪ On 9/18/13 and 9/30/13, training on transitions was part of the training provided to IDT members. ▪ On 11/4/13, training on the Most Integrated Setting Policy was part of the training provided to QIDPs. ▪ QIDPs had begun calling families and guardians before the ISP meeting to discuss a number of items, including the most integrated setting discussion that	Noncompliance

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		would occur at the meeting. This provided the family member and/or guardian to express their opinions, and for the QIDP to potentially answer questions. ▪ In October 2013, Facility staff identified nine individuals for whom the living options discussions potentially were not thorough and/or accurate, and/or for whom the obstacle(s) that teams identified did not appear to be accurate (e.g., the obstacle was LAR choice, but the individual did not have an LAR). ISPA meetings were held, and the Living Options Discussions were revisited. According to documentation provided five of these nine individuals subsequently had been referred for transition to the community, and for others, additional action steps had been developed to address obstacles. It was positive that the Facility had taken these steps to identify potential issues with Living Options Discussions and to take actions to reevaluate individuals' appropriateness for movement to the most integrated setting appropriate to meet their needs. This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. Ten individuals' ISPs were reviewed. These included those for: Individual #153, Individual #307, Individual #390, Individual #133, Individual #405, Individual #417, Individual #195, Individual #160, Individual #403, and Individual #406. The following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of five ISPs reviewed for which the Monitoring Team requested all assessments (i.e., Individual #153, Individual #307, Individual #390, Individual #133, and Individual #405), for none (0%), all of the assessments included the applicable statement/recommendation. For a number of individuals, multiple assessments were late or not provided, and as a result, the IDTs did not have access to nor could the Monitoring Team confirm that the assessors had made the required recommendations. o Of the 10 ISPs reviewed, two of the individuals had been referred for transition to the community (i.e., Individual #133, and Individual #405). Four of the 10 individuals' ISPs (40%) included a clear recommendation from the professionals on the team to the individual and LAR (i.e., Individual #133, Individual #405, Individual #153, and Individual #160). For four of the 10 individuals (40%), adequate justification was	

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		provided for the full team's recommendation (i.e., for Individual #133, Individual #405, Individual #195, and Individual #160). The following provide examples of the problems identified: ▪ For individual #307, according to the ISP narrative, all discipline team members independently recommended the individual could be supported in a less restrictive environment. However, without justification, the discipline members did not jointly recommend transition to the individual and guardian, and instead concluded that: "There were medical issues which occurred in this past year which appeared that [Individual #307] had some changes within her. The IDT believed that with these medical issues, the LAR should be involved in this discussion before recommending that [Individual #307] is able to live in a less restrictive setting." However, none of the team members referenced these concerns in their assessment recommendations related to transition, and the ISP narrative did not explain or identify any medical concerns that could not be supported in a community setting. In addition, the team relied on information from a previous guardian in determining that the guardian's opposition to community transition was the reason for not making a referral. Although the narrative of the ISP indicated further follow-up would occur with the new guardian, no related action step was included in the ISP action plans. ▪ For Individual #390, the team's statement was contradictory: "The **facility discipline members…** determined that [Individual #390] can be served in a less restrictive setting, although at this time her health is unstable. [Individual #390] has had multiple hospitalizations in the past year for syncope, labile heart rate and blood pressure of unclear etiology as well as apneic episodes. She needs 24 hour nursing care at this time and needs to be monitored closely by health professionals." Based on a review of the assessments, there was disagreement between assessors (i.e., five said yes, and two said no, and medical was unclear). However, these differences were not reconciled. Individual #390 could not express an opinion about community transition, and she did not have a guardian. The team concluded that she would not be referred, but although they cited medical issues and the need for "24-hour nursing care," the team did not detail what community living situations	

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		they had considered, and why they believed 24-hour nursing care could not be provided in a more integrated setting. ▪ For Individual #153, the team indicated that guardian was opposed, so the final recommendation was not to refer. However, the rights assessment indicated that the guardianship had lapsed. ▪ The discipline members indicated Individual #417 could be supported in a more integrated setting. However, there was no discussion documented or reconciliation of the vocational assessor's disagreement with the rest of the team, so it was not clear how the team reached a consensus recommendation. The individual objected to moving, so the team did not recommend referral. However, it appeared that the team did not believe he was competent to make decisions on his own, and although the team did not make a referral for a guardian, the ISP indicated the Facility Director provided consents for Individual #417. ▪ For Individual #195, the section for the discipline members' recommendation indicated that the majority of team members believed Individual #195 could be supported in a more integrated setting, but the vocational team member did not. It appeared the team left it as two different recommendations, and there was no reconciliation of the differences of opinion. The LAR objected to a referral, so one was not made. ▪ For Individual #403, the discipline members did not make one coherent recommendation. Rather the team members' stated: "The **facility discipline members** (independent of the resident and LAR/family) determined that [Individual #403] can be served in a less restrictive setting at this time. This determination is based on her independence in her self-help skills overall health and behavioral stability... [Individual #403] is non-verbal and has not indicated a preference in her living options although she has been refusing to leave her home. The IDT agreed that [Individual #403] would need to be willing to leave her home in order for her to be able to participate in community visits and outings." It was unclear why the Facility discipline members recommended transition if they did not believe it was possible at this point in time. The final team decision for Individual #403, as written, appeared to be based on the individual's choice. However, as noted above, the team previously indicated her choice was unknown, and given she	

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		had a guardian in the past, her ability to make informed decisions was questionable. ▪ The discipline members indicated that Individual #406 could not be supported in a more integrated setting "based on his current behavioral issues that pose a safety threat to himself and/or others. [Individual #406] currently requires physical restraint supports that are not provided in the community at this time..." It was unclear: 1) why the team believed individuals requiring physical intervention could not be supported in the community; and 2) given that his team rated him to be a medium risk in relation to behaviors, why Individual #406's behaviors were viewed as so significant to preclude transition to the community. Although the LAR's Choice was listed as a reason for the decision not to refer, as noted above, behavioral issues also were listed as a reason, and the team had not justified this reason. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals being referred to the most integrated setting, and plans to overcome such obstacles. In summary, teams were identifying obstacles, but the lists were not consistently accurate, and/or teams had not identified the specific reasons for the LAR's choice not to pursue transition to the community. Action plans generally were being developed, but they were not sufficiently individualized and often did not address the all of the perceived obstacles. Although many team members were including statements in their assessments with regard to individuals' appropriateness for community transition, all team members were not. Teams generally were making recommendations to the individuals and/or LARs, but these recommendations most often were not justified. The plans to overcome obstacles to transition were not yet addressing the specific issues related to individuals' and their LARs' reluctance to consider a referral, did not address all perceived obstacles, and were not individualized. The Facility remained out of compliance with this provision.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		

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F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS Policy #004.2 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; and topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" <u>Identification and Use of Individuals' Preferences and Strengths</u> Based on a review of ISPs, teams were making efforts to identify individuals' preferences. The Facility was supposed to be using the Preferences and Strengths Inventory. However, this had not been consistent, as illustrated in the review of the sample of five ISPs for which no PSIs had been completed. The Facility had developed a Corrective Action Plan, which was in the process of implementing it. The goal of the plan was to have PSIs completed prior to the ISP Preparation Meetings by 3/31/14. The plan involved training Unit QIDPs, and a competency component requiring QIDPs to submit their first PSI for review and constructive feedback. The QA Department also was responsible for developing a schedule for the completion of PSI, and working with the QIDP Department to ensure the PSIs are completed 10 days prior to the ISP Preparation Meetings. Based on review of the sample of ISPs:	Noncompliance

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		▪ All five of the ISPs reviewed (100%) included a listing of individuals' preferences and strengths. Although teams had begun to expand the lists of preferences and strengths, some lists were still quite limited. Strength lists often were largely comprised of individuals' adaptive living skills. Although these were important strengths, it will be important for the lists to be expanded to include other qualities. ▪ The quality of PSIs could not be assessed, because they had not been completed for the individuals in the sample. ▪ Although some progress was seen, none of the individuals' teams (0%) had effectively incorporated their preferences into related action plans, or used these preferences in creative ways to address individuals' needs (e.g., building in incentives) or to expand individuals' horizons. Many examples were provided in previous reports of missed opportunities for incorporating individuals' preferences into action plans in a manner that would build upon them, and potentially result in growth for the individual. The following provide a couple of examples: o Although Individual #133 had a lengthy list of preferences at the beginning of his ISP, the only one incorporated into action plans appeared to be his preference to go to an amusement park and concert. He had a goal to save money for these purposes. Although some of his preferences related to employment were discussed during the ISP, the related action plan did not reflect this discussion or incorporate the stated preferences. o The ISP Action plans for Individual #405 included a couple of examples of incorporation of the individual's preferences, including an action step for Individual #405 to make beaded chains with a friend on campus, investigation into a rocking chair that would be safe and not tip, and an action step for Individual #405 to regularly listen to Spanish music. Further work was needed, but this was a good start. o Minimal integration of Individual #307's preferences were seen in the ISP action plans (e.g., purchasing music), even though the team had done some work to identify preferences in different categories, such as items, activities, and interactions. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. Strengths were not regularly built upon to address other need areas. Again, examples were provided in previous reports of missed opportunities to build upon individuals' strengths. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of the sample of ISPs and ISP Preparation Meeting documentation (i.e., only available for Individual #133 and Individual #405):	

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		▪ None of the plans or ISP Meeting Preparation documentation reviewed (0%) included a list of priority needs. ▪ In none of the plans or ISP Meeting Preparation documentation (0%) was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. For Individual #405, the team made some mention in the ISP narrative about why learning certain skills were of less priority than others, but this was not consistent throughout the various subsections of the ISP. Although the ISP Preparation Meeting documentation (i.e., only available for Individual #133 and Individual #405) now included a list of goals the team had decided upon, no explanation was provided of how the team made these decisions. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. ▪ In one of the five ISPs reviewed (20%), barriers were identified, and in one (20%) the team sufficiently addressed them. Individual #405's team identified transportation as a barrier to her attending day program, and an action step was included for the QIDP to follow-up with the Unit Director. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ None of the five ISPs reviewed (0%) included specific skill acquisition plans for implementation in the community. ▪ Five of five individuals' ISPs (100%) included at least one measurable objective to enhance individuals' general participation and integration into their communities. However, some of these were quite limited (e.g., for Individual #153 and Individual #307, the objective was for the individual to be involved in community trips two times per month, or for Individual #405, once a month). ▪ Of continuing concern, the community-related objectives generally were not written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. Although AUSSLC had made some limited progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals and some expansion of these was noted, in many cases, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. ISPs reviewed did not include action plans that addressed	

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		community skill acquisition. Although most plans included some community activities, they generally did not encourage participation in the community with nondisabled peers.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. Based on interview and documentation in the Presentation Book for Section F, on 9/24/13, the State Consultant had provided training to QIDPs on writing action plans. Given that the IHCP is a key part of the ISP, and the RN Case Managers had primary responsibility for drafting these, it will be important for them to complete similar training. The following summarizes the findings related to action plans: ▪ None of the five plans reviewed (0%) included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. ▪ None of the plans (0%) included a full set of measurable objectives. ▪ This negatively impacted the intensity of individuals' active treatment and habilitation, the supports they were provided, and the teams' ability to measure progress, or lack thereof. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, action plans related to obstacles to transition were not sufficiently individualized, and often did not address the obstacles identified. The following briefly summarizes concerns related to action plans: ▪ As noted in the previous monitoring reports, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Since the last review of AUSSLC, the scope of these goals and objectives had continued to increase. This was a positive development. Action plans in ISPs included skill acquisition plans, and teams were developing the Integrated Health Care Plans. However, IHCPs continued to require significant	Noncompliance

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		improvements, and limited discussion of them occurred during ISP meetings, particularly in relation to the measurable goals that teams needed to include in them. Generally, specific PBSP objectives were not included. Similarly, psychiatric and medical treatment plans generally were not incorporated into the ISP through the inclusion of measurable goals or objectives in IHCPs. Generally, the roles of clinical staff were missing from the IHCPs. ▪ Clearly, efforts were being made to make ISP action plans and IHCPs more measurable, but more work was needed in this regard. ▪ The plans had begun to include some clinical indicators in the form of goals. Most often, these "goals" were not measurable, because the action plan did not include processes for collecting data and no one was assigned to monitor the information on a regular and specifically stated basis. The following examples were representative of other ISPs reviewed, and are used only as examples of the larger issues. o For Individual #405, the following was difficult to measure: "will receive supports per her PNMP and MAR for the next 12 months to prevent episodes of aspiration, choking, and GERD." Based on this goal, it was not clear what the baseline was for the individual, or what would be considered an improvement. The following was more measurable, but undefined terms such as "medical intervention" resulted in it still not being measurable: "With supports, [Individual #405] will have regular bowel elimination or increase in frequency of bowel movements as evidenced by a decrease in episodes of constipation requiring medical intervention less than 6 times over the next 12 months." Given that according to the IRRF, the individual had had no bowel interventions over the last year, it was unclear why the team viewed a goal/objective to have less than six interventions in the coming year as a good measure of improvement or maintenance of her current clinical status. o For Individual #307, the overall goals generally were not measurable (e.g., "[Individual #307] will receive the following measures to prevent illness and injury related to the risks listed here over the next 12 months"). For Individual #390, the IHCP included a number of measurable action steps, but the goals/objectives were not measurable (e.g., "will receive supports per her PNMP and MAR for the next 12 months to prevent episodes of aspiration, choking, and GERD," or "will have measures in place per her PNMP to reduce the risk of impaired skin integrity over the next 12 months"). ▪ Of ongoing concern, the objectives or actions steps for vocational and day program activities were extremely limited. Limited, if any, goals or objectives were targeted towards expanding individuals' day and vocational options or helping them to learn new skills.	

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		▪ As is discussed in further detail with regard to Section I, the action plans teams had developed for individuals' at-risk issues did not adequately address their needs, and most did not include measurable objectives necessary to determine: a) if the supports outlined were provided as required; or b) whether or not the supports and strategies were having the desired outcome (i.e., were they effective in improving the individual's health, or maintaining his/her current status). ▪ Objectives often were not individualized. For example, many action plans related to overcoming obstacles to referral to the community were identical from ISP to ISP, showing no individualization. ▪ In most plans, objectives were not seen in relation to staff training requirements. Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to provide education to QIDPs to improve the measurability and individualization of objectives and action steps. However, these remained areas in which significant work was needed. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on observations of meetings and team discussions, and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ Integration of various plans (e.g., medical treatment plans, dental plans, PBSPs, psychiatric treatment plans, PNMPs, nursing protocols/plans, desensitization plans, respiratory therapy plans, walking plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. Although the PNMPs often were identified in action plans as needing implementation, reference usually was not made to the specific plan approved (i.e., by date), and limited, if any, goals/objectives/action steps were included in the ISPs in relation to the plans. Components of other plans, such as medical treatment plans, were included as action steps, many components of these plans had not been integrated into the ISPs/IHCPs. ▪ Delineation was not sufficiently clear of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.). The focus tended to be on implementation, and other areas often were missing or not well defined. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. The plans generally did not define roles for medical, psychiatric, Habilitation	Noncompliance

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		Therapy, or Behavioral Health Services staff. ▪ The IHCPs did not consistently include the supports that the team identified in the IRRF. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ Most plans included reference to skill acquisition plans, as well as service objectives. On a positive note, the measurable objectives for the SAPs generally were set forth in the ISPs. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. Previous reports have provided details about what was missing. ▪ Although this was an area in which more work was needed, based on the review of the sample of ISPs, rights restrictions was an area in which teams sometimes discussed action plans to assist in potentially reducing the need for the restriction. None of the five plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Some limited improvements were seen. However, teams will need additional coaching and mentoring to develop ISPs that meet this requirement of the Settlement Agreement.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The following findings are based on reviews of the sample of ISPs: ▪ For none of the five ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the five ISPs (0%), the roles of the persons identified as responsible were clearly defined. This most recent review showed some improvement from previous reviews, and as noted above, it was clear that efforts were being made to improve the measurability of action plans. However, the following summarizes some of the areas of improvement and problems noted: ▪ Many of the action steps were measurable, and included specific expectations regarding implementation (e.g., each meal, once per shift, etc.), but the frequency was not always specified. ▪ Timeframes often were missing for the frequency of review. For example, in	Noncompliance

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		many ISPs, a number of action steps required direct support professionals and nursing staff to "monitor for signs and symptoms of..." However, a frequency was not provided. As a result, the frequency of monitoring was unclear, and it was not clear how the team would know that proactive monitoring was occurring. ▪ In IHCPs, in some very limited cases, overall goals now included measurable indicators to allow measurement of an individual's status. However, the methods for measuring or the staff responsible for measuring them generally were not provided. ▪ Often two positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. ▪ Although persons responsible generally were identified, many steps were missing, so it was unclear who was responsible for specifics such as wheelchair/adaptive equipment maintenance, role of Respiratory Therapist, etc. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. It will be important, though, as discussed elsewhere to ensure that their roles are clearly defined, as well as the methodologies they should use to implement action steps. For example, as noted above, when direct support professionals and clinical staff were listed as both being responsible for the same action steps, definition was needed of for what the direct support professionals were specifically responsible as opposed to clinical staff. With regard to methodologies in action plans: ▪ In none of the five plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although more of the methodology was included than seen during past reviews, steps were often missing, and in many cases, no methodology was provided at all ▪ Methodologies were often reactive as opposed to proactive. For example, nursing protocols were to be implemented when signs and symptoms of illness were reported, as opposed to using nursing protocols proactively. In addition, most often, the etiology of the healthcare concern was missing, so it was unclear what steps reasonably could have assisted with these risk areas. ▪ Sometimes methodology was included in the IRRFs for addressing at-risk issues, but the ISPs did not include action plans with the necessary detail. ▪ In addition, as is discussed with regard to Section I, action plans for individuals, identified as being at risk, frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The IHCPs set forth plans that were not sufficiently aggressive to either further evaluate and/or address	

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		individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and specific team members should be identified as responsible for the various steps required to complete the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. None of the five plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to the lack of inclusion in ISPs of plans to address conditions that placed individuals at-risk, psychiatric treatment plans, nursing care plans, OT/PT treatment plans, speech therapy plans, and PBSPs. All plans included some practical and functional interventions. In fact, most skill acquisition plans identified functional skills to be taught. However, as discussed above, information was not found in the ISPs or ISP Preparation documentation to show why one skill over another was selected for each individual. As a result, it was difficult to determine if these training programs were individualized to improve functional skills that were meaningful for the individual. In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Even when Individual #133 specifically indicated he wanted to learn to cook more recipes, this was not included as an action plan or SAP. Similarly, individuals generally did not have objectives related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at AUSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. An area on which the Facility reportedly was working was to review individuals at the Facility that did not attend day or vocational programs or had part-time schedules for work or day activities, but this continued to be a work in process.	Noncompliance

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		Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. The Facility remained out of compliance with this provision.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on the review of the sample of ISPs: ▪ Although some improvements were seen with regard to teams' use of data, none of the five ISPs reviewed (0%) appeared to be driven by a review of objective data for each of the related action plans, and the presence or lack of progress on measurable objectives and outcomes. In reviewing ISPs, often the action steps in the IHCPs identified the frequency of data collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. Generally, in the IHCPs reviewed, in the column for "Persons Responsible for Reviewing Progress and Effectiveness & Frequency of Review," the Persons Responsible were identified, but not the "Frequency of Review." In addition, as noted above, often data collection methodologies were not included to determine whether or not the overarching goals were being met. The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., goals/objectives related to nursing care plans, psychiatric treatment plans, PBSPs, PNMPs, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Although teams discussed data in the context of the IRRF, the data available on the IRRFs varied in quality and comprehensiveness. This is discussed in further detail with regard to Section I. Of ongoing concern was the lack of data presented in the ISP and/or IRRF in relation to SAPs, behavioral health plans (i.e., PBSPs, psychiatric treatment plans, and counseling plans), as well as direct therapy plans. Since the last review, some improvement was seen with some teams in terms of defining the data to be collected, frequency of data collection and review, and persons responsible. However, much work was still needed in this regard. The Facility remained	Noncompliance

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		in noncompliance with this provision.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As noted in the previous reports, and based on the current review of ISPs, this was an area that required improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; and nursing and medical. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. DADS Policy #004.2 at I.C.22 required the ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISPs were part of the Table of Contents for Individual Notebooks. As such, staff responsible for providing individuals with direct supports had access to them. AUSSLC had taken some steps to provide information to direct support professionals in an easily understood manner. For example, at the time of the review, Active Treatment Daily Plans had been developed for individuals or groups of individuals. According to documentation provided, as of 2/14/14, these plans had been developed for all individuals on campus. For staff on the 2 p.m. to 10 p.m. shift and the 6 a.m. to 2 p.m. shift, these plans provided information about individuals' schedules, including expected times for SAP implementation, as well as other opportunities for training or active treatment, communication strategies, leisure interests, physical and nutritional management needs, and behavioral strategies. Staff reported that an interdisciplinary approach had been used in the development of these plans to ensure they included the various programs that staff needed to implement, as well as broad opportunities for habilitation. Based on review of the Active Treatment Daily Plans for the five individuals in the sample, they provided valuable information in user-friendly formats. The QIDPs were responsible for maintaining these sheets, and providing in-service training to direct support professionals on the ISP action plans.	Noncompliance

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		As discussed in previous reports, an issue related to comprehensibility of the ISPs reviewed was the lack of delineation of responsibility for the implementation of the plan. Although as noted above, the role of direct support professionals was becoming better defined, the ongoing issue in large part was due to the fact that the ISPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports. The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily understood terminology.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. DADS Policy #004.2 at III.A addressed ISP monthly reviews. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. It required that within 10 calendar days after the end of the review period, the monthly reports would be filed in the individual's record. For the five individuals in the sample, no monthly reviews were submitted. As a result, the following findings were made: ▪ Based on the sample of five records, none of the individuals (0%) had three monthly reviews, and none (0%) had timely monthly reviews each month for the previous three months. ▪ The following indicators were not assessed: o For ____ of the monthly reviews completed (___%), the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. o For ____ of the ___ individuals, a lack of expected progress was noted requiring action. For ___ of the ____ (___%) did it appear action was taken, and/or action was taken for all identified issues.	Noncompliance

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		Based on interview, in the weeks following the Monitoring Team's onsite review, the QIDPs were scheduled to undergo training on the monthly review process. Training for other staff responsible for monthly reviews was expected to follow. Examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Examples of this are provided with regard to nursing care, as well as physical and nutritional management supports. The Facility did not yet have a monthly review process in place. The Facility remained out of compliance with this provision.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on information staff provided, in the six months prior to the Monitoring Team's onsite review, over half the QIDPs were new, and the Facility had switched from a model in which Unit QIDPs were responsible for developing and drafting ISPs to one of having Facilitator QIDPs primary responsible for these tasks. A lot of work has been done to provide training to the new QIDPs on many of their duties and responsibilities, and to provide more specialized training to Unit and Facilitator QIDPs. A number of valuable training sessions, as well as resources, such as a QIDP Manual, had been offered. Although the Facility recognized that additional focused training would be needed, hopefully, this comprehensive training effort had laid some important foundations. The State Consultant conducted many of the training sessions. In addition, subject-matter experts sometimes conducted specific components of the training. The following provides a list of these training sessions: ▪ 9/11/13 - PSI/ISP Preparation/Goals training with QIDPs; ▪ 9/12/13 - ISP Meeting Training with QIDPs; ▪ 9/16/13 - Level of Supervision (LOS) Training with QIDPs, which was provided due to the identified need to better define the individual's requirements within the broader supervision levels. At the time of the review, Town Hall meetings also were covering this subject; ▪ 9/17/13 - FSA, SAP, Monthly Reviews, ISPAs, and Trust Fund/ Work Earnings Training with QIDPs; ▪ 9/18/13 - Assessments and Transitions Training with IDT members; ▪ 9/19/13 - LOS, Rights, Desensitization, and ISPAs Training with IDT members; ▪ 9/24/13 - Action Plans, Client Injury Reports, and Falls Database Training;	Noncompliance

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		▪ 9/25/13 - ISP Facilitation with ISP Facilitator QIDPs; ▪ 9/25/13 - LOS, Rights, Desensitization, and ISPAs Training with IDT members (make-up training) ▪ 9/26/13 - PSI/ISP Prep/Goals training with QIDPs (make-up training); ▪ 9/30/13 - Assessments and Transitions Training with IDT members (make-up training); ▪ 10/1/13 - ISP Meeting Training with QIDPs (make-up training); ▪ 10/2/13 - Active Treatment Training with Castner QIDPs, Active Treatment Program Coordinators (ATPCs), Skills Engagement Specialists (SESs), and Home Managers; ▪ 10/3/13 - FSA, SAP, Monthly Reviews, ISPAs, and Trust Fund/Work Earnings Training with QIDPs (make-up training); ▪ 10/30/13 - IRRF, IHCP, Change of Status (COS) IRRF, COS IHCP, Hospital/ Infirmary Discharge/COS ISPA Training with RN Case Managers, QIDPs, Habilitation Therapies, and QA. This training was provided to improve the quality of the ISPA related to hospital or Infirmary discharge, because the Facility identified that often these ISPA included many reactive action steps, and the more focus was needed on preventative steps; ▪ 11/4/13 - Training on the Systems Improvement Agreement (SIA), Active Treatment Daily Plans, Most Integrated Setting Policy, and Client Injury Reports; ▪ 11/18/13 - QIDPs had refresher training on the PSI and Hospital/Infirmary Discharge/COS ISPA; ▪ 12/2/13 - SAPs, Falls Database, and ISPA Tracking training with QIDPs; ▪ 1/2/14 - LOS Training with QIDPs; ▪ 1/13/14 – Four or more Restraint ISPA training with QIDPs. The State Office Discipline Coordinator for Behavioral Health had provided this training; ▪ 1/27/14 - SIA, Role of the QIDP, and SAP overview training with QIDPs; ▪ 2/3/14 - IRRF, LOS, Self-administration of Medication (SAM) and Money Management, and Active Treatment training with QIDPs; and ▪ 2/10/14 – Individual Rights Assessment; Abuse, Neglect, and Exploitation Resource Guide, and new Allegation ISPA training. One of the Human Rights Officers provided training on the Individual Rights Assessments. The QIDP Director also shared with the Monitoring Team a list of additional training she was requesting from the Competency and Training Department's Advisory Committee. The list of training requests, dated 2/24/14, also identified the target audience, which included IDT members as well as QIDPs for many of the sessions requested. The training requested included important topics, such as root cause analysis, level of need, post-referral transition process, programming for individuals with autism, programming for individuals with vision and/or hearing deficits, annual assessments, goals/objectives, and living options.	

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		The QIDP Director also shared a copy of the QIDP Manual. It appeared to be a helpful collection of documents, including, for example, policies, forms, written instructions for the completion of forms, examples of completed forms, training modules, and descriptions of QIDP roles and responsibilities. As a supplement to training, this manual should provide QIDPs with a quick reference to assist them in completing their duties. Although the completion of the foundational training was positive, areas in which additional work was needed to reach substantial compliance with the Settlement Agreement included: ▪ As discussed with regard to Section F.1.a, QIDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. Documentation the Facility submitted indicated that none of the QIDPs had been deemed competent in ISP meeting facilitation. ▪ The Facility had not yet begun to implement competency-based measures for the writing of ISPs. It will be important for specific competency measures to be identified in relation to the writing of ISPs (as well as facilitation). It also will be important to clearly define the process, including what will happen if some QIDPs are not able to meet the competency requirements. ▪ Competency measures for other team members had not yet been identified. Such measures should be identified and used to evaluate whether additional training is needed. ▪ As recommended in previous reports, there should be additional training on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. Although since the last review, some training had been provided on action plans, the Facility staff indicated writing action plans continued to be a struggle. ▪ This section of the Settlement Agreement also requires: "Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency-based training when the plans are revised." As discussed above, this was an area in which the Facility was still working. Focus should be placed on ensuring that the training for staff includes all relevant portions of the ISP, and that staff in both residential services as well as	

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		day and vocational services complete the necessary training. The Facility had invested significant effort in training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts on providing additional training and technical assistance to improve the development of action plans, competency measures should be developed/revised and implemented for facilitation of ISP meetings and the development of the ISP documents. The Facility also should ensure that staff responsible for the implementation of the plans successfully complete competency-based training.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on information the Facility provided, since the last review, no individuals had been admitted to the Facility. As a result, the following indicator was not applicable: ____ of ____ individuals' 30-day ISP meetings (____%) had been held within 30 days of their admission. Based on data the Facility provided, 281 ISP meetings were held between 1/24/13 and 1/24/14. One ISP meeting occurred more than 365 days after the previous annual meeting. This was a significant improvement from previous reviews. In previous Monitoring Team reports, concerns were noted with regard to the Facility's lack of ability to accurately track the number of ISPs that were finalized within 30 days of the ISP meeting. On a positive note, beginning on 7/1/13, the Facility implemented a system to track the timely completion of ISP documents. Based on data the Facility provided, between 7/1/13 and 12/31/13, 143 individuals' ISP meetings were held, and of these, only 64 (45%) were completed timely. The Facility was taking some steps to improve timeliness. These included working to obtain computers so that all ISP meeting rooms had computers, thereby allowing some of the modifications to draft ISPs to be made during meetings; implementing a corrective action plan to improve timely completion of ISP Preparation meetings to complete more pre-planning for ISP meetings; and as noted above, using Facilitator QIDPs to allow more focused time on the development and writing of ISP documents. Hopefully, these steps will assist the Facility to complete ISP documents in a timely manner. Facility staff recognized that for the ISP to be "put into effect" within 30 days, the ISP needed to be completed and filed, but actions also were needed to ensure it was being implemented. QIDPs were responsible for training staff on ISP action plans. As noted in other sections of this report, other disciplines, such as Habilitation Therapies and Behavioral Health Services, were responsible for training staff on specific components of ISPs, such as PNMPs and PBSPs. Nursing staff also should be expected to play a role in training staff on the implementation of IHCPs. Although some work was being done in	Noncompliance

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		this regard, this was an area that required concerted efforts to ensure staff responsible for the implementation of ISPs were competent to do so. As the Facility's Administration appeared to recognize, it will be important to have a system that identifies the specific components of the ISP on which staff require training, and provides supervisory staff with an easy mechanism to identify which staff have successfully completed training on individuals' ISPs as they are making staffing assignments. The Facility remained out of compliance with this provision. Progress was made on holding ISP meetings annually. Areas in which more work was needed included QIDPs completing the ISP documents within 30 days of the ISP meetings, and ensuring that staff are trained on ISPs to make sure the implementation of the ISPs began timely.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. DADS Policy #004.2 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. Based on discussions with the Director of QA and the QIDP Director, as well as review of documents, the Facility was in the process of revamping the monitoring tool used to assess the ISP development process and ISP documents. According to a document the Facility provided (i.e., TX-AU-1402-V.3), "The facility trialed the previous Section F tool in November and December of 2013. December results were entered into the database… Based on the trials and needs of the Systems Improvement Agreement, the tool is under revision and will be re-implemented by 3/1/2014." The Facility submitted a copy of the tool it had used in late 2013 to the Monitoring Team, as well as the draft instructions for this tool. However, as noted above, this tool was currently under revision. It was positive that the Facility was working to construct one tool that would provide staff with the information they needed with regard to the ISP requirements of the Settlement Agreement, as well as the Systems Improvement Agreement. It also was positive that the Facility was developing instructions for the draft ISP Monitoring Checklist. As noted in previous Monitoring Team reports, although the tool submitted, dated 11/7/13, included some valuable indicators to assist the Facility in determining its compliance with the requirements of the Settlement Agreement, some significant concerns remained with regard to the indicators. Some of them could be answered in the	Noncompliance

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		affirmative without the auditor assessing the quality as opposed to just the mere presence of an item (e.g., Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate?). For many other indicators, terms and/or standards were not defined, and the draft instructions did not yet include specific standards. As a result, it was not clear that quality would be assessed consistently [e.g., Did the IHCP (for all medium and high ratings) reflect all appropriate services and supports to reduce the impact of risk?]. In finalizing the tools and instructions that the Facility was currently in the process of revising, the Monitoring Team recommends that the Facility develop clear probes/indicators and standards to ensure the monitors assess the quality (as opposed to just the mere presence) of the ISP development process and related documentation, and there is consistency between monitors. Based on discussions with staff, at the time of the review, a QA Department Program Compliance Monitor had just begun completing reviews of ISP meetings and documents, and the plan was for the QIDP Coordinator and another staff member to begin completing reviews in March 2014. The data from the monitoring tools was not yet being shared with the QA/QI Council. As a result, data was not yet being used to identify problematic trends and/or take actions to remediate such trends. The QA Department had assisted the QIDP Department in maintaining data with regard to team member attendance at ISP meetings, and timeliness of assessments for ISP meetings. This data was being shared with the QA/QI Council. Staff also reported that the QA Department and QIDP Department were meeting monthly to discuss monitoring, as well as other data being generated. Formal meeting minutes were not yet being maintained for these meetings. The Facility remained out of compliance with this provision. It was positive that the Facility was working to develop a revised tool, including instructions, and that progress had been made in developing other sources of data related to ISP development. As the monitoring tool is revised, it will be important for the Facility to ensure it is comprehensive, and that valid and reliable data are collected. Such data, as well as the other sources of data, should be utilized to identify and address problematic trends.	

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section G; o Five most recent post hospital Individual Support Plan Addendums (ISPA): Individual #168, Individual #336, Individual #159, Individual #147, and Individual #414; and o For one individual from each residence, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all Integrated Progress Notes (IPN) commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISPA related to the consultant report: Individual #195 general surgery on 10/21/13, Individual #195 neurology on 11/22/13, Individual #151 general surgery on 10/21/13, Individual #151 gastroenterology on 12/10/13, Individual #268 neurology on 11/22/13, Individual #268 gastroenterology on 12/10/13, Individual #268 otolaryngology on 12/19/13, Individual #448 general surgery on 11/25/13, Individual #448 neurology on 11/22/13, Individual #448 orthopedics on 12/9/13, Individual #453 otolaryngology on 6/20/13, Individual #453 gynecology on 9/20/13, and Individual #453 neurology on 9/27/13. ▪ **Interviews with**: o Chrishanthi Perera, MD, Medical Director; and o Flor Lopez, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: a process to audit consultant report reviews, and an audit to review attendance through Individual Support Plan documentation. o These monitoring/audit tools included some indicators that allowed the Facility to determine its progress in compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews, review of committee minutes, and attendance sheets. o The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o Instructions/guidelines for the staff using the monitoring/auditing tools were not submitted for review.

	○ The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse. ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be incomplete, but accurate. ▪ The Facility presented some data in a meaningful/useful way, but some issues were noted. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Consistently did not measure the quality as well as presence of items. ▪ The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to provide proof of closure.
	Summary of Monitor's Assessment: The Facility had made progress in the area of integrated clinical services. The look-back record review for hospitalized individuals had continued. Individual Support Plan Addendum templates had been implemented for post-hospital, post-Emergency Room visits, and Infirmary admissions. ISPA completion was tracked at the morning medical meeting. Areas needing focus were documentation of attendance at morning meetings. The morning meeting minutes did not include this information, and attendance at specific morning meetings could not be determined. The look-back record review process needed quality assurance monitoring. ISPA completion needed further interdisciplinary support to provide timely responses for those hospitalized, going to the ER, or admitted to the Infirmary. The Facility had identified the need for providing evidence of closure to other concerns assigned at the morning medical meeting, and a corrective action plan had been developed. This will need implementation. The morning medical meeting continued to be an important forum of interdisciplinary collaboration in responding to change of health status. The Medical Department had developed several tools to provide guidance and evidence of integrated clinical services. The Medical Department continued to make gains in this area.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, Pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.</td><td>The Facility was asked to provide data concerning attendance at the morning medical meeting for the two weeks prior to the Monitoring Team's visit. The Facility response was that the data was not available. The following table was provided as a template for recording the departmental attendance at the morning medical meeting per week:

<table>
<tr><th>Department</th><th># of Days Attended</th><th>Department</th><th># of Days Attended</th></tr>
<tr><td>Nursing administration</td><td>Not available</td><td>Infirmary</td><td>Not available</td></tr>
<tr><td>Hospital liaison</td><td>Not available</td><td>Infection control</td><td>Not available</td></tr>
<tr><td>Habilitation Therapies</td><td>Not available</td><td>Physical and Nutritional Management Team</td><td>Not available</td></tr>
<tr><td>Qualified Intellectual Disabilities Professionals</td><td>Not available</td><td>Residential</td><td>Not available</td></tr>
<tr><td>Dietary</td><td>Not available</td><td>QA/QI</td><td>Not available</td></tr>
<tr><td>Chaplain</td><td>Not available</td><td>Pharmacy</td><td>Not available</td></tr>
<tr><td>Psychology</td><td>Not available</td><td>Psychiatry</td><td>Not available</td></tr>
<tr><td>Dental</td><td>Not available</td><td>Medical</td><td>Not available</td></tr>
<tr><td>Incident Management</td><td>Not available</td><td>RN Case Manager</td><td>Not available</td></tr>
<tr><td>Medical</td><td>Not available</td><td>Compliance RN</td><td>Not available</td></tr>
</table>

Submitted were documents entitled: "Medical Morning Meeting Attendance Tracker" for the months of September 2013 through January 2014. Listed were 19 departments for which attendance was tracked daily. Findings were difficult to interpret. For instance, physician attendance was 384 percent. Daily totals for the month ranged from 21 to 31 staff on a daily basis, but the final daily total (average number or percentage) was listed as 44.86. It was not clear how the Medical or Quality Assurance Departments utilized this information. It appeared there was a system in place to track attendance by department, and the data appeared thorough, but the report generated needs to be revised with explanations in order for it to have value in guiding the interdisciplinary process.

<u>Look-Back Record Reviews</u>
The Facility used a "Look Back Tool" to review information preceding an acute illness, which resulted in a hospitalization, an ER visit, or an admission to the Infirmary. The time period to be reviewed was 30 days. Areas of focus included nursing services, medical services, the Physical and Nutritional Management Plan (PNMP), Medication</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Administration Record (MAR)/Treatment Records, non-clinical staff interviews, and clinical staff interviews. There was an additional area that reviewed applicable tests, such as Modified Barium Swallow Study (MBSS), diet texture, respiratory therapy evaluation, etc. These look-back reviews were assigned by the RN Case Manager, and tracked until completion. An example of the tracking log was provided from November 2013. It was not determined if this tracking process continued. Additionally, a document was submitted entitled: "ER, Hospital, Infirmary Discharge ISPA Tracker." This was a blank log to be completed on a weekly basis that identified 12 areas, which were followed to completion. As no examples of a completed log were submitted, it was not clear if this form had been implemented at the time of the Monitoring Team's visit or remained in draft form. Data was provided that did track the timeliness of ISPA completion for individuals referred to the ER, hospitalized, or admitted to the Infirmary. One hundred thirteen ISPAs were assigned/expected from September 2013 through December 2013. Timely completion ranged from 55 percent in December 2013 to 81 percent in October 2013. As of 1/9/14, 21 percent of ISPAs had not been completed from the time period September 2013 through December 2013. This is an area, which will need interdepartmental cooperation to improve compliance. <u>Post-hospital ISPA</u> The Facility had developed a template for completing ISPA documentation for IDT meetings held for change of status, post hospitalizations, and Infirmary discharges. This included designated areas for responses by each of the clinical departments specifically listed [i.e., medical, nursing, infection control, respiratory therapy, Physical Therapist/Occupational Therapist/Speech and Language Pathologist (PT/OT/SLP), PNMT, Dietary, Psychology, Psychiatry, Dental, and Pharmacy.] Whether the IDT made consultations/referrals, and whether changes of risk rating occurred was also recorded. Specific plans the IDT reviewed at the meeting also were identified (e.g., IHCP, PNMP, diet order, etc.). The template also included a determination of any changes needed for level of supervision, residential services, and active treatment. A summary of the IDT deliberations were then placed in table format, including such information as action plan, person responsible, desired outcome, and due date. When completed properly, this information provided the needed structure to ensure identification of all significant clinical areas involved in the ongoing care of the individual. This form was developed and implemented on 10/24/13. Also implemented were templates entitled: "Integrated Progress Note: Change of Health Status Considerations Summary of Care Plan" for ER visits, hospitalizations, and Infirmary admissions to be completed by applicable departments, and then discussed at the morning medical meeting prior to discharge to the Facility or prior to discharge to the residence. The physician was to provide the diagnosis, evaluation completed,	

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		consultations completed, and follow-up plan. Other departments were to provide entries reflecting the supports needed for the individual. This included all clinical departments, as well as residential services, IDT meeting determinations, and level of supervision needed. Requested for review were five post-hospital ISPAs. Submitted were two post-hospital ISPAs, one post-ER visit ISPA, two Infirmary discharge ISPAs, and one for which there appeared to be conflicting information as to whether the individual had been hospitalized or placed in the Infirmary, or both. For one, the dates of hospitalization or Infirmary admission and discharge were not provided. This information is essential in determining timely meeting of the IDT to review the clinical needs and develop an ISPA within five business days of the discharge of the individual from the hospital or the Infirmary. To ensure this information is recorded in each of the post-hospital ISPA, it is recommended that the template be expanded to include specifically whether the ISPA was for a hospitalization, Infirmary admission, and/or ER visit. It also should include the dates of hospitalization or Infirmary stay (i.e., not just an admission date). This information was recorded in three of five ISPAs. These five ISPAs were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization. Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDTs did demonstrate one or more processes in a number of cases. The findings included the following: ▪ Reference to a formal record review/look-back record review was documented in zero of five individuals. For the two individuals hospitalized, there was no reference to a look-back record review. ▪ Reference to IPNs, ER visit information, and other active record information was included in the ISPA in three of five ISPAs. These appeared to provide the needed clinical information for the IDT review. ▪ The IDT identified new triggers or early signs/symptoms in zero of five individuals. ▪ The IDT identified the need for increased monitoring in one or more aspects of care in zero of five individuals. ▪ The IDT identified training needs in two of five ISPAs. ▪ The IDT identified a need for additional consultation in one of five ISPAs. ▪ The IDT identified a need for additional testing/follow up of testing in one of five ISPAs.	

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		▪ The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization, or if contagious, steps to minimize spread, in three of five individuals. However, the action steps were, at times, vague. For instance, the notation: "hand washing and infection control measures will be emphasized" provided the goal, but did not indicate the steps to be taken to reach the goal (i.e., in-service of specific educational materials on each shift by a certain date by specific staff). There needed to be additional focus on preventive steps by the IDT. For an individual developing an infection following a wound or scratching, there was no information concerning a discussion of how to prevent further injury or SIB. For an individual that fell, the IDT did not discuss the need for the development or revision of a fall risk plan. ▪ The IDT identified additional treatments to be administered in four of five ISPAs. ▪ The time from the start of hospitalization or discharge from the hospitalization to the creation of the initial ISPA was within five days in five of five (100%) ISPA submitted. The Self-Assessment for Section L indicated that post-hospital ISPAs were tracked through the morning medical meeting. <u>Closure tracking</u> The Medical Department did not have documented evidence of closure to issues identified at morning medical meetings for up to 60 days prior to the Monitoring Team's visit. On 1/17/14, a corrective action plan was created to address this issue. Closure had only been tracked by closure date, without documenting the evidence for the closure. This had been entered into a Word document, but the corrective action plan indicated it would be tracked in an Excel spreadsheet. Several steps were outlined, including the process of tracking and documenting the information, as well as concerns, which remained pending. Additionally, the Medical Department submitted a document entitled: "Follow up Items Tracker for Medical Morning Meeting." This was submitted for February 3, 2014 through February 25, 2014. It showed eleven items that had been tracked. All were considered closed. On further review, it is recommended more detail be provided to confirm the closure. Examples included statements such as: "campus will be coming to check the faxes over the weekend." It was not clear who was to check and the frequency (i.e., daily, every shift, etc.). It appeared a nursing policy or procedure was needed, with documentation of in-service training before this would be considered closed. There was one entry in which the first person was used. It is recommended that the position title be used. It was not clear if the person was being quoted or paraphrased. When an in-service is part of the closure, then a copy of the training roster(s) is needed until the eligible population (e.g., RNs, etc.) is trained. Documentation in the tracking system would provide the needed accountability to ensure the completion of the tasks in a timely	

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manner. When an evaluation has been completed, a copy of the evaluation with date of evaluation should be available, and the name of the document and date completed should be entered into the closure log. A separate file should have a copy of the evidence (i.e., training logs, assessments, etc.), to prove the closure. All closure concerns need an assigned person and a due date to present the closure information or an update of information at the morning medical meeting.

Attendance at ISPs was one measurement of integrated clinical services. Information from the QA Department was used, and was not confirmed by separately submitted evidence. However, the following provides information for several clinical departments per month (the number of ISPs per month that each department was required to attend each month, and the percentage of those that had departmental representation:

Department	October # ISPs Required to Attend	October % of Required ISPs Attended	November # ISPs Required to Attend	November % of Required ISPs Attended	December # ISPs Required to Attend	December % of Required ISPs Attended
Medical	19	74%	21	81%	16	81%
Dental	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0
Psychiatry	8	100%	6	67%	5	100%
Nursing	19	100%	22	100%	16	100%
OT	7	43%	13	77%	5	100%
PT	10	80%	7	71%	6	100%
Speech	7	57%	6	50%	2	100%
Psychology	16	94%	21	86%	15	100%
Dietary	0	0	0	0	2	100%

However, as discussed with regard to Section F.1.b, the Facility's data with regard to ISP attendance was not considered valid. The Facility did not yet have a process in place to accurately identify the team members whose presence was required at ISP meetings. In addition to teams not regularly meeting to conduct ISP Preparation Meetings (i.e., the Facility had a corrective action plan in place to address this issue), when teams did meet they did not consistently identify team members whose attendance was necessary based on individuals' needs and preferences, or provide adequate justification for not requiring their attendance.

The PNMT appeared to be well integrated into the clinical care of the individuals. Requested were the ten most recent PNMT recommendations for which physician orders

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		were written based on these recommendations. Eight examples were provided from August 2013 through January 2014. Most physician orders (i.e., seven of eight) were written the same day as the PNMT presentation during the ISP meeting. As noted above, based on this limited review, the Facility remained in noncompliance with this provision. However, AUSSLC had made some progress, particularly with regard to developing and beginning to implement an ISPA process for individuals with acute changes in health status.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Facility submitted consultant reports for one individual from each PCP caseload, as well as any IPNs commenting on the consultant reports. Consultations for five individuals were submitted, with a range of two to three consultations per individual. A total of 13 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 13 reviewed, 13 (100%) included the PCP initials, indicating review by the PCP. ▪ Of the 13 reviewed, 13 (100%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. The Medical Department created a "Consultation Report: Primary Care Provider's Recommendation" form. This provided a summary of the PCP review of the consultation. Choices included the following: "Adopt Consultant's Recommendations," "Reject Consultant's Recommendations," "Adopt partial Consultant's Recommendations," and "Refer Recommendations to IDT for integration with existing supports and services" with either a yes response or not recommended/not necessary. There was room for explanation when the consultant recommendations were rejected or adopted partially. This provided clear guidance to the IDT as to whether the consultant recommendations required an IDT meeting for discussion and response. ▪ Of the 13 reviewed, 13 (100%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these, 12 (92%) included Primary Care Practitioner (PCP) IPN entries. ▪ Of these, there was guidance from the PCP whether or not to recommend an IDT meeting by completion of the "Consultation Report: Primary Care Provider's Recommendation" in 12 of 13 (92%).	Noncompliance

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		▪ Of the 13 consultations submitted, none were recommended by the PCP for IDT review for integration with existing support and services. For these 13 submitted consultations, an ISPA was not indicated. The Self-Assessment had identified that tracking of consultant recommendations referred to the IDT had not occurred until September 2013. A monitoring tool was developed that tracked the consultation process through measurement of completion of up to nine steps. The audit per month varied in the number of steps reviewed, from six to nine steps. From September 2013 through January 2014, the range of compliance was 71 percent to 100 percent. Inter-rater reliability was also tracked. The most recent months of December 2013 and January 2014 indicated 100 percent, which was an improvement from earlier months. IDT notes/ISPA also were identified as needing additional content to reflect discussion of the consultant recommendations. It was noted that emphasis for tracking appeared to be for on-campus consultation follow-up by PCPs and IDTs. However, there were a large number of off-site consultations, which were completed. It is recommended that the sample chosen for review begin to include these consultations. As noted above, the parties agreed that the Monitoring Team would conduct a limited review, and the noncompliance finding would stand. The Facility clearly had made progress, and it appeared from the Facility's own data that this progress had occurred in recent months. The major challenge would appear to be the quality of the ISPAs developed in response to consultant recommendations when the PCP determines the consultant report needs to be addressed by the IDT.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; and o For four individuals from each PCP's caseload, four diagnoses identified from the active problem list of the most recent annual medical assessments, with criteria for justification from the active record, including copies of supporting documentation, for the following individuals: Individual #457, Individual #84, Individual #45, Individual #142, Individual #303, Individual #81, Individual #260, Individual #278, Individual #97, Individual #389, Individual #151, Individual #375, Individual # 264, Individual #40, Individual #269, Individual #31, Individual #178, and Individual #249. ▪ **Interviews with**: o Chrishanthi Perera, MD, Medical Director; and o Flor Lopez, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Cross Referenced with ICF-MR Standards Section H: Minimum Common Elements of Clinical Care – Constipation, Diabetes mellitus, ER/Hospital Visits, Hypertension, Osteoporosis, Seizures, chart review of change of health status concerning documentation by PCP and other clinical disciplines, and audit of diagnoses to determine accuracy of selected diagnoses based on criteria/evidence in the active record. o These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews in auditing criteria for diagnoses identified in the Active Problem List. o The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools did not have instructions/guidelines submitted. o The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse, staff physicians, and the external physician. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools.

	▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be incomplete, but information appeared accurate for the databases used for Section H. ▪ The Facility presented some data in a meaningful/useful way, but some concerns were noted. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the presence of items, but had less data concerning the quality of items, such as the quality of the annual medical assessments. ▪ The Facility rated itself as being in compliance with the following subsections of Section H: H.2 and H.6. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility was in compliance with Section H.2, but not H.6. ▪ The Facility's data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the lack of timely completion of the annual medical assessments for the ISP process, and the lack of sufficient serial data to provide trends on QA tools that had been implemented.
	Summary of Monitor's Assessment: Much effort had been directed to ensuring annual assessments were updated. Annual medical assessments were current in 97 percent of the records. Annual dental assessments were current in 91 percent of records. Quarterly Drug Regimen Reviews were current in 100 percent of records. Based on a sample of records, the significant diagnoses on the Active Problem Lists were based on appropriate criteria (i.e., consultations, test results, physical examination) in all records the Monitoring Team audited. Areas needing improvement included ensuring the medical and dental assessments were submitted in a timely manner as part of the ISP process. Quarterly medical reviews will need a system for tracking to completion, with demonstration of analysis and corrective actions, if needed. Internal Medical Department QA monitoring needed to expand to other clinical areas not covered by the peer review audits. QA efforts need evidence of analysis of audit results, and action plan based on findings, along with follow-up audits to determine impact of corrective actions. In addition, teams needed to include individualized clinical indicators in IHCPs, and implement mechanisms to track determine the efficacy of treatments, and to make changes to individuals' plans as needed. Such data also needed to be analyzed and responded to on a systemic level.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

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	years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The following provide some brief updates regarding the Facility's status in relation to Section H.1. Routine and periodic assessments for several clinical departments were reviewed for timeliness using submitted documents. These included the following: ▪ One hundred ninety two of 276 (70%) of the most recent medical annual assessments were completed within 365 days of the prior assessment. ▪ Two hundred thirty four of 276 (85%) annual physical examinations were completed within 365 days of the prior annual physical examination. ▪ Two hundred sixty nine of 276 (97%) charts had annual medical assessments and annual physical examinations completed since 1/1/13. ▪ One hundred seventy five of 193 (91%) annual dental evaluations reviewed were completed in a timely manner. ▪ During the past two quarters, 100 percent of QDRRs were completed in a timely manner. ▪ The Medical Department was not able to provide data concerning timely completion of quarterly medical reviews. Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. The following information was provided by the QA Department. Several months had no data, due to "QA resetting the program."	

Department	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
#of ISPs completed	NA*	NA	19	N. AV.	19	26
Dental	NA	NA	15 (79%)	NA	11 (58%)	11 (42%)
Medical	NA	NA	6 (32%)	NA	10 (53%)	6 (23%)
Psychiatry	NA	NA	2 (11%)	NA	3 (16%)	3 (12%)
Nursing	NA	NA	10 (53%)	NA	11 (58%)	10 (38%)
OT/PT	NA	NA	1 (5%)	NA	12 (63%)	9 (35%)
Speech	NA	NA	12 (63%)	NA	11 (58%)	20 (77%)
Psychology	NA	NA	8	NA	9 (47%)	7

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		<table><tr><td></td><td></td><td></td><td>(42%)</td><td></td><td></td><td>(27%)</td></tr><tr><td>Dietary</td><td>NA</td><td>NA</td><td>1 (5%)</td><td>NA</td><td>4 (21%)</td><td>6 (23%)</td></tr></table> *NA = Not Available Although clearly work was needed to improve timeliness of assessments for ISP meetings, as discussed with regard to Section F.1.c, the Facility's data with regard to ISP assessments was not considered valid. The Facility did not yet have a process in place to accurately identify assessments needed for ISP meetings. In addition to teams not regularly meeting to conduct ISP Preparation Meetings (i.e., the Facility had a corrective action plan in place to address this issue), when teams did meet they did not consistently identify necessary assessments based on individuals' needs and preferences, or provide adequate justification for not requiring such assessments. The Facility remained in noncompliance with this provision.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	A sample of diagnoses listed in individuals' active problem lists was submitted. The sample was derived from four active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. The PCPs were asked to provide the criteria or evidence used to determine if the diagnosis clinically fit the information in the corresponding assessments or evaluations for one diagnosis chosen by the Facility. Evidence was provided through various sources (e.g., consultant reports, test reports, extensive annual medical assessment documentation, medication lists, etc.). For 20 of 20 (100%) diagnoses submitted with supportive documentation, the criteria listed were consistent with the diagnosis listed. The Medical Department conducted an internal QA review of one diagnosis from each PCP caseload, for a total of five records reviewed. Date of review was not determined. Each record was reviewed for a different diagnosis. Diagnoses included clostridium difficile, GERD, colon cancer, seizure disorder, and angioedema. The record review focused on supporting documentation for these diagnoses. Compliance was found to be 100 percent. The Facility submitted information that there were no in-services provided to the PCPs concerning International Classification of Diseases (ICD) and DSM diagnostic criteria in the prior six months. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed for Section J, there was adequate clinical justification for the diagnosis of record for 17 of the 17 individuals (100%). With the completion of Comprehensive Psychiatric Evaluations and ongoing quarterly updates for individuals prescribed psychotropic	Substantial Compliance

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		medication, the Facility had made improvements in its diagnostic practices related to psychiatric disorders. Based on the Monitoring Team's review of medical and psychiatric records, the Facility was found to be in substantial compliance with this provision.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Medical Department utilized several mechanisms to ensure timely, quality treatment and interventions. The morning medical meeting was an interdisciplinary forum to address acute change of status of all individuals as problems arose. Change of status was discussed the next business day, with several routes to ensure timely intervention and/or treatment. Discussions among the PCPs provided feedback concerning quality care and additional diagnoses to be considered, tests to be ordered, consults and/or Facility services to be considered. A look-back record review was completed on hospital admission, ER visits, and Infirmary admissions to review timely treatment, as well as quality of care of the appropriate clinical disciplines. This information was discussed at the morning medical meeting as a follow-up. For those individuals hospitalized, a post-hospital ISPA process was required and they were presented at the morning medical meeting. The morning medical meeting attendees reviewed the quality/content of the ISPAs. There were other clinical areas not categorized as requiring an ISPA that needed answers/resolution and these were assigned, but as discussed above with regard to Section G.1, more work was needed to track these to closure. Individuals refusing or missing appointments were reported to the medical morning meeting. The morning medical meeting was an efficient daily monitoring forum for acute care concerns. The Monitoring Team member did not observe the morning medical meeting group's review and discussion of ISPAs, because the days attended were not assigned days of ISPA review. However, the agenda that was followed indicated ISPAs were to be reviewed at regular intervals. Providing documentation of closure remained a challenge, but the clinical discussions and follow-up appeared to occur. As a measure of timely quality treatment/interventions, the Medical Department completed external and internal, general QA and medical management audits. One external medical peer review audit was completed in the prior six months, and two internal medical peer review audits were completed in the prior six months. Compliance per PCP is further discussed with regard to Sections L.2 and L.3. Although the role of the QA Department was clearly defined in following up on corrective action plans for these audits, and providing evidence of timeliness in correcting areas needing improvement, this did not occur. The QA Department was unable to provide any data in the prior six	Noncompliance

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		months concerning follow-up of external or internal, medical peer review, general QA, or medical management audits at 30, 60, or 90 days following the audit. This information would provide evidence of timely response by the PCPs, but the QA Department was not yet obtaining or documenting the information. In addition, these audits only covered a limited number of diagnoses. Given that Section H addresses all clinical care, other Department's at the Facility will also need to focus their efforts in illustrating compliance with these requirements. The Facility remained out of compliance with this provision.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. There were two systems in place in which clinical indicators were used to measure quality of care. The external and internal medical management audits focused on six diagnoses, and are reviewed with regard to Sections L.2 and L.3. In addition, the Medical Department utilized the medical management topics and questions, and added additional audits for specific diagnoses, creating a formal monthly audit process for the following conditions: constipation (four clinical indicators), diabetes mellitus (six clinical indicators), ER/Hospital visits (three clinical indicators), Hypertension (seven clinical indicators), osteoporosis (five clinical indicators), and seizures (five clinical indicators). Copies of these monitoring tools were submitted. Audits were completed monthly for September, October, and November 2013. Results were submitted, and are discussed with regard to Section H.5. As is discussed in further detail with regard to Section I, to assess the efficacy of treatments, individual clinical indictors need to be included in individuals' IHCPs and data collected should be regularly evaluated to determine whether treatments are effective or need to be reviewed and revised, as appropriate. The Facility remained in noncompliance with this provision.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. For the internal Medical Department audits of constipation, diabetes mellitus, ER/Hospital visits, hypertension, osteoporosis, and seizures, results of audits were provided. Compliance per topic/condition ranged from 78 to 96 percent in September 2013, to 88 to 100 percent in November 2013. This indicated improvement in audit	Noncompliance

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		results. Inter-rater reliability was 100 percent for four of the conditions: ER/hospitalizations, hypertension, osteoporosis, and seizures. Inter-rater reliability had not been achieved for constipation or diabetes mellitus. These audits continued on a monthly basis. Sampling methodology changed at the beginning of October 2013, and focused on highest acuity. As this was a change to the audit process, trend data was not available. This might provide a closer monitoring system for those with the most severe state of these conditions. For instance, the total number of individuals considered to have constipation in September 2013 was 135, which was the eligible population for auditing. When individuals with the most severe degree of constipation were identified, this reduced the eligible population to 38. Three charts (or about a 10 percent) sample per month for 135 individuals might no result in the review of any severe cases, but three charts from the 38 high acuity individuals would provide a measure of care in these most complex individuals. This change in methodology occurred with each of the five clinical areas (i.e., constipation, diabetes mellitus, hypertension, osteoporosis, and seizures). The November data appeared to indicate improvement in quality care and documentation. This provided an internal check on the quality of care assessed through the clinical indicators in each of the Monitoring Team's audits. Maintenance of quality is an important and often overlooked fundamental in ensuring quality care, and these audit tools can be used to continue to audit care to ensure maintenance. The QI process included identifying areas of concern that needed improvement, followed by in-service and other training mechanisms as indicated, and a follow-up audit after a period of time to verify impact of the in-service training. As part of the QA/QI process, there will need to be documentation of analysis of results, as well as discussion of results with the PCPs, and in-service training. When audit results indicate 100 percent compliance and repeat audits indicate maintenance of compliance, the Medical Department is encouraged to initiate reviews in areas of ongoing challenge or that have been identified as concerns, and to create monitoring tools followed by training and follow-up evaluation to determine impact on improvement. As a separate focus, from ongoing monitoring efforts at periodic intervals, an efficient system had been developed and implemented for acute changes of health status. For acute care, the morning medical meeting each business day provided an up-to-date review of all acute health status changes for those individuals on campus as well as those hospitalized. This was done through a series of reports (i.e., the on-call PCP report, a review of the 24-hour log, the Hospital Liaison Nurse report, and the Infirmary admission/medical observation report). The minutes provided written documentation of review and discussion of each case. All acute changes of health status were reviewed	

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		at the morning medical meeting through one of the above processes. Look-back record reviews were assigned and, when completed, were reported at the morning medical meeting. This allowed rapid feedback of the events leading to hospitalization, including the quality of nursing monitoring and assessment, and a review of PCP assessment, interventions, orders, and review of lab tests and other data. It is recommended that an audit process be created to review the quality of the look-back record reviews. Post-hospital ISPA, post-ER visit ISPAs and Infirmary admission ISPAs were tracked at the morning medical meeting. These were reviewed for content at this meeting. The Medical Department was able to track timeliness of completion of the post-hospital ISPAs. Again, it will be important for teams to develop individual clinical indictors and to collect and assess data to identify more subtle changes in health status, and respond appropriately. The Facility remained in noncompliance with this provision.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As one indicator of compliance with this subsection, the Medical Department needed to demonstrate creation of audit tools with clinical indicators focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (i.e., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit should be sufficiently sensitive to determine whether there was evidence that change occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, the need for further consultation, or a need for further lab testing, scans, etc. Most of the clinical indicators the Facility was currently assessing required a PCP order, focused on completion of a minimum set of monitoring steps, nationally recognized as reflecting on-going quality of care for specific diagnoses. The focus of this section is providing a quality improvement process that tracks medical care response to abnormalities in test results, or clinical findings. The Medical Department is encouraged to further review clinical indicators based on lab and radiographic findings, providing an audit mechanism to review the appropriateness and timeliness of the PCP response to abnormalities as one approach to demonstrating compliance in this area. The data did not specifically address change in treatment (i.e., frequency or type of lab tests, change in medication, change in dosage, additional medication, additional consults, etc.) based on the clinical indicators used. The clinical indicators focused on routine treatment expectations, such as frequency of Hemoglobin	Noncompliance

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		A1C (Hgb A1C) in diabetes mellitus or whether periodic specialty consultations were obtained. In most instances, the quality indicators were not sensitive enough to measure responsiveness and timeliness of responsiveness to abnormal lab and test results. The focus in this section is not just preventive care/maintenance care, but demonstration of acute and ongoing care quality/response to abnormal findings or test results. Again, this will require teams to define expectations for improvements in individuals' health status in their IHCPs, as well as mechanisms to regularly assess individuals' clinical indicators, and the Facility should have mechanisms in place to monitor the teams' responses individually and across the system. For instance, if a Dilantin level was returned as abnormally high or low, was the PCP response appropriate and timely? If the database indicated five abnormal Dilantin levels in the month, was there a QI process in place to track the PCP response and timeliness to the abnormalities? When data was reviewed for acute care interventions to abnormal Dilantin levels, was there a trend, and what were the steps taken (i.e., training, etc.) to improve care, followed by further tracking of this information for indications of resolution? Similarly, if a Complete Blood Count (CBC) result indicated an abnormally high or low hemoglobin, did the PCP modify treatment or order additional tests, were the treatments or tests appropriate (i.e., based on specific standards), and was the response timely? This approach answers a different set of clinical questions than many of the current clinical indicators. This would require a revision of some of the clinical indicators to reflect changes in treatment.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As the morning medical meeting organization and process develops, along with the role in reviewing post-hospital ISPA content, look-back record reviews, etc., it will be important for the Medical Department to create policies and procedures reflecting these processes. Such policies can then be readily included in a Medical Department policy and procedure manual. There currently was no policy and procedure manual for this Department. In addition, once State Office finalizes a policy on Section H, it should be localized and incorporated into the AUSSLC policies.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC's Self-Assessment; o AUSSLC's Section I Presentation Book; o Presentation for Section I from entrance meeting; o AUSSLC At-Risk Individuals list; o For the following individuals' active records, selected documents: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries past one year, ER report past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form past one year, risk action plan past one year for the following individuals: Individual #210, Individual #321, Individual #147, Individual #13, and Individual #45; and o The following documents: Integrated Risk Rating Forms (IRRFs), Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/Integrated Health Care Plans (IHCPs) for the following individuals: Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls. ▪ **Interviews with**: o J. Mike Fitch, Assistant Director of Programs; o Holly Lindsey, Quality Assurance Director; o Michael Gayle, PT, DPT, MA, OCS, Director of Habilitation Therapy; o Diane Hierholzer, OT, Physical and Nutritional Management Team; o Sharon Price, RN, BSN, CEN, Interim Nurse Operations Officer, Physical Nutritional Management Team; and o Maryann Clark, RN, Chief Nurse Executive from El Paso SSLC. o Observers: ▪ Becky McPherson, State Office Program Compliance Coordinator; ▪ Debra V. Woodruff, State Office Program Compliance Coordinator; and ▪ Renee Nolen, State Office Operations Coordinator. ▪ **Observations of**: o ISP Meeting for Individual #323, on 2/26/14; and o ISP Meeting for Individual #40, on 2/27/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2)

	the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools. At the time of the review, the Facility had little to no data addressing Section I, and reported they were in the process of reviewing the possibility of using monitoring tools from Section F that would yield data reflecting issues related to the At-Risk process. In doing so, the Facility should include all of the requirements of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment: o Since the last review, the Facility continued to experience significant staffing challenging and changes, including a complete turnover of the staff overseeing the At-Risk Individuals systems. Consequently, since the last review, the Facility had lost traction and momentum in some of its previous efforts regarding the development and implementation of the Facility's At-Risk system. In December 2013, the Facility hired a new Assistant Director of Programs (ADOP) who was assigned oversight for Section I. In addition, in January 2014, a new Habilitation Therapies Director was hired, whose department had a key role regarding the At-Risk system. On a very positive note, at the time of the review, all positions for Physical Therapy, Occupational Therapy, Speech Therapy, the Physical Nutritional Management Team, Orientation and Mobility specialists, and Audiology had recently been filled. However, at the time of the review, these staff were in the process of becoming familiar with their departmental roles and responsibilities, and were not yet familiar with the details and conceptual framework of the At-Risk system. Also, the continual chronic turnover of the Chief Nurse Executive position as well as other key nursing positions had resulted in a lack of consistent leadership and appropriate clinical direction regarding nursing's role and responsibilities in the At-Risk system in areas such as conducting nursing assessments in alignment with nursing protocols and implementing the required nursing documentation. From discussions with the Facility staff, it was clear to the Monitoring Team that there was a significant lack in the depth of understanding of the complexity and overall purpose regarding the At-Risk process and system. Without having a solid structure in place to address the At-Risk system, the existing pieces of the system, such as the Integrated Risk Rating forms, the Integrated Health Care Plans, the validity of the risk ratings, the implementation of action steps, and discipline-specific assessments, lacked the critical links to ensure that individuals with elevated health/mental health risks were being consistently provided the care they required. As the Facility continues to develop the At-Risk system, it is encouraged to continue to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations, especially regarding the quality of the documentation. o In developing and implementing monitoring tools for this area, the Facility should develop adequate instructions to address the methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews,

	and this would result in inaccurate data. In addition, specific definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. o Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples are pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) should be included with all of the data presented in the Self-Assessment, to facilitate the interpretation of the relevance of the data. Adequate sample sizes should be used to ensure the data is representative of the actual practices being monitored. In addition, inter-rater reliability and specific criteria to define compliance regarding the quality of the documentation and supports provided need to be addressed in order for the Facility's data to be accurate and reliable. o Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the supports provided and documentation maintained, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s). For example, in determining compliance regarding the quality and adequacy of the assessments conducted for the at-risk individuals, a number of disciplines likely will need to be involved. o As noted above, adequate inter-rater reliability should be established for the final Section I monitoring tool. The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings due to the lack of systems in place to address the needs of the At-Risk Individuals, as well as the problems found regarding the quality aspect of the supports provided and documentation reviewed.
	Summary of Monitor's Assessment: Since the last review, there continued to be a significant amount of work yet to be done regarding the At-Risk system and understanding what the system represented and what it entailed. The Facility continued to experience significant staffing challenging and changes, including complete turnover regarding the staff overseeing the At-Risk Individuals systems. Consequently, since the last review, the Facility had lost traction and momentum in some of its previous efforts regarding the development and implementation of the Facility's At-Risk system. In addition, it was clear to the Monitoring Team that there was a significant lack in the depth of understanding of the complexity and overall purpose regarding the At-Risk process and system. As a result, significant weaknesses were found in the existing pieces of the system, such as the Integrated Risk Rating forms, the Integrated Health Care Plans, the validity of the risk ratings, the implementation of action steps, and discipline-specific assessments necessary to ensure that individuals with elevated health/mental health risks were being consistently provided the care they required. Since the last review, the establishment of the Pneumonia Workgroup had been a positive step forward.

	However, efforts need to be directed at addressing the day-to-day clinical care of the individuals in addition to determining differential diagnoses. On another positive note, the Facility's review of data regarding Gastrostomy tubes resulted in initiation of bedside competency training for all nurses involved in providing nutrition and medications by G-tube. From meetings observed the week of the Monitoring Team's onsite review, there was some good discussion of information, use of the Risk Guidelines, and some good clinical discussions regarding the risk indicators. Although some positive changes were noted during the ISPs observed, there continued to be significant issues regarding the accuracy and documentation of the risk levels, the reflection in the IHCPs of supports with the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process. Consequently, at the time of the review, the efforts the Facility put forth had not yet translated into any consistent measurable progress in this area.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, AUSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ The Facility's Self -Assessment indicated that 82% of nurses required to be trained received training regarding the At-Risk Individuals Policy. Although the Self-Assessment indicated that other disciplines were being "evaluated" regarding the training, no other information was provided regarding how the Facility was evaluating the other disciplines and when all required staff would actually receive the required training. ▪ In addition, the Facility indicated that the percentage of individuals with a current risk rating had not been reviewed, however, teams continued to designate risk levels for individuals annually, and as a change of status was recognized. However, the Monitoring Team noted problematic issues regarding the documentation of the risk levels in that only five of ten IRRFs reviewed contained the risk levels for each health/mental health risk category. The Facility's Self-Assessment indicated that at the time of the review, there had been no review of the quality of the risk ratings, or review to measure if the IDTs integrated the risk process, including the teams' discussion of the IRRFs and the IHCPs, into the ISP document. In addition, there had been no review of the quality of assessments each department conducted "due to the need to formally	Noncompliance

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		structure these reviews across the facility." ▪ Although the Facility included data regarding the submission of required assessments 10 days prior to the Individual Support Plan meeting for December 2013, the data could not be interpreted. ▪ In a positive step forward, the Facility indicated that additional tracking and reviews of activities related to cases of pneumonia had been initiated through the establishment of the Pneumonia Workgroup in order to identify individuals with high risks and occurrences of pneumonias. However, no information was contained in the Self-Assessment describing what actions were initiated in response to the information that was reviewed. Continued efforts need to be directed at addressing the day-to-day clinical care of the individuals in addition to determining differential diagnoses. ▪ In addition, on a very positive note, since the last review, the Facility had begun reviewing data regarding G-tubes. This resulted in the provision of bedside competency training for all nurses involved in providing nutrition and medications by G-tubes. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "based on the findings of the self-assessment this provision is not in compliance as evidenced by a lack of consistent implementation of a regular risk screening, completion of quality assessments and the lack of a consistent system which identifies individuals at risk." At the entrance meeting at the beginning of the Monitoring Team's onsite review week, the Facility indicated that a number of steps had been initiated regarding Section I. Although these steps indicated a positive move forward and were necessary, a number of the steps presented represented establishment of basic pieces of the system's infrastructure within the different departments. Such steps included, for example, standardizing and reviewing the Behavior Health Assessments, the initiation of psychiatric peer review, training on and tracking the completion of the MOSES/DISCUSS tools, and revising and implementing Physical Nutritional Management Team Guidelines. At the time of the review, the problematic issues that were found in just the basic infrastructure of many of the Facility's departments continued to hamper the understanding, development, and implementation of an adequate At-Risk system. In addition, the overall lack of clear documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes for the sample of 10 individuals discussed with regard to Sections I.2, and I.3. Consequently at the time of the	

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		review, the efforts the Facility had put forth had not yet translated into any consistent measurable progress in this area. To assess the Facility's revised risk screening process, members of the Monitoring Team observed two individuals' ISPs meetings (i.e., Individual #40 and Individual #323) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at one (50%) of the observed ISP meetings. Dental staff were not present at the ISP observed for Individual #323 who had a high risk for dental issues. ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for one (50%) of the ISP meetings. The dietician and Nurse Case Manager at the ISP for Individual #40 were substitutes and not the actual staff that worked with the individual. ▪ The individual was present at both (100%) of the ISPs meetings observed. The QIDP explained initially that Individual #40 was refusing to come to the meeting, but then joined in after about 30 minutes and participated for about half the meeting. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at all (100%) of the ISP meetings. ▪ The IDT consistently used supporting clinical data when determining risks levels for none (0%) of ISPs observed. There was a lack of supporting clinical data presented at the ISP meetings for both Individual #323 and Individual #40. Regarding medium risks for constipation and falls for Individual #323, the IRRF did not include specific clinical data, such as the number of suppositories needed this year as compared to last year, or the number of falls this year as compared to the previous year when reviewing the risk levels for these areas. In addition, regarding poly-pharmacy which was rated as being a medium risk for Individual #323, the IRRF noted that the individual was prescribed poly-pharmacy for the treatment of constipation and osteoporosis and that labs values were within normal limits. However, no specific labs and lab values were included on the IRRF indicating these medications were actually effective. In addition, for Individual #40, although many of the risk ratings were based on relevant clinical data, there were missing data noted. For example, Individual #40 had hypertension, and the section addressing cardiac disease in the IRRF indicated that blood pressures were taken twice daily with parameters in place to hold medication. However, no data was provided in relation to his actual blood pressure readings recently, over the last year, or in comparison with the previous year. With regard to circulatory disease and fluid imbalance, the IRRF for Individual #40 mentioned labs related to his diagnosis of kidney disease that had been completed, but no specific data was provided, nor was there	

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		comparison with previous data to determine whether or not his status had changed. ▪ Overall, the risk levels the IDT designated were appropriate for each category for none of the ISPs observed (0%), based on information and data provided by the IDTs. Although many of the risk ratings for both individuals appeared to be appropriate based on the information provided, due to the missing data discussed above, for some, the Monitoring Team could not determine if they were actually correct. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in two (100%) of the ISPs meetings observed. For example, Individual #40's team discussed the risk level for weight. Originally, the dietician proposed a medium rating, because technically he had lost weight, but was still within his Estimated Desired Wight Range (EDWR). However, other team members pointed out it was unplanned weight loss, and the Psychiatrist pointed out the etiology of the weight loss was unknown. After some discussion, the team agreed to rate his risk with regard to weight as high. ▪ Team disagreements regarding risk levels were noted in one of the ISP meetings and were resolved appropriately (100%). ▪ Based on the ISP meetings the Monitoring Team observed, the ISP facilitators kept the team focused in both (100%) of the ISPs meetings. In addition, other positive observations from the Monitoring Team regarding the ISP meetings included: ▪ Individual #40 had refused nine gastroenterology (GI) appointments, and the team was concerned due to his ongoing complaints of abdominal pain as well as unplanned weight loss. Although the work-ups that had been completed thus far were negative, the GI specialist had requested a Computed Tomography (CT) scan. The team discussed creative and person-centered options for making an additional attempt to obtain Individual #40's cooperation to attend the needed appointments, including arranging the time of the appointments to suit his preferences, and building in incentives based on some of his specific preferences. ▪ The Team for Individual #40 demonstrated respectful and professional discussion with interdisciplinary input related to the risk ratings. ▪ Individual #323's and Individual #40's teams had drafted the IRRF prior to the ISP. ▪ The direct support professional present at the ISP for Individual #323 was very attentive to the individual throughout the meeting. ▪ The physician for Individual #323 was actively involved in a number of team discussions during the ISP, not just those related to medical issues.	

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		Problematic areas needing focus or improvement included: ▪ It was not clear that Individual #40's team had developed an aggressive approach to dealing with his current medical issues and refusals with regard to medical appointments. For example, as noted previously, Individual #40 was consistently refusing appointments. Although it was positive that the team was trying to be creative, it was not clear what had been done as the multiple refusals had occurred. ▪ Individual #40's team did not discuss, nor did the draft IHCP include measurable goals and objectives to determine whether he was improving, regressing, or remaining stable. For example, a draft goal in the IHCP was: "will not demonstrate any signs of reflux, gastritis, abdominal pain, or diverticulosis including gastrointestinal bleeding, vomiting, or loss of appetite during the next 12 months." In addition to many symptoms all being included in one goal making it difficult to determine what was being measured, a methodology for tracking these symptoms was not included in the draft IHCP or discussed at the meeting. ▪ The IHCP for Individual #323 did not include nursing assessments that would be required by the nursing protocols for health issues, such as his medium risk for constipation. ▪ The Action Step in the Individual #323's IHCP regarding weight indicated that staff should provide adequate fluid intake while he is receiving lactulose and calcium. However, there was no indication what "adequate fluid intake" specifically represented in order to adequately address this step. ▪ The annual IRRFs for both Individual #40 and Individual #323 did not consistently present a baseline and/or provide data to support if the individual had improved over the past year, maintained, or had gotten worse. ▪ The teams for Individual #40 and Individual #323 did not refer to specific data when assessing their current programs. As noted above, from meetings members of the Monitoring Team observed, there was some good discussion of information and use of the Risk Guidelines, some good clinical discussions regarding the risk indicators, and some positive steps were noted regarding the structure and format of the ISP meetings. However, continued efforts were needed to ensure that the risk levels are accurate and documented on the IRRFs, that the IHCPs reflect the needed clinical intensity in alignment with the appropriately designated risk levels, objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. As the development of this system progresses, the Facility should begin ensuring that the information contained in the At-Risk List is accurate and regularly updated, and use this information as a method to assess the acuity of the	

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		individuals who reside at AUSSLC. In addition, the Facility should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on a review of the Facility's Self-Assessment, since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that for the past six months, no Quality Assurance or discipline-specific monitoring reviews had occurred for Section I to: assess the Interdisciplinary Teams' actions to develop a Change of Status (CoS) ISPAs within five days, determine whether any CoS information from the Morning Provider meetings was appropriately addressed, to determine whether data from the Participation Report for Observing and Reporting Clinical Indicators of Health Status was reviewed, or monitor the quality of discipline-specific assessments. This was due to there being no monitoring tools that adequately addressed these areas. As a result, no data were generated. <u>Self-rating</u>: The Facility reported that: "based on the findings of the self-assessment this provision is not in compliance due to data indicating that changes of status were not consistently acted upon within 5 days and the supports implemented were not consistently found to be clinically adequate." Based on a review of records for 10 individuals determined to be at risk (i.e., Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 falls), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators. As a result, it was unclear whether further assessment was needed; ▪ The Integrated Risk Rating forms the Facility provided did not consistently include the risk ratings for each of the risk categories and/or was incomplete for	Noncompliance

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		five of the 10 individuals reviewed including: Individual #430, Individual #270, Individual #72, Individual #206, and Individual #452; ▪ Due to the lack of documented dates and year (2012 versus 2013) on the various forms, the Monitoring Team was unable to consistently determine what new information was added to a revised Integrated Risk Rating form, and what additional assessments were needed and/or conducted in response to the revised information or possible change of status; and ▪ When recommendations for further assessment were found on the Risk Action Plans/IHCPs, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums, making it impossible to determine what precipitated the recommended assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 10 individuals' records for which assessments were to be completed to address the individuals' at-risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls. More specific details are provided with regard to Section M.2. In addition, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 10 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Monitoring Team found considerably less information or no information at all documented regarding the high and medium risk health indicators. Consistent with previous review findings, nursing had no specific procedure in place to address the process regarding the nursing assessments and the analysis of the identified risk indicators. Consequently, the nursing assessments for the At-Risk individuals were not adequate in addressing the health risks of the individuals reviewed as had been found during all previous reviews for this area. In addition, regarding the Integrated Risk Rating forms, a review of these 10 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories for which nursing was responsible. As mentioned above, only five of the five IRRFs included the designated risk levels for each of the risk categories, making it impossible for the Monitoring Team to determine if risk ratings were clinically justified.	

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		However, the Monitoring Team did find that on some of the IRRFs for a few of the risk categories, there was a promising increase in the specific clinical information contained on the IRRF forms, but it was not compared to clinical data from the previous year to indicate if the individuals' health status for the specific health/mental health issue was better or worse to justify the risk rating, if it was assigned. However, overall, for the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, falls, injuries, and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that was assigned in the cases where the risk rating was actually included on the IRRF. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Medical Assessments</u> There were no significant concerns for acute illness on review of the five medical records (i.e., Individual #210, Individual #321, Individual #147, Individual #13, and Individual #45). Additionally, each major diagnosis was documented with rationale for evaluation and treatment verifying diagnosis, as well as responding in a timely manner to any complication or change in severity of conditions. Considerable attention was given to one individual (Individual #210) that had refusals of tests, medications and appointments, and diligence by the PCP in meeting the individual's needs was well documented. For two individuals, the PCP and other members of the IDT worked with family members in determining if and when a feeding tube should be considered (Individual #147 and Individual #13). There were some clinical and documentation concerns that made it difficult to track completion of tasks or the evaluation during the record review. These activities might have occurred, but from the limited submitted information, there appeared to be gaps in documentation or in follow through to closure. Many of these areas required cooperation and follow through by departments other than the Medical Department. One example is provided in detail: ▪ Individual #13 had a history of falls, with 20 falls in the past year, which was an improvement from prior years due to change in residence with a decrease in peer-to-peer aggression. However, the frequency of falls remained high and the individual was considered high risk for falls in the IRRF. A gait belt had been discontinued. A PNMP was referred to as addressing falls in the ISP, but no significant areas of the PNMP concerning falls were added to the IRRF/IHCP except that "adapted supportive shoes" had been bought to assist in ambulation. There was bilateral leg edema and compression stockings/socks were worn. It was not clear if the edema contributed to difficulty with ambulation. Falls in part were considered to be due to a seizure disorder, although the last seizure	

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		was recorded in 1990. There was no checklist approach to ensure all aspects of safety and health with focus on reducing falls (e.g., footwear, any oversized clothing or blankets which may contribute to falls, etc.), potential of glare could not be determined from the entry concerning vision in the annual medical assessment, accommodation to vision impairment, medication side effects or drug interactions, loss of muscle strength or loss of sensation, post prandial syncope, distractions and loss of balance, potential benefit of consults (i.e., PT, physiatry, neurology, etc.). The dysphagia evaluation appeared complete. There was an attempt to delay the need for a feeding tube while the individual was hospitalized, and a temporary tube was placed, but a follow-up MBSS indicated the need for nothing by mouth (NPO) status. However, the team's consideration of this was thoughtful and specific to the individual. It was noted the IRRF did not indicate that the individual had a fundoplication in the past. On 6/6/13, it was not noted if this was intact or had slipped. There was a recent esophago-gaastroduodenoscopies (EGD), which indicated gastritis, but there was no information about the status of the fundoplication. The individual required TIVA for a dental exam, and at that time, two teeth were extracted. The ISP indicated that the IDT discussed plans to implement a desensitization SAP (for tooth brushing), but the follow-up action steps did not appear to address this further. Suction tooth brushing was ordered, but it was not clear whether she had received the needed equipment, and whether this had started. The ISP indicated it would start in 2014. It was noted that the suction tooth brushing would ultimately assist with reducing potential aspiration pneumonia, as it would have a positive impact on oral hygiene. It was not clear how the Facility was meeting the dental needs of the individual when the individual had lost teeth. There was a need to fast track activities to address this concern. As the individual was in the sixth decade of life and had Down syndrome, a discussion of Alzheimer's disease with family and staff and potential training to identify signs of dementia would have been appropriate. However, documentation was not found to show this had occurred. Overall, the members of the IDT, led by the PCP, had incorporated the process outlined by the Aspiration Pneumonia Task Force in reviewing many areas, which might contribute to aspiration pneumonia. In this case, a feeding tube was required. Suction tooth brushing had been ordered. The individual already had a fundoplication, but it was not known if this was functioning adequately,	

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		nor if a gastric emptying study was needed. An EGD recently had been completed. The IRRF needed to reflect additional information concerning prevention of frequent falls. This document provided little information concerning additional steps taken to prevent the frequency of falls. A dental desensitization plan was considered, but there was no tracking to ensure it was created and implemented. As the documents reviewed were limited, there was the potential for other areas of the records having addressed the above information. That the IRRF did not document this information suggested these areas remained unresolved, and reflected a need for a review of the record to determine if all areas of care were addressed and documented in one place, such as the IRRF. Most of these areas were beyond the traditional role of the PCP, as the suction tooth brushing and DEXA had been ordered, and fall assessments are more interdisciplinary in nature. However, the PCP remained a member of the IDT and should provide essential guidance with these areas of need. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on review of the Facility's Self-Assessment, since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that for the past six months, reviews and the generation of QA monitoring data for Section I to address the development and integration of an Integrated Health Care Plan regarding high and medium risks into each individual's ISP and implementation within 14 days, and the IHCPs to determine if they appropriately addressed the required components had not occurred. This was due to there being no monitoring tools to adequately address these areas. As a result, no data had been generated. <u>Self-Rating</u> The Facility's Self-Assessment indicated that: "based on the findings of the self-assessment this provision is not in compliance due to needing continued improvement in several areas to demonstrate immediate action has been taken when risk to the individual warrants. Additionally, the development of a system to systemically monitor clinical indicators reflected in ISP action plans has not been developed."	Noncompliance

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		Based on a review of 10 records for individuals determined to be at risk (i.e., Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ None (0%) of the IHCPs sufficiently addressed the health risk in accordance with applicable nursing protocols. Although some of the IHCPs included nursing protocols in response to an acute event, none were included for existing health issues, such as constipation or aspiration, where the implementation of nursing assessments in alignment with the nursing protocols would be implemented on a regular basis and not just in response to an acute event. ▪ Implemented a plan within fourteen days for each individual, as appropriate, in none (0%) of the cases reviewed. The 10 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage compliance with a healthy diet and encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the IHCP/Risk Action Plans into the ISPs in 0 of the 10 cases (0%). Based on a review of the IRRFs, risk ratings sometimes were not included, and as a result, the Monitoring Team could not determine if the necessary IHCPs to address high/medium risk indicators had been developed and integrated into ISPs. In addition, the IHCPs the Facility provided did not appear to be a part of the ISP document, but rather worksheets for the IHCPs that also appeared incomplete. ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan.	

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		▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily, weekly, or "PRN" without the specific shift, day, or criteria included to ensure accountability. At the time of the review, the Facility indicated it was not in substantial compliance with the requirements of the Settlement Agreement for this area. This finding was consistent with the findings of the Monitoring Team. AUSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. These plans should meet the individuals' needs, contain functional and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o The following sections of the records for 17 individuals: The annual medical history, Physical Exam, Active Problem List, the Psychiatry section, the Behavioral Health Services (BHS) section, Monitoring of Side Effects Scale (MOSES)/Dyskinesia Identification System: Condensed User Scale (DISCUS) screening section, Rights section (including "Human Rights section" and "consents"), the Pharmacy section, the Neurology section (from the consultation section), and documentation concerning the use of "pre-treatment sedation" medication for dental appointments. If the individual had a rights restriction regarding pre-treatment sedation for dental appointments, documentation of the Desensitization Plan. The following 17 (or 15% of the 114 individuals prescribed psychotropic medication) were included in the sample; o The following seven individuals were selected during the on-site review: Individual #294, Individual #425, Individual #394, Individual #409, Individual #304, Individual #90, and Individual #2; and o Of the records that were produced in response to the pre-review document request, the Facility considered the following ten individuals to be stable: Individual #291, Individual #204, Individual #6, Individual #127, Individual #353, Individual #358, Individual #397, Individual #141, Individual #292, and Individual #412; o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS, with scores and completion dates for all individuals followed in Psychiatric Clinics; o The MOSES and DISCUS evaluations for the prior year for the individuals prescribed Reglan who were not also prescribed a psychotropic medication; o Attendance Sheets for the two in-services for nurses related to the conduct of DISCUS evaluations; o Presentation Book for Section J; o Minutes of the monthly Polypharmacy Committee Meetings for the prior six months, as well as the material prepared for the 2/27/14 meeting; o List of individuals who have been administered the Reiss Screening instrument; o List of individuals who, in the last six months, were referred for a psychiatric evaluation as a result of an elevated score on the Reis Screen; o The Reiss Screening Score Sheets for the following eight individuals: Individual #5, Individual #332, Individual #417, Individual #335, Individual #311, Individual #138, Individual #206, and Individual #408; o Quality Assurance internal audits related to psychiatric services; o Job description for Psychiatrists; o List of Psychiatrists employed at AUSSLC; o Curriculum Vitae (CVs) of all Psychiatrists employed at AUSSLC;

	○ Weekly schedules for Psychiatrists; ○ List of meetings and rounds Psychiatrists attend; ○ List of individuals receiving anticholinergic medication, with names of medication(s) prescribed, start/stop dates, and duration of use; ○ Facility-wide data regarding polypharmacy, including intra-class polypharmacy; ○ Minutes of the Pre-Treatment Sedation Committee for the last six months, as well as the material prepared for the 2/25/14 meeting; ○ List of individuals prescribed psychotropic medication, including medication and psychiatric diagnosis; ○ List of individuals prescribed intra-class polypharmacy; ○ Separate lists of individuals receiving each of the following medications: a) anti-epileptic drugs being used for psychotropic purposes; b) lithium; c) tricyclic antidepressants; d) Trazodone; e) beta blockers being used for psychotropic purposes; f) Clozaril/Clozapine; g) Mellaril; and h) Serentil; ○ List of individuals with tardive dyskinesia; ○ List of individuals receiving benzodiazepines, with names of medication(s) prescribed, start/stop dates, and duration(s) of use; ○ The documentation related to the 2/25/14 Psychiatric Clinics; and ○ Chemical restraint data for the following episodes of chemical restraint: Individual #109, on 12/11/13, 12/12/13 (x2), 12/13/13, and 12/15/13. ▪ **Interviews with**: ○ Interviewed the following individuals, in the context of the Psychiatry weekly meeting: Scott Murry, Psychiatrist; Marti Granger, Psychiatric Nurse; Laura LeBlanc, Psychiatry Assistant; Angie Hutchison, Psychiatry Assistant; Susan Hill, Psychiatry Assistant; Judi Stonedale, Psychiatrist; and Selina Maldonado, Psychiatry Assistant, on 2/24/14; ○ Stacey Thompson, Director of BHS; Kimberly Testa, Assistant Director of BHS; Angela Somers, BHS; and George Race, M.D., on 2/25/14; ○ Judi Stonedale, D.O., Psychiatrist III, on 2/25/14, in the context of the Psychiatric Clinic; ○ Scott Murry, M.D., Psychiatrist III, on 2/26/14, in the context of the Psychiatric Clinic; ○ Kenda Pittman, Director of Pharmacy Services; Guy Campbell, Pharm.D.; and Bethany Whittaker, Pharm.D., on 2/24/14; ○ James Boston, Clinical Dentist, and Sue Neel, Dental Hygienist, on 2/24/14; ○ George Race, M.D., Section Chief for Psychiatry, on 2/24/14 and 2/25/14; and ○ The following individuals were present during an extended meeting to review the Facility self-assessment process, which took place on 2/26/14: George Race, M.D.; Selina Maldonado; Stacey Thompson; Kimberly Testa; and Amelia Somers, Behavioral Health Services 5/Quality Assurance (BHS 5/QA). ▪ **Observations of**: ○ Pre-Treatment Sedation Committee Meeting, on 2/25/14; ○ Psychiatry Clinic with Judi Stonedale, M.D., on 2/25/14; ○ Psychiatry Clinic with Scott Murry, M.D., on 2/26/14; ○ Psychiatry Clinic with George Race, M.D., on 2/26/14;

	○ The following individuals were observed during the visits to the individuals' residences and vocational sites: Individual #84, Individual #272, Individual #112, Individual #338, Individual #306, Individual #181, Individual #180, Individual #42, Individual #224, Individual #382, Individual #284, Individual #80, Individual #127, Individual #244, Individual #184, Individual #89, Individual #412, Individual #33, Individual #312, Individual #151, Individual #341, Individual #353, Individual #8, and Individual #90.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 2/4/14. In its self-assessment for each subsection, AUSSLC had identified: 1) activities engaged in to conduct the self-assessment, 2) the results of the self-assessment, and 3) a self-rating. The documents assembled in the Presentation Book indicated the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. On 2/25/14, during the onsite review, these materials, including the Facility Self-Assessment, were reviewed with the Section Chief for Psychiatry, the Psychiatric Assistant, and the Behavioral Health Services 5/Quality Assurance (BHS 5/QA). During that meeting, the methodology and results of the internal Psychiatry Department reviews were discussed in considerable detail. The Psychiatry Department's internal record review process was changed in the August/September 2012 timeframe, due to the availability of the new Section J auditing tool that DADS State Office introduced. Currently, the Department was reviewing five individual records each month, which equated to four percent of the population served on a monthly basis (12 percent per quarter). At the time of the Monitoring Team's review, 114 individuals were receiving psychotropic medication. The BHS 5/QA randomly selected five records from the list of individuals who had a Quarterly Review in the prior three months. The BHS 5/QA reviewed three of the five (one of which was used for inter-rater reliability) and the Psychiatry Department also reviewed three individual records (one of which was used for inter-rater reliability). These reviews were distributed among the members of the Psychiatry Team and one reviewer was always a Psychiatrist. The following narrative discusses specific elements of the Facility Self-Assessment process: ▪ The Facility used monitoring/auditing tools: ○ The monitoring/audit tool the Facility used to conduct its self-assessment consisted of: the "Section J – Psychiatric Care and Services Monitoring Tool," finalized by the DADS State Office on 8/8/12. ○ This monitoring/audit tool included a number of indicators to assist the Facility's assessment of their progress toward compliance with the Settlement Agreement. Specifically, the instrument included a total of 39 indicators, which collectively addressed 13 provisions of Section J. Specifically, the elements of this process included a tutorial by an experienced Reviewer, and a test review of a standardized individual record. A score of 90 percent agreement with the established Reviewer was considered to be a passing score that then enabled the staff member to perform an independent review. ○ The monitoring process was based on an adequate methodology, which consisted of the review of approximately 60 records per year (the specific methodology for selecting records is described above) by two independent reviewers, with an assessment of inter-

	rater reliability. o The Self-Assessment monthly sample(s) sizes were composed of five individuals who underwent Quarterly Reviews during the prior three-month period, and were adequate to consider them representative samples. o The audit tool contained instructions and guidelines to prompt consistency in monitoring and the validity of the results. However, the tool was not constructed in such a manner as to stand-alone in this regard. As noted above, the Department had developed a training and competency curriculum. o The following professionals were responsible for completing the audit tools: The BHS/5QA would review three of the records (two individually and one for inter-rater reliability), and members of the Psychiatry Department reviewed three, one of which was used for the inter-rater reliability. o With regard to inter-rater reliability, in general, the method the Facility utilized consisted of comparing the results of the two different ratings to ascertain to what degree they were in agreement. The results were presented monthly as simple percentages of agreement by individual criteria. ▪ AUSSLC used other relevant data sources to augment its monitoring methods. The additional sources of data primarily consisted of the databases and spreadsheets used to track the Facility's progress in the completion of the documentation needed to fulfill various sections of the Settlement Agreement. Examples of this were: 1) the Reiss Screen spreadsheet (as discussed with regard to Section J.7); 2) the MOSES/DISCUS Completion-Tracking spreadsheet (as discussed in relation to Section J.12; 3) the Consent-Tracking Database; 4) the Neurology Department Collaborative spreadsheet; 5) the Polypharmacy database; 6) Quarterly Psychiatry attendance rate at the ISPs; 7) the Pre-Treatment Tracking database; and 8) the Comprehensive Psychiatric Evaluation (CPE) Completion database. In regard to the latter, the Psychiatry Department also had developed a CPE monitoring tool, and a monthly peer-review tool. ▪ The Facility consistently presented data in a useful way, as indicated below: o The work of the QA Department for Section J was completely integrated in the self-assessment process of the Psychiatry Department. As indicated in the narrative description of the process above, the BHS 5/QA worked closely with the Psychiatry Department. In reviewing the individual sections of the Self-Assessment, it was noted that the Facility had relied on the results of their internal audits for a number of provisions. The results of the internal audits were discussed for each provision in the Facility Self-Assessment, with the exceptions of J.1 and J.5. Databases/spreadsheets were used for those sections to which they were relevant. ▪ With the exceptions of J.4 and J.12, the Facility rated itself as being in substantial compliance with all of the remaining subsections of Section J. The results of the Monitoring Team's review were similar, with the exception of Sections J.3, J.8, J.9, and J.10, for which the Monitoring Team's review showed noncompliance. The discrepancy with regard to J.3 related to deficiencies in the chemical restraint documents. The differences in the ratings for Sections J.8, J.9, and J.10 were due to deficiencies in the ISP documentation, as described in those sections. ▪ The Facility Self-Assessment identified areas where more improvement was needed. This

	observation was true for all provisions for which the Facility Self-Assessment indicated a current status of noncompliance. For most of these areas, the Facility indicated that some action was being taken to address the issues. However, it would be helpful for the Facility's Self-Assessment to reference the particular action plans the Facility had in place to address outstanding issues. In summary, the Psychiatry Department was actively engaged in the process of self-assessment. The progress they had made over the past several months in meeting the requirements of the Settlement Agreement was related to the thoroughness of the self-assessment process, and the actions they had implemented to address outstanding areas.
	Summary of Monitor's Assessment: The comments below are organized into functional groupings of the provisions of the Settlement Agreement. **Section J.1 and Section J.5:** These provisions relate to both the qualifications of the Psychiatrists as well as the number of Psychiatrists. At AUSSLC, the current Psychiatrists were all Board Certified by the American Board of Psychiatry and Neurology, and the numbers appeared to be adequate for the individuals served at the Facility. **Section J.3:** This provision relates to the question of whether psychiatric medications were used for punishment or for the convenience of staff at the Facility. During the visits to the vocational programs and the residences, direct observation of approximately 22 percent of the individuals prescribed psychiatric medication did not reveal individuals who appeared to be overly medicated, lethargic, or experiencing obvious side effects, such as impaired gait or abnormal movements. The use of chemical restraint frequently involved the Intramuscular (IM) injection of an antipsychotic or other medication to an individual against their will, and if administered improperly, could be considered to be punishment. Based on the Monitoring Team's review, there were deficiencies in the documentation for the episodes of chemical restraint reviewed, which made it impossible to determine if these interventions were used appropriately. **Section J.4:** This provision addresses the use of pretreatment sedation and the development of Desensitization Plans and other strategies to minimize the use of these interventions to the extent possible. Currently, AUSSLC had only developed a few of these plans. The rates of pre-treatment sedation for medical procedures were much greater than the corresponding rate for dental procedures, and had received less attention. **Section J.2 and Section J.6:** These provisions address the issues of the psychiatric diagnosis and the Comprehensive Psychiatric Evaluations (CPEs). The criterion for each individual's psychiatric diagnosis was listed at the beginning of the psychiatric Quarterly Reviews and was carried forward in each review. The Psychiatry Department had made considerable progress in both of these areas. **Section J.7:** The Reiss Screen was utilized for those individuals who had not had a CPE and had been newly admitted, or experienced a change in status. Individuals who were discharged from the Psychiatric Clinic

	after their medications had been discontinued received a Reiss Screen a few months after discharge, as part of the follow-up procedure. There was also a protocol for the administration of the Reiss Screen to individuals who had a potential change in their psychiatric status. This review indicated that the Facility was performing a CPE for individuals who had elevated Reiss Scores, unless there were extenuating circumstances. **Section J.8 and Section J.9:** These two provisions primarily relate to the integration of the Psychiatry Department and Behavioral Health Services. Observation of the Psychiatric Clinics of the three Psychiatrists indicated that the BHS Department played an integral role in the meetings. This material also should be reviewed in the ISP, and although the review sample of individual records indicated that the integration between the two services was occurring, review of the ISPs indicated information that discussed these important documents was still deficient. **Section J.10 and J.14:** These provisions discuss the related issues of the Risk-versus-Benefit Analysis and the Informed Consent. The Psychiatric Quarterly Reviews, the CPEs, and the Psychiatric Treatment Plans the Monitoring Team reviewed all included extensive discussions of the risk-versus-benefit considerations, and verified that the consents were up-to-date for all of the prescribed psychotropic medications. **Section J.11:** This provision specifically relates to the issue of polypharmacy. The Facility had reduced their absolute rate of polypharmacy to 15.5 percent, and the adjusted rate (taking into account those for whom the medication had been justified) was 9.4 percent. Also, many of those in the "Active" category had tapering plans in place for their remaining medications. **Section J.12 -** The Nurse Case managers carried out MOSES/DISCUS side effect monitoring. The Facility had identified some difficulties in the timely completion of these assessments, and the review sample of 15 percent of individuals prescribed psychotropic medication confirmed that there were deficiencies in the monitoring of side effects. **Section J.13:** This provision primarily relates to the conduct and documentation in the ongoing psychiatric reviews. The Facility tracked the occurrence of the Quarterly Reviews, and they had occurred as scheduled. In addition, the Psychiatrists often did follow-up or urgent consults in between the Quarterly Reviews. **Section J.15:** This provision relates to the coordination of treatment between the Departments of Psychiatry and Neurology. The Psychiatrists routinely attended all Neurology Clinics, and this was documented in both the psychiatric section of the record, as well as in the Neurology Consultation Note.

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J1	Effective immediately, each Facility shall	Historically, AUSSLC relied on as little as seven hours of Psychiatry Consultation time per week. In May 2008, Dr. Scott Murry joined the Department on a full-time basis. Dr. Judi Stonedale had been with the Facility on a full-time basis for four years. In May 2012, Dr. George Race joined the Facility as the Section	Substantial Compliance

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	provide psychiatric services only by persons who are qualified professionals.	Chief for Psychiatry. The Psychiatrists who practiced at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. All of the Psychiatrists had extensive experience working with individuals with intellectual and developmental disabilities (ID/DD) through their previous employment. This was apparent in the conduct of the Psychiatric Clinics, and in the individual discussions with the Psychiatrists. The specific past experience of Drs. Stonedale, Murry, and Race was described in prior reports. The finding of substantial compliance for this provision was established because all Psychiatrists who provided services to the individuals at AUSSLC were Board Certified by the American Board of Psychiatry and Neurology, and had extensive experience in providing care to individuals with ID/DD. This was consistent with the finding from the Monitoring Team's last compliance review at AUSSLC in November 2012.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At AUSSLC, a total of 114 individuals were prescribed psychotropic medication. A sample of individuals was selected for the current review, as described in the section above listing the documents reviewed. This included 17 individuals, or 15 percent of the 114 individuals prescribed psychotropic medication. As noted above, at the time of the review, the Psychiatrists who diagnosed and treated the individuals at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The Psychiatrists had extensive prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. Although the psychiatric diagnoses appeared in a number of sections of the individuals' records, the clinical justification that supported the validity of the diagnosis primarily appeared in the related sections of the CPEs and the Quarterly Psychiatric Reviews. As noted in the Monitoring Team's prior reports, the Facility had developed an initiative to complete a thorough CPE that would comply with the terms of the Settlement Agreement for all individuals prescribed psychotropic medication. The review of the current sample of 17 individuals prescribed psychotropic medication determined that for 16 of the 17 (94%) individuals, up-to-date completed CPEs that complied with the specifications of the Settlement Agreement were available in the individuals' records. The only exception was Individual #412, for whom it appeared an update was overdue. The status of the Facility's current overall completion rate for the CPEs is discussed in more detail with regard to Section J.6. The diagnostic section of the CPE contained important information regarding the rationale and documentation for the individuals' psychiatric diagnoses. However, the Quarterly Review documentation at AUSSLC also contained very detailed information related to the symptoms that supported the individuals' psychiatric diagnosis. For many individuals, this included a complete listing of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria for the	Substantial Compliance

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		diagnosis, and identified the specific criteria that applied to the individual. The individual records that did not contain the actual listing of the diagnostic criteria did contain a listing of all symptoms of the diagnosis that the individual manifested. This documentation appeared in the diagnostic section of the Quarterly Review, and was sufficient to support the diagnosis for all of the 17 (100%) individuals. A prior problem with the diagnostic process at AUSSLC had been the dual classification of behaviors as being present on a behavioral basis, and also being classified as a behavioral target of the psychotropic medication. The Facility had largely rectified this problem by joint case formulation between Psychiatry and BHS, which included a separate entry in the Positive Behavior Support Plan (PBSP) and the Structural and Functional Assessment report that discussed the psychiatric diagnosis. This issue is discussed in more detail with regard to Sections J.8 and J.9. These results indicated that the BHS Department and the Psychiatry Department had been successful in resolving this problem. The Facility did not regularly utilize the "Deferred" terminology to qualify a specific diagnosis as being incomplete. There was only one individual in the present sample (i.e., Individual #141) whose diagnoses utilized "not otherwise specified" (NOS) terminology, which is used for individuals who do not fit the typical pattern for the diagnosis. The review of the diagnostic information compiled for this individual indicated that it was an appropriate use of this diagnostic term. The Facility maintained records related to the individuals for whom there had been a change in their psychiatric diagnosis during the prior six months. This material contained diagnostic changes that had been made for 17 individuals during this timeframe. A review of the documentation for these changes showed it was extremely detailed and included the supportive criteria from the DSM-IV-TR. The Facility was found to be in substantial compliance with this provision, due to the thoroughness and consistency of the psychiatric diagnoses that were found in 100 percent of the individual records reviewed.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program;	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatry Clinics, as well as the review of the records of 17 individuals prescribed psychotropic medication did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. The Monitoring Team's previous reports indicated that for a number of individuals, the behaviors identified as the "target behaviors" of the psychotropic medication also were identified in the Structural and Functional Assessment and related PBSP as being present on a behavioral basis and/or related to environmental factors. This observation suggested that, for these individuals, the prescribed psychotropic medications could be construed as having been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this section	Noncompliance

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	in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	of the Settlement Agreement. In other words, they potentially were being used in the absence of adequate behavioral treatments or interventions, which could be construed as being "for the convenience of staff" who were not equipped to respond with the appropriate behavioral interventions. During the Monitoring Team's onsite interviews, it was noted that collaboration with the BHS Department had led to the development of a systematic approach to address this problem. This consisted of including a specific section in both the PBSP and the Structural and Functional Assessment to address the individuals' psychiatric diagnosis, as well as the impact of that disorder on the individuals' behavioral presentation. Both of these documents were found in all of the individual records in the sample (100%). The quality of these documents is discussed with regard to Section K. The Psychiatry Department also had added a section in their Quarterly Review documentation. In this section, the derivation of the target behaviors of the psychotropic medication was discussed, as well as the link between these target behaviors and the symptoms of the psychiatric disorder. This topic also was discussed in the Bio-Psycho-Social-Spiritual Formulation section of the CPEs. As indicated with regard to Section J.6, the CPEs had been completed within the prior year for 16 of 17 (94%) individuals. However, documentation in the BHS section of the record and the Quarterly Psychiatric Reviews was sufficiently detailed to ascertain that the prescribed psychotropic medications were not being used for punishment or for the convenience of staff for all of the 17 (100%) individual records reviewed. The use of chemical restraint also could be construed as punishment, because it frequently involved the IM injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint was extremely important in differentiating between the necessary uses of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further investigate the use of chemical restraint at AUSSLC, a request was made for documentation related to the five most recent administrations of chemical restraint, which are reviewed below: **INDIVIDUAL** / **DATE** / **TIME** / **MEDICATION** Individual #109 / 12/11/13 / 8:49 a.m. / Zyprexa IM (dose not specified) Individual #109B / 12/12/13 / 12:26 p.m. / Zyprexa 10mg IM Individual #109C / 12/12/13 / 11:20 p.m. / Zyprexa 10mg IM Individual #109D / 12/13/13 / 4:28 p.m. / Zyprexa 10mg IM Individual #109E / 12/15/13 / 12:30 a.m. / Zyprexa 10mg IM The individual restraint data was reviewed for the presence and quality of the five components of documentation the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections, and the results of this review are as follows:	

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		▪ The information contained in the section of the form following the prompt to provide a description of the events leading to behavior that resulted in restraint was reviewed. This section of the documentation was completed for all of the episodes of chemical restraint, and provided a description of the events that led up to these episodes of chemical restraint. ▪ The section designed to describe the interventions attempted to avoid restraint also was reviewed. This section was completed for all of the episodes of chemical restraint, and provided useful/practical information. ▪ The portion of the documentation, which included the physiological post-restraint monitoring, was completed for only two of these episodes. However, for Episode 109B, there was only a statement that indicated: "refused VS" and 109D provided only one set of vital signs. The lack of attention to this important aspect of chemical restraint monitoring could suggest that the Facility staff were viewing it as routine, rather than as a serious intervention that requires careful monitoring. ▪ The section of the documentation entitled "restraint debriefing" was completed for all five episodes of chemical restraint. ▪ The Chemical Restraint "Clinical Review" was completed for all episodes. However, although the comments of the Clinical Pharmacist were thorough, those of the Psychiatrist were minimal in comparison. In general, these comments seemed to simply agree with the pharmacist's observations and did not thoroughly address the important issue of how further episodes might be prevented going forward. Thus, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of intramuscular medications were not fully completed for any of the five episodes in this sample. Accordingly, although no instances were found, in which the documentation showed chemical restraint was definitively used as punishment, the documentation should be improved so that the Facility staff, as well as external reviewers, can determine that it was not used as punishment or for the convenience of staff. The Facility had made substantial progress in the differentiation of behaviors that were derived from a psychiatric disorder, as opposed to being related to environmental and/or behavioral factors. As noted above, the chemical restraint documentation was insufficient and without this it was not possible to conclude that chemical restraint was not being used inappropriately for punishment, or, in some cases, for the convenience of staff. However, it should also be noted that there was no overt evidence that it was being used for these inappropriate reasons. The Facility was found to be in noncompliance with this provision.	
J4	Commencing within six months of the Effective Date hereof and with full implementation	The Psychiatry Department was coordinating the implementation of the Behavioral Desensitization Plans for dental and medical appointments. In order to facilitate this process, a Pre-Treatment Sedation Committee had been established. Review of the minutes of the prior Committee meetings indicated representatives were present from Psychiatry, Medicine, Pharmacy, Dental Services, and BHS.	Noncompliance

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	within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Dental Services Department had been gathering data on the frequency with which intravenous (IV) sedation and pre-treatment oral sedation was required to accomplish successful dental appointments. This data for the time period of 7/1/13 through 12/31/13 was as follows:	

Months 2013	# Attended Appointments	# No Sedation Required	# Oral Sedation	# IV Sedation
July	90	78	0	12
August	55	27	2*	27
September	74	45	2**	29
October	96	65	3**	31
November	62	44	3**	18
December	43	32	2**	11

* *One of these was for cleaning and the other was for transport to Dental Office for General Anesthesia (GA.)*

** *Given for transport to Dental Office for administration of GA.*
As indicated above, only one administration of oral pretreatment sedation was actually utilized to accomplish the dental procedures. The others were utilized for transportation from the residence to the Dental Office, where GA was then administered.

The Dental Services staff indicated that it was important to note this data was reported on a per appointment basis. The observation that the data is reported on a per appointment basis is significant, because an individual who did not require any sedation for a routine cleaning might require pre-treatment oral sedation or even IV anesthesia for a complicated extraction. Thus, the data was specific to the appointments, and not the individual.

Review of the Facility orders for oral pre-treatment sedation for dental procedures indicated that the orders were primarily for Lorazepam (Ativan) in a range from 0.5 milligrams (mg) to 2.0mg (Ativan range: 1 to 2.5mg). These were conservative dosages, and during the interview with the Dental Services staff, they indicated that if standard, conservative dosages of sedative medications were not effective consultation would be obtained from the Psychiatry staff and/or the Pharmacy.

The monitoring for the physiological effects of the oral pre-treatment sedation took place in three different settings. The medication was administered at the individual's residence approximately one hour before the dental appointment. Thus, the post-administration monitoring was begun in the residence and then transitioned to the Dental Office at the time of the appointment. After the work in the Dental Office was completed, each individual was transferred to the Infirmary for further monitoring, and then was released back to the residence at the discretion of the Infirmary Unit Nursing Staff. Therefore, in order to track the physiological monitoring, it was necessary to review data from three different

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		sources: the individual's residence, the Dental Office, and the Infirmary. A more efficient means of monitoring in the post-administration stage would be to create a form that accompanies the individual throughout the whole process, as is done at some of the other DADS SSLCs. This would decrease the risk of omissions, and should facilitate communication between the different professional staff that interact with the individual during the course of the pre- and post-dental appointment experience. The topic of physiological monitoring related to the use of pre-treatment sedation for dental appointments is discussed in more detail with regard to Section Q of this report. As noted above, the Facility was devoting more attention to addressing the use of pre-treatment sedation for dental procedures than that for medical procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 7/1/13 to 1/31/14 indicated that the majority of pre-treatment sedation at AUSSLC was utilized for medical appointments. The utilization data for pre-treatment sedation related to dental procedures is described above. The review of utilization data for medical procedures indicated that the Pharmacy Department had made a great deal of progress in removing the ambiguity that was noted in the interpretation of this data during the Monitoring Team's November 2012 review. Specifically, the Facility had developed a patient-tracking system that made it possible to identify each administration of pre-treatment sedation for medical and dental procedures, separately, as well as the efficacy of those interventions, based on the rating of the nurse. The review of this data indicated that from 7/1/13 to 1/31/14, there were 205 administrations of pre-treatment sedation for medical procedures. Thus, the utilization of oral pre-treatment sedation for medical procedures was greater than the corresponding utilization rate for dental procedures. However, it had received much less attention than had been devoted to dental pre-treatment sedation. The medications utilized for oral pre-treatment sedation for medical procedures indicated that orders were primarily for Ativan (in the range of 0.5mg to 2.5mg), followed by Benadryl (in the range of 25mg to 100mg). On 2/25/14, a member of the Monitoring Team was able to attend the Pre-treatment Sedation Committee Meeting, and also reviewed the minutes of these meetings for the prior six months. This was a productive meeting with active participation of the different professionals who were present. Much of the focus was on the plan for further deployment of the Treatment Plans developed as a result of the Dental Task Analysis. The following data was presented at the meeting of the Dental Pre-treatment Sedation Committee, which summarized their progress in developing Pre-treatment Sedation Plans for medical and dental procedures, and also ensuring that the entire ISP Team reviewed them: <u>January ISP Report</u> 1) Numbers of ISPs done in January was 25.	

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		2) Sample audit numbers where pre-treatment sedation is discussed in them/over all sample ISP number for the period: four of four ISPs monitored in January included pre-treatment sedation discussion. 3) Total number of desensitization plans currently in force for pre-treatment sedation for medical and for dental = # of Medical Desensitization is three and # of Dental Desensitization is 18. 4) Absolute numbers of recommended pre-treatment sedation plans that have not been not started or are incomplete for each medical and for dental pre-treatment sedation patient = zero, all have been written and implemented at this time In addition, the Facility had been developing Skill Acquisition Plans (SAPs) to reduce the need for the use of pre-treatment sedation. The summarized data for this aspect of their work was as follows: MEDICAL AND DENTAL DESENSITIZATION – 2013 <u>Dental</u> SAPs Implemented - 18 SAPs in Process - Zero No SAP - Zero Assessment Not Completed Yet - Zero Exempt by Doctor - Zero **Total SAPs Completed – 100 percent** <u>Medical</u> SAPs Implemented - Three SAPs in Process - Zero No SAP - Zero Assessment Not Completed Yet - Zero Exempt by Doctor – Zero **Total SAPs Completed – 100 percent** The Facility remained in noncompliance with this provision. Although the Facility had made progress in developing and implementing Pre-Treatment Desensitization Plans for dental procedures, actual plans had been implemented for a small number of individuals. The efforts to develop corresponding plans for medical procedures and appointments were just in the beginning stages. The initiative to develop desensitization or other strategies for individuals requiring pre-treatment sedation for medical procedures would benefit from a similar comprehensive organization of the related data similar to that	

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		which the Facility had completed for the use of dental pre-treatment sedation. The gathering of this data should also take into account the type of medical appointment/procedure and whether the appointment took place at the Facility or at an external site. As discussed while the Monitoring Team was on site, it is essential that in addition to considering formal desensitization strategies, that teams also consider other strategies that might reduce the need for dental or medical pre-treatment sedation (e.g., explanations in advance of procedures, times of day of appointments, favorite staff accompanying the individual, etc.), and that attempts to utilize such strategies and the results are clearly documented.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	As indicated in the comments concerning Section J.1, at the time of the review, AUSSLC employed three full-time Psychiatrists. A total of 114 individuals were prescribed psychotropic medication. Thus, if the caseloads were divided equally, each of the full-time Psychiatrists would be responsible for approximately 37 individuals. However, the Section Chief did not carry a full clinical caseload, due to administrative responsibilities and quality-improvements projects. The Psychiatry Department had prepared an analysis of the Psychiatrists' time commitments. The time analysis worksheet took into account the time necessary to complete the CPE, Quarterly Review documentation, Treatment Plans, information needed for the Informed Consent process, and the annual summaries required for the ISP reviews. The review also accounted for the time necessary to attend the Morning Medical Report, the annual ISPs, the Individual Support Plan Addendum (ISPA) meetings, the Quarterly Review Meetings, as well as the monthly follow-ups, and the urgent psychiatric consultations that are required at times. The calculations supported the conclusion that three full-time Psychiatrists were sufficient to perform all of these functions. The information reviewed indicated that AUSSLC employed an adequate number of Psychiatrists to provide clinical services to the individuals who resided there. At the time of the Monitoring Team's last compliance review (i.e., November 2012), the Facility was found to be in substantial compliance. The Facility remained in substantial compliance, because it was found to have a sufficient number of qualified Psychiatrists to provide services to the individuals who reside at AUSSLC.	Substantial Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment,	As indicated above, the Facility had continued their initiative to complete a thorough CPE for each individual prescribed psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The Monitoring Team's review of the medical records of 17 individuals receiving psychotropic medication identified a current completed CPE, which met the formatting requirements specified in the Settlement Agreement, for 16 of the 17 (94%) individuals. The only exception was Individual #412, for whom the most recent CPE was dated 10/1/12. However, a subsequent review of the spreadsheet the Facility maintained with regard to the CPE completion status indicated that the annual update was due to be completed in February to coincide with an upcoming ISP. It is possible that the update had been completed and not filed, but since it could not be located in the record, it was considered overdue. At the time of the Monitoring Team's previous reviews, the Facility had revised the format of the CPEs to	Substantial Compliance

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	diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	ensure that it was consistent with the format specified in the Settlement Agreement. The review of the CPEs undertaken at the time of the November 2012 review, as well as the current review, indicated that the CPEs completed were thorough and uniformly met the standards of the Settlement Agreement. The spreadsheet the Facility maintained to track the status of the completion rate of the CPEs, which was updated monthly, identified 114 individuals with current CPEs and annual updates. The review of this documentation indicated that the Facility was transitioning to a system that would coordinate the completion of the annual CPE update with the annual ISP. The spreadsheet contained additional columns entitled "Annual Update" and "ISP Date." The purpose of these two columns was to record the annual updates of the CPEs that were prepared to coincide with the individuals' ISP date. Tabulation of the CPE dates, coupled with the information in the annual update column, indicated that all of these 114 CPEs had been completed or updated within the past year, although there were several for whom an update would be required in 2/14, as was also noted for Individual #412, discussed above. The finding of substantial compliance for this provision was related to the Facility's completion of CPEs that met the criteria set forth in the Settlement Agreement, and also to ensure that this material was updated annually.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible	A spreadsheet updated on 2/17/14 listed the individuals to whom the Reiss Screen for Maladaptive Behavior had been administered. The Monitoring Team's initial three reports included the results of an analysis of a distinct 20 percent sample of individuals who had been administered the Reiss Screening instrument. This methodology verified the accuracy of the data by comparing the information contained in the spreadsheet to a copy of the actual Reiss scoring sheet for each individual in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate, and thus, a similar study was not repeated again this time. The Monitoring Team's previous reports discussed problems with adherence to the portion of this provision that relates to completion of the CPEs for those individuals whose scores on the Reiss Screening instrument were above, or very near, the clinical cut-off score that should have prompted further psychiatric assessment. The current review focused on those individuals for whom the Reiss Screen had been administered since the Monitoring Team's previous review. The review of the current spreadsheet indicated that the Reiss Screen had been administered to 41 individuals in 2013. The Reiss protocol indicated that individuals with elevated scores on the Reiss Screening instrument should be referred for a mental health evaluation. AUSSLC responded to these elevated scores with a CPE. Accordingly, a request was made for all CPEs completed within the last six months as a result of an elevated Reiss score. The individual with a CPE as a result of an elevated Reiss Screen (date of CPE) was Individual #281 (8/30/13). The Psychiatry Department's current protocol for administering the Reiss Screen called for	Substantial Compliance

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	psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	administration when an individual was discharged from the Psychiatric Clinic, when he/she was referred to the Psychiatric Clinics, or a Psychiatric Consultation, which might not lead to a clinic referral. This procedure was summarized in a procedural flow sheet. The first four steps reproduced below described the initial actions that were involved. The other steps (5 through 16) not reproduced here primarily related to the procedural details involving the actions that take place after the individual was reviewed in the psychiatric clinic. <u>Initiating Psychiatric Clinic Services</u> 1. Individual has change in behavioral presentation or emergence of psychiatric symptoms. 2. Psychologist is informed about the change or emergence of symptoms. 3. Psychologist completes Reiss Screen (psychopathology measure) and presents results to Interdisciplinary Team. a. If cut-off score is reached in any area, IDT refers for psychiatric evaluation: i. Psychologist contacts Psychiatric Assistant to request they schedule the initial consult. 4. Psychiatric clinic is held with IDT members and guardian (if guardian wishes to attend). . As noted by the description of the initial steps in this process, the identification of individuals who have experienced a change in status was primarily subjective and dependent on the clinician's observations, because there were no specific criteria. As indicated above, during 2013, the Reiss Screen had been administered to 41 individuals. These individuals were administered the Reiss Screen as a result of the Facility's protocol to perform a follow-up Reiss screening a few months after an individual was discharged from the Psychiatric Clinic following the discontinuation of their psychotropic medication, as a result of a complete psychological reassessment by the BHS Department, or due to a change in their clinical status, as per the aforementioned protocol. The spreadsheet did not contain the results of the Reiss Screening. Accordingly, a random sample of eight individuals (20 percent of those administered the Reiss) was selected to verify that those with elevated scores were referred to Psychiatry for evaluation. These individuals (date of Reiss Screen) were as follows: Individual #5 (2/15/13), Individual #332 (7/19/12), Individual #417 (2/26/14), Individual #335 (8/29/13), Individual #311 (3/15/12), Individual #138 (2/12/13), Individual #206 (2/15/13), and Individual #408 (1/16/14). As noted by these completion dates, some of the individuals had Reiss screens that were done either before or after 2013, and thus, the list appeared to be more of an ongoing list with the majority of the evaluations being performed in 2013. The review of the Reiss Scoring Sheets for these individuals indicated they all had scores that were either zero or well below the clinical cut-off score (nine), with the exception of Individual #5, whose 2/15/13 scoring sheet indicated a score of 15.5. This individual was then discussed with the Psychiatry Department and additional documents were requested. The discussion and related documentation indicated that this individual was well known to the Psychiatry Department. The rationale for the prior discontinuation of the psychotropic medications was that she usually presented with what was described as a "calm and with pleasant affect" (Quarterly Psychiatric Review, 3/21/11). The primary monitored	

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		behavior was aggression, which was determined to be contextual in nature and was eventually thought to represent a form of communication. Accordingly, the psychotropic medication reductions were continued and the medication was subsequently discontinued, with the plan that the aggression would be addressed with environmental and interpersonal approaches. The items noted on the Reiss Screen were consistent with those described in the Psychiatry Department's previous Quarterly Review documentation, as described above. The Facility was found to be in substantial compliance with this provision. They had developed a strategy to obtain Reiss Screenings for individuals who had been discharged from the Psychiatry Clinics following the discontinuation of their medications, as part of a comprehensive behavioral health reassessment, or due to a change in their clinical status. This review also indicated that a CPE was performed for those individuals who had an elevated score, unless there were extenuating circumstances, as described above.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The integration between Psychiatry and BHS was apparent in discussions with the three Psychiatrists. These interactions also were visible in the Psychiatric Clinics of each of the three Psychiatrists. It was apparent that the BHS Department staff had a central role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The data was presented in both tabular and graphic formats and was discussed during the course of the meeting. There was also a discussion of interpersonal and environmental factors that might be affecting the individual's presentation. Where appropriate, a member of the nursing staff would comment on any recent medical issues that might be having an effect on the individual's presentation. In addition, the efficacy of the prescribed medications was reviewed, with a view toward challenging medications for which there was any doubt about their continued necessity. Thus, the observations of the Psychiatric Clinics and the related documents illustrated the active collaboration between the two disciplines of BHS and Psychiatry. A prior deficit in this collaboration, in terms of case formulation, had been the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Assessment and the PBSP. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The Psychiatry Department, working in conjunction with the BHS Department, had developed a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, which it had begun to implement. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. The discussion with regard to Section J.9 also describes the considerable progress that the Psychiatry Department and BHS Department had made in rectifying these problems. The primary disciplines that routinely attended the Psychiatric Clinics were Nursing, Psychiatry, BHS staff, direct support professionals, and the Qualified Intellectual Disabilities Professional (QIDP).	Noncompliance

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		Disciplines such as medical, Speech Therapy, Occupational Therapy, and Physical Therapy were not able to attend the Psychiatric Clinics, due to the additional constraints on their time allocation. However, these disciplines often did attend the individual ISP meetings. The Psychiatrists also had begun to attend these meetings. The attendance at the annual ISP meetings, as well as the content, was reviewed for the 17 individuals in the sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP Meeting for 15 of the 17 (88%) individuals. The exceptions were as follows: ▪ The record of Individual #397 contained only a page that read "No ISP" in the section of the report where the ISP would usually appear. ▪ The Signature Sheet for Individual #358 (9/30/13) did not contain the signature of a member of the Psychiatry Department. ▪ A Psychiatry Assistant represented the Department at the ISPs of Individual #394 (1/16/14), Individual #90 (1/30/13), and Individual #425 (1/18/14), while the Attending Psychiatrist participated in the others. Although a member of the Psychiatry Department had attended 88 percent of the individual ISP meetings of the individuals in the sample, the documentation contained in the ISPs did not fully reflect the integration between BHS and the Psychiatry Department, as specified in this provision of the Settlement Agreement. For example, the Integrated Risk Rating Form (IRRF) was missing in the record of Individual #291 (8/6/13), and the sections following the prompts for specific items were blank for Individual #127 (5/16/13). In addition, the IRRFs contained only minimal responses for Individual #353 (6/13/13) and Individual #2 (12/10/13). The IRRFs that were found to be comprehensive, often included graphs to support the findings, and were those of Individual #304 (10/22/13), Individual #425 (1/8/14), Individual #409 (12/31/13), and Individual #90 (1/30/13). The others were not adequate, because they contained the types of deficiencies described above. The results with regard to the narrative sections were similar, in that many contained only a sentence indicating that the Psychiatric Treatment Plan had been reviewed. Examples of this were the ISP of Individual #141 (5/7/13), and that of Individual #353 (8/2/13). The only records that contained both narrative discussions and IRRFs that were detailed and comprehensive were those of Individual #304 (10/22/13) and Individual #425 (1/8/14). The other ISPs contained either a deficient narrative and/or IRRF. The Psychiatry Department remained out of compliance for this provision, because the documentation in the individuals' ISP was deficient for the majority of the individuals reviewed. However, the Attending Psychiatrist, or a member of the Psychiatry Department was now routinely attending the ISP meetings, and the more recent ISP documentation had improved considerably.	
J9	Commencing within six months of the Effective Date	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of the Psychiatry Department and the BHS Department was evident in the conduct of the Psychiatric Clinics, as well as in the documentation found in the sample of 17 records of individuals prescribed psychotropic medication.	Noncompliance

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	hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic	When making decisions about potential changes in an individual's psychotropic medication, the Psychiatrist relied heavily upon the data related to the frequency of those behaviors that had been identified as the target behaviors of the prescribed psychotropic medication. The Monitoring Team's previous reports identified a deficiency in this process related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified in the Structural and Functional Assessment Report and the PBSP as being present on a learned/behavior basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were potentially being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the corresponding BHS Treatment Plans had been developed through parallel processes that were not fully integrated. The review of the sample of the records of 17 individuals prescribed psychotropic medication indicated the Facility had substantially rectified this problem through combined assessment and case formulation. The Psychiatry Department had addressed this problem by identifying the symptoms of the psychiatric diagnosis in their Quarterly Review documentation. This information also discussed the derivation of the behaviors identified as targets of the psychotropic medication in those instances where the monitored behaviors were not also overt symptoms of the psychiatric disorder. However, in the initial reviews, this information was not reflected in the BHS sections of the record. The BHS Department had added a specific section to both the PBSP and the Structural and Functional Assessment report to address the aspects of the individuals' presentation that were derived from or contributed to by their psychiatric disorder, and they worked in conjunction with the Psychiatry Department in formulating this information. The review of the 17 individual records in this sample indicated that this information was included in the aforementioned sections of the record and was consistent with the information contained in the psychiatric section for all of the 17 (100%) individuals. The differentiation of the maladaptive behaviors with which the individual presented was related directly to the concluding requirements in this provision that addresses: "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors that were (in reality) related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk the individual would be prescribed unnecessary psychotropic medication. In addition, the individual might not receive the behavioral supports appropriate to address the problem. Alternately, the appropriate identification and differentiation of these factors, as was found during the Monitoring Team's most recent review, decreased (if not eliminated) the risk that a psychotropic medication would be inappropriately utilized to suppress learned behavior. In a corollary manner, it also assisted in ensuring the least intrusive and most positive interventions were used to address the individual's challenging behaviors. AUSSLC had made significant progress in the aforementioned problems in the individual records.	

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	medication to the degree possible.	However, the Facility was found to be in noncompliance with this subsection of the Settlement Agreement, due to the insufficient discussion in the individuals' ISPs of the teams' deliberations with regard to whether the use of psychotropic medications represented the least intrusive approach to address the individuals' target behaviors. As discussed with regard to Section J.8, the ISP documentation also will need to contain more detailed descriptions of the rationale for the use of psychotropic medications and the considerations that went into those decisions. This information should specifically include a discussion of whether psychotropic medication represented the least intrusive and most positive intervention, and should also identify the role of behavioral and/or programmatic interventions being utilized. As indicated with regard to Section J.8, although the Psychiatrists were now regularly attending the ISP meetings, their specific contributions to the meetings were not identified in the ISP documentation. Thus, the Facility should focus on including these aspects of the individuals' psychiatric treatment considerations into the ISP discussions, as well as the documentation of the deliberation on which such decisions were based. The finding for this provision of the Settlement Agreement is noncompliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The Monitoring Team member's initial reviews of these sections of the records indicated that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors identified as the targets of the psychotropic medication. Previously, the discussion of these factors primarily occurred in the Human Rights Committee section of the record, as well as the PBSP. However, additional detailed discussions of this subject had been added to the psychiatric quarterly documentation, and the CPEs. The Psychiatry Department had previously made extensive revisions to the form utilized to document the Quarterly Review of individuals' clinical status. This initiative was discussed in the Monitoring Team's prior reports. The revised format contained a section related to an empirical, individualized, risk-versus-benefit analysis. This analysis took into account both the potential and realized side effects of the prescribed medication, the morbidity associated with the symptoms of the psychiatric disorder that was being treated with these medications, and the degree to which the prescribed medications had been effective in diminishing the symptoms and maladaptive behaviors related to the underlying psychiatric disorder. The composition of the Quarterly Review documents, as well as the Facility's status with regard to the completion of this documentation for all individuals prescribed psychotropic medication is discussed with regard to Section J.13. Working in conjunction with the BHS Department and the members of the IDT in attendance at the Psychiatric Clinics, the Psychiatrist formulated this information, which discussed both the realized and potential side effects of the medication, and then weighed them against the realized and potential benefits of the medication. These reviews were completed for each individual medication the individual was prescribed. For most individuals, the actual, realized benefits could be documented, but for newly prescribed medications, a rationale was provided regarding what	Noncompliance

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	alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	benefits would be expected. The current review found an adequate discussion of the risk-versus-benefit analysis in all of the 17 (100%) individual records contained in the review sample. The documentation included a discussion of both the potential and realized side effects of the medication, as well as the benefits. In those situations where the individual was already receiving the medication, the actual benefits were described, and if the medication had not been started and/or the effects had not yet been realized, the expected benefits were discussed, as well as the expected timelines for realizing those benefits. (There is further discussion of this process below with regard to Sections J.13 and J.14.) Prior observations of the Human Rights reviews indicated that they were very detailed, and there were instances in which the HRC rejected behavioral plans because of insufficient information. The review of the minutes of the HRC Meetings indicated that this thorough review process had been continued. The Monitoring Team's current review of the ISP documentation for the sample of 15 percent of individuals prescribed psychotropic medication (which is reviewed in Sections J.8 and J.9) did not consistently document a discussion of these important issues that was commensurate with the detailed information that routinely appeared in other portions of the individuals' records. In addition, the discussion of the potential risk-versus-benefits of other alternate forms of treatment considered by the IDT, as referred to in the text of this provision of the Settlement Agreement, was not adequately covered in the majority of the ISP documentation for the individuals reviewed. Accordingly, the Facility was found to be in noncompliance with this provision, although it should be noted that this was primarily due to the deficiencies in the ISP documentation, because the information contained in the sections of the individual record identified above were comprehensive. As noted above, the Facility was found to be in noncompliance with this provision. The Settlement Agreement specifies that the Interdisciplinary Team should weigh the risk-versus-benefit considerations and determine "whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." At the time of the Monitoring Team's review, the documentation was not adequate to show that teams were engaging in this discussion and documenting the results.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and	AUSSLC had continued its policy of reviewing every individual whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The Monitoring Team reviewed the "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" for the prior six months. The Psychiatry Section Chief, the Staff Psychiatrists, Director of Pharmacy Services and/or the Clinical Pharm. D., Psychiatric Specialty Nurse, and the Psychiatry Assistants attended these meetings. The Meeting Notes indicated that the group engaged in a detailed case-by-case discussion of each individual whose psychotropic medications met the criteria for polypharmacy. On 2/25/14, a member of the Monitoring Team met with the Section Chief and a Psychiatry Assistant to review the data for January 2014 that would be presented	Substantial Compliance

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	implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	at the February 2014 meeting. Direct observation of prior meetings indicated that the meeting format included the prescribing Psychiatrist providing a brief review of the status of each individual whose profile met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for each individual. Documentation for the 2/27/14 meeting provided a summary of the Facility's progress, as of 1/31/14, towards minimizing polypharmacy. The total number of individuals meeting the criteria for polypharmacy was 18. This included those receiving two or more medications from the same class and/or three or more medications regardless of class. Historical data from several years ago was not available for comparison. However, monthly comparative data was available going back to July 2010. Tabular representation of that data is as follows:	

DEFINITIONS OF POLYPHARMACY	July 2010	October 2011	October 2012	October 2013	January 2014
# individuals prescribed 2+ medications from the same class	13	8	8	5	5
# individuals prescribed 3+ medications regardless of class/indication	49	31	20	15	17
# individuals prescribed both I & II (above)	12	7	7	4	4
Total # individuals on polypharmacy	50	32	21	16	18
Total # individuals prescribed psychotropic medication	184	160	135	119	116
Percentage individuals prescribed psychotropic medication who met the criteria for polypharmacy	27%	20%	16%	13.4%	15.5%

This provision of the Settlement Agreement also states it is necessary "to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this provision also relates to the documentation that all prescribed medications can be empirically demonstrated to be effective.

Previous Monitoring Team reports indicated that the Facility's progress in reducing polypharmacy could be better tracked by dividing the data on the individuals prescribed polypharmacy into the following four categories: 1) those individuals admitted from the community on polypharmacy within the last year, with

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		notation of the progress made since their admission in reducing the number of medications they receive; 2) delineation of those individuals who the Psychiatry Department believed were receiving psychotropic medication regimens that met the criteria for polypharmacy, but the continuation of these medications was necessary for their continued stability; 3) the individuals continuing to receive polypharmacy, but for whom there is a plan in place to challenge those medications that might not be necessary; and 4) those individuals (if any) that did not fit into one of the prior three categories. The rationale for this suggestion was that the compilation of data in the categorical format described above would provide a more accurate representation of the Facility's progress in reducing polypharmacy. The data prepared for the 2/27/14 Polypharmacy Committee Meeting continued to follow this format. As the Facility had not had any new admissions since the Monitoring Team's last review, the two categories utilized were those of "Active" and "Justified." The Active notation was utilized to categorize those individuals whose active tapering processes were in progress, or the individual was not clinically stable, and the medications were still being adjusted. The "Justified" category was utilized for those individuals for whom the Facility had been able to assemble historical data to document the utility of the medication. This evidence was presented in a separate column on the Polypharmacy Committee data sheets entitled, "Evidence of Efficacy." The information contained in this section of the summary tables was detailed and reported the improvement in the symptoms/behaviors as a percentage. This information was also included for those individuals who were in the "Active" category. For many of those individuals, some of their prescribed medications had been justified, and they had been placed in this category only because of a continuing taper of a remaining medication whose efficacy had not yet been proven. Thus, within the "Active" category there was a distinct subcategory of individuals on tapering schedules that would result in a medication being removed in the next several months. If this were not possible due to a behavioral deterioration, the process would have generated the data necessary to justify its efficacy. The Settlement Agreement is clear that polypharmacy regimens that can be justified are acceptable, and the review of the information presented by the Facility indicated that it was sufficiently detailed to substantiate the clinical justification of the medications. The Facility currently reported 18 individuals whose regimens met the criteria for polypharmacy, and seven of these were clinically justified. Eleven individuals were still receiving polypharmacy regimens that had not been justified (9.4 percent of the 116 individuals who were prescribed psychotropic medication) as of 1/31/14. The Facility's polypharmacy statistics previously did not provide any indication of the number of individuals completely removed from psychotropic medication. The complete discontinuation of an individual's psychotropic medication can actually increase the Facility's polypharmacy rate, because this rate is calculated as a percentage of the total number of individuals receiving psychotropic medication. Thus, when the total number of individuals receiving psychotropic medication is decreased by the removal of an individual receiving one psychotropic medication, the percentage of individuals prescribed polypharmacy will increase slightly due to a reduction of the total number. As the Polypharmacy Minutes did not include data on this subject, a request was made at the time of the Monitoring Team's November 2012 review for information related to the number of individuals who had been completely removed	

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		from psychotropic medication. The response indicated that, as of October 2012, 36 individuals had "been discharged from Psychiatry Clinic as a result of discontinuation of psychotropic medications." The Facility began tracking these numbers on an ongoing basis, and this data indicated that from January 2012 to January 2014, 15 individuals had all psychotropic medication tapered and discontinued. This number did not include individuals discharged into the community. In addition, data from January 2012 to January 2014 indicated that an additional 15 individuals were transitioned from polypharmacy status to regimens that did not meet the criteria for polypharmacy. As noted above, the Psychiatry Department had made substantial progress over a number of years in reducing the use of polypharmacy with psychotropic medications at AUSSLC. The Facility was found to be in substantial compliance with this provision, because they continued to actively assess individuals' need for continued polypharmacy on a monthly basis, as well as in the Psychiatric Clinics. In addition, the rate of polypharmacy that could not yet be justified with the empirical data had been reduced to nine percent of the total number of individuals prescribed psychotropic medication at AUSSLC. As noted above, many of these individuals were on tapering schedules that would either lead to the eventual discontinuation of the medication or would provide the clinical justification for continuing the medication.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the DISCUS, and the monitoring of more general systemic effects related to psychotropic medication with the MOSES every six months (per the Healthcare Guidelines). An important component of this provision was the latency between the time the nurse completed the exam, and the prescribing physician reviewed the documentation. The review of the sample of the records of 17 individuals prescribed psychotropic medication indicated that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for 16 of the 17 (94%) individuals. The individual for whom the testing had not been completed in a timely manner was Individual #394, for whom the most recent MOSES was dated 5/6/13. The records of the 17 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all (100%) of these individuals. The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 17 individuals indicated the following three individuals were not prescribed an antipsychotic medication: Individual #90, Individual #353, and Individual #141. The review of the records of the remaining 14 individuals indicated that the DISCUS had been completed within the prior three months and at three-month intervals prior to that for all but the following six individuals (most recent DISCUS evaluations): Individual #294 (9/26/13), Individual #304 (9/13/13),	Noncompliance

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		Individual #204 (9/13/13), Individual #6 (7/29/13), Individual #358 (9/26/13), and Individual #292 (9/26/13), for whom there was also a gap of three months between the 4/30/13 and 9/26/13 evaluations. Thus, the DISCUS had been completed as specified for eight of the 14 (57%) individuals and had been reviewed in a timely manner by the prescriber for all of the 14 (100%) individuals. The numbers and specific information for the individuals whose records comprised this sample have been provided to enable to Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for the Monitoring Team's review. The MOSES and DISCUS also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of three individuals (100 percent of those who fit the above criteria) was selected: Individual #200, Individual #169, and Individual #270. The review of records for these individuals in relation to the MOSES indicated that the examination had been performed as required for none of the three (0%) individuals. The most recent MOSES Evaluation for Individual #270 had been completed on 5/23/13. The most recent evaluation for Individual #200 had been completed on 4/30/13, and the prior one had been completed on 8/7/12. The only MOSES in the record for Individual #169 was dated 4/23/13. The prescriber had reviewed all of these records in a timely manner. The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified for only two of the three (67%) individuals: Individual #270 and Individual #200. More specifically, the DISCUS for Individual #169 had been completed on 1/3/14, but the prior one had been done on 4/22/13, so there was a gap of greater than three months. The prescriber had signed all of these in a timely manner. The discrepancy was significant between the results of the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those prescribed Reglan and no traditional psychotropic medication. The monitoring of individuals prescribed Reglan, but not also a psychotropic agent clearly needs to be improved, because this medication can cause significant side effects. These may include acute extrapyramidal motor side effects, which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. As indicated in the Monitoring Team's reports for the reviews conducted in November 2011 and November 2012, the responsibility for performing the DISCUS had transitioned from the Psychiatric	

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		Nurses to the RN Case Managers assigned to individuals' residences. Accordingly, during the Monitoring Team's current onsite review, a request was made for evidence supporting training of the nurses responsible for performance of the DISCUS. The materials submitted in response to this included the list of the nurses that had completed this training on one of the following dates: 2/27/13 and/or 5/16/13. The Facility was found to be in noncompliance with this provision. This finding is related to the deficiencies in the completion of the DISCUS side effect monitoring tool for individuals prescribed antipsychotic agents, and the completion of both the DISCUS and MOSES for those prescribed Reglan.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that	This provision of the Settlement Agreement addresses processes essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." Based on a review of the records of a sample of 17 individuals (15 percent of those prescribed psychotropic medication), a description of the specific symptoms supporting the psychiatric diagnosis(es) of record could be identified for all 17 (100%) individuals. This provision also addresses the Facility's ability to measure and monitor "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy." The Quarterly review forms carried forward several months of behavioral data presented in tabular and graph form. The behavioral data monitored was specific to the individual and included the overt behavioral manifestations of the psychiatric disorder and, where relevant, the specific symptoms of that disorder. The mechanism by which the overt behavior was derived from the psychiatric disorder was reviewed in the section of the Quarterly Review documentation, entitled: "Target Behavior/Monitored Symptoms." The Facility had standardized this process so that the material was present in 100 percent of the individual records reviewed. The behavioral data was actually collected by direct support professionals and maintained by members of the BHS Department. It first appeared in the monthly summaries, and then was transferred to the Quarterly Review documents. However, the discussions regarding which behaviors were derived from the psychiatric disorder occurred in the context of the Psychiatric Clinics, as well as informal discussions between the BHS Department and Psychiatry staff. The section of the Quarterly Psychiatric Review labeled: "Current Psychiatric Medications," included a discussion of the timelines when positive effects of newly prescribed medication could reasonably be expected to occur and would also indicate if that time had passed due to the length of administration. It was in this section that the addition of a new medication or the change in the dosage of an existing medication would be documented and then elaborated on in the narrative section of the document. It also should be noted that the addition of a new medication or a change in the dosage of an existing medication would automatically trigger a follow-up review in one month during which the effects of that change would be monitored and discussed. These reviews were performed in addition to the Quarterly Reviews and did not replace a Quarterly Review. Thus, an individual whose medication was actively	Substantial Compliance

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	will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	being titrated would be followed on a monthly basis in between the scheduled Quarterly Reviews. This information also was routinely incorporated into the Quarterly Review document format so that it was uniformly present in 100 percent of the records reviewed. AUSSLC Progress Notes, from the Psychiatry Department and BHS Department, routinely carried forward more than two years of objective behavioral data. This was extremely valuable and clinically useful historical information. Prior Monitoring Team reports indicated that the utility of this information could be greatly enhanced by the inclusion of a longer longitudinal summary of the contemporaneous behavioral data that would support the subjective rationale for any medication changes that had occurred. The length of longitudinal data required would vary according to the individual, but could extend back for several years. The Psychiatry Department had summarized this data for the individuals in their "Justified" polypharmacy group to demonstrate the necessity of the medications prescribed for these individuals. They also maintained an ongoing list of medication changes and the rationale for those changes in the Quarterly Review documentation. The final section of this provision relates to the frequency and adequacy with which the Psychiatrist reviewed individuals receiving psychotropic medication. The review of a sample of the records indicated that Quarterly Reviews were performed as specified in this provision for all of the 17 (100%) individuals reviewed. The format for the Quarterly meetings in general followed the format of the corresponding form that documented the meeting and the relevant data. In addition to the behavioral and pharmacological data discussed above, this material included basic information, such as the individual's weight and vital signs. The laboratory data included the most significant metabolic and hematological lab values, as well as the results of the most recent electrocardiogram (EKG). If the individual was prescribed a medication that required periodic monitoring of blood levels, such as a mood stabilizer, these would also be reported. The results of the most recent MOSES/DISCUS evaluations were reported, as well as any significant medical changes or events, including the individual's seizure status, if applicable, and whether they had recently seen the Neurologist. All of this information was available in the Quarterly Review documentation for the team members to review, and would be discussed according to its relevance to the individual's current status. The BHS Department staff reviewed the behavioral data with the team members present. Nursing would review the relevant medical and laboratory data. The Psychiatrist chaired the meeting and would provide his/her insights on the current issues and guide the discussion as to whether any medication or programmatic changes might be beneficial. During the onsite review, a member of the Monitoring Team observed the Psychiatric Quarterly Review Meetings for all three of the full-time Psychiatrists. The Psychiatrist usually saw individuals on the morning of the Clinic or (depending on the schedule) the afternoon before. The results of the Psychiatrist's observations were documented in the Mental Status section of the Quarterly Review form. The duration of the individual reviews ranged from 30 to 45 minutes, with ample time for team discussion.	

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		The Psychiatry Department had made significant progress with the requirements specified in this section of the Settlement Agreement, as described above. The Quarterly Review documentation was comprehensive and had been consistently completed, and the reviews took place as specified for all of the individuals in the sample of 15 percent of the individuals prescribed psychotropic medication. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 17 individuals receiving psychotropic medication indicated that 13 individuals had a Guardian of the Person. Those individuals who did not have a guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for all of the 17 (100%) individuals in the sample. As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit analysis contained in the Psychiatry section of the record demonstrated considerable improvement from previous reviews in the description and quantification of both the benefits and side effects of the prescribed psychotropic medication. These discussions had been modified to contain a description of the probability the beneficial effects of the medication would actually be realized, or had been realized for those individuals already receiving the medication for a lengthy period of time. The risk section of these discussions had been modified to include a comprehensive listing of the side effects. This included information on the relative risk of the more common side effects. Approximately two years ago, the Psychiatry Department had assumed the responsibility for the consent process from the BHS Department. Previously, the BHS Department would coordinate the process of obtaining both the verbal and written consents for the medication. However, the prescribing Psychiatrist frequently would attempt to obtain verbal consent by calling the guardian after the recommendation to utilize the medication was finalized in the corresponding Psychiatric Clinic meeting. Currently, the consent process began in the context of the Psychiatric Clinic or Psychiatric Consultation, during which the decision to utilize psychotropic medication was formulated. Specifically, the Psychiatrist made an attempt to directly speak with the guardian by telephone. The "Consent Tracking" spreadsheet contained three columns regarding attempts to reach the guardian. Medication was not administered without guardian consent, unless there was a psychiatric emergency. The titles of the 14 columns contained in the Consent Tracking spreadsheet were as follows: Doctor – Home – Name - ISP Date – LAR - Consent Attempt #1 - Consent Attempt #2 - Consent Attempt #3 - Routing Slip Submission Date (if necessary) - Date of Signed Consent - Consent Expiration Date yearly OR when medication is changed/added - HRC Submission Date - HRC Approval Date - and Expiration Date.	Substantial Compliance

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		The review of this spreadsheet indicated that it had been continuously maintained and was up-to-date. The information sent to the guardians was found to fulfill the criteria for informed consent. It was adequate without being overwhelming. As indicated above, the Psychiatry Department had developed a sophisticated risk-versus-benefit system and the review of 17 individuals' records indicated that this analysis was consistently applied to each medication. The documentation for this analysis appeared in the Quarterly Review documentation. AUSSLC was found to be in substantial compliance with this provision, because the risk-benefit-analysis and the related informed consent process were comprehensive and signed consents were found in 100 percent of the individual records reviewed.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	In order to address this provision of the Settlement Agreement, several months ago, the Psychiatrists had begun to attend the Neurology Clinics so that they could be present to discuss the individuals' care with the Neurologist. The Section Chief for Psychiatry indicated that this interaction was documented via a note in the individuals' record. In addition, a signature sheet had been added to the Neurology Consultation reports, which included a signature line for the Attending Psychiatrist to indicate that they had been present. The methodology used to assess the degree to which the requirements set forth in this provision were being adhered to involved locating a recent (within the last year) Neurology Consultation Note in the Consultation section of the individuals' record. The next step was to ascertain if the Psychiatrist had signed the document, and/or if the Psychiatrist had made a corresponding note in the Psychiatry section of the record that made reference to the Neurology Consultation. The Psychiatry Team indicated that the note, which was contained in the Psychiatry section, was also duplicated in the Integrated Progress Notes. The rationale for the dual filing of the note in these two separate locations was to ensure that those clinicians who needed to be aware of this documentation could readily locate it. In addition, if it was difficult to locate in the Integrated Progress Notes, it could be found easily in the Psychiatry section of the individual's record. Neurology Consultation Notes were located in the Consultation section of the record for the following five individuals: Individual #425, Individual #2, Individual #409, Individual #397, and Individual #353. In order to determine if adequate consultation had occurred between the Consulting Neurologist and the Attending Psychiatrist, the Neurology notes were assessed for reference to the individuals' psychotropic medication, as well as other aspects of the individuals' psychiatric status. The existence of a corresponding reference to the Neurology Consultation in the Psychiatry section of the record also was assessed. The information that provided the most complete description of the interaction between the Neurologist and the Psychiatrist appeared in the Progress Note that the Psychiatrist prepared soon after the Neurology Consultation, and which appeared in the Integrated Progress Notes. As noted above, this	Substantial Compliance

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Note also was reproduced as a document in the Psychiatry Section of the individual's record to make it easier to locate. This note, which usually consisted of a full paragraph, described the clinical issues discussed with the Neurologist in the context of the consultation and the conclusions of that discussion with regard to any necessary changes to the individual's medication.

The documentation the Psychiatrist had attended the Neurology Clinic and summarized this with a descriptive note in the individual's record was verified for all five (100%) individuals in the sample who had received a Neurological Consultation in the prior year. This finding that the Psychiatrists had attended the Neurology Consultation and had produced corresponding documentation also had been noted in the Monitoring Team's prior report.

The language of this provision specifically addresses individuals who are prescribed anticonvulsant medications for both seizure control and for psychiatric purposes. At the time of the current review, there were eight individuals who met these criteria. All of these individuals had been seen in consultation with Neurology within the last year with the exception of individual #208. The information related to the coordination of their care by Psychiatry and Neurology is summarized in the following chart:

Austin State Supported Living Center
Department of Psychiatry
List of Individuals on Anticonvulsants with Seizure and Psychiatric Indication

Individual #	Home	Anticonvulsant That Has Dual Indication	Indications	Date Last Seen in Neurology Clinic	Psychiatry/ Neurology Collabora-tion	Location of Evidence
Individual #273	729	Lamotrigine 250 MG BID	Seizure Disorder, Intermittent Explosive Disorder	11/1/13	Yes	Psychiatric Progress Note
Individual #208	783	Carbamazepine 400 MG TID	Bipolar II Disorder with Mixed Features; Seizure Disorder	9/27/10	Yes	States Neurologist spoke with Psychiatrist
Individual #359	784	Carbamazepine 400 MG TID	Bipolar/seizures	2/21/14	Yes	Psychiatric Progress Note
Individual #179	788	Oxcarbazepine 900 MG BID	Autistic Disorder, Seizure Disorder	2/21/14	Yes	Consultation report signed by Psychiatrist

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		Individual #409	788	Carbamazepine 300 MG BID	Autistic Disorder Seizures Disorder	1/14/13	Yes	Psychiatric Progress Note	
		Individual #403	789	Carbamazepine SUSP 200 MG TID	Agitation 2ND TO Autistic Disorder, Seizure Disorder	11/1/13	Yes	Psychiatric Progress Note	
		Individual #382	791	Divalproex sprinkles 1,000 MG AM & 1,250 MG PM	Mood Disorder/Seizure Disorder	5/1/13	Yes	Consultation report signed by Psychiatrist	
		Individual #246	794	Clonazepam wafers 1 MG BID	Seizure Disorder & Mood Disorder	11/1/13	Yes	Psychiatric Progress Note	
		The Facility was found to be in substantial compliance with this provision of the Settlement Agreement. This was due to the findings that the Psychiatrists continued to regularly attend the Neurology Clinic appointments for individuals for whom they were clinically responsible. They also maintained related documentation. This documentation showed they had engaged in adequate processes to coordinate the use of those medications utilized for both neurological and psychiatric purposes.							

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation of Section K at Entrance Meeting, 2/24/14; o Section K Presentation Book; o Section K Self-Assessment, updated 2/4/14; o Completed Section K Monitoring Tools: Individual #180, Individual #96, and Individual #158; o DADS Behavioral Health Service Department Policy, effective 12/19/13; o Minutes of the Behavior Therapy Committee (BTC), from 8/19/13 to 12/30/13; o External Peer Review Committee meeting minutes, dated 9/13/13, 10/11/13, 12/13/13, 1/17/14, and 2/24/14; o Austin Case Specific Internal Peer Review draft proposal, dated 2/11/14; o Case Presentation Guide for BTC and Internal Peer Review, revised 2/13/14; o Psychology Monthly Progress Notes (10/13 to 12/13) for: Individual #246, Individual #153, and Individual #421; o Psychology Monthly Progress Notes (11/13 to 1/14) for: Individual #78, Individual #448, Individual #159, and Individual #13; o Psychology Monthly Progress Notes (9/13 and 11/13) for Individual #409; o Psychology Monthly Progress Notes (11/13 to 12/13) for Individual #425; o Psychology Monthly Progress Notes (12/13 to 1/14) for: Individual #263 and Individual #406; o PBSP Data Sheets (10/13 to 12/13) for: Individual #246, Individual #153, Individual #421, Individual #302, and Individual #409; o PBSP Data Sheets (12/13 to 2/14) for: Individual #263, Individual #406, Individual #78, Individual #448, Individual #159, Individual #13, and Individual #425; o PBSP Data Sheets 2/24/14 to 2/28/14 for: Individual #445, Individual #429, Individual #215, Individual #302, Individual #159, Individual #105, and Individual #280; o Individual Notebook (I-Book) for: Individual #160, Individual #325, Individual #153, Individual #159, Individual #220, Individual #13, Individual #33, Individual #288, Individual #344, and Individual #56; o Behavioral Health Assessment for: Individual #263, Individual #406, Individual #78, Individual #421, Individual #448, Individual #302, Individual #409, and Individual #13; o Psychological Evaluation for: Individual #246, Individual #153, Individual #159, and Individual #425; o Counseling Treatment Plan for: Individual #291, Individual #158, and Individual #7; o Counseling Treatment Plan Progress Note (10/13 to 12/13) for: Individual #291, Individual #158, and Individual #7; o Treatment Plan for Art Therapy and accompanying Patient Progress Notes for Art Therapy (11/1/13 to 1/ 17/14) for Individual #180;

	○ Alphabetical list of individuals with a Positive Behavior Support Plan; ○ Positive Behavior Support Plan for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; ○ Bathing Compliance Data Sheet, 10/13 to 12/13 for Individual #302; ○ Lists of dates of consent for current PBSPs and safety plans; ○ Behavioral Health Services Department Meeting minutes, from 7/9/13 to 12/17/13; ○ Human Rights Committee Meeting minutes, from 7/25/13 to 1/2/14; ○ Positive Behavior Support Plan Treatment Integrity Forms for: Individual #263 (9/13 to 10/13, and 1/14), Individual #406 (10/13 to 2/14), Individual #78 (8/13 to 1/14), Individual #246 (11/13 to 12/13), Individual #153 (12/13 to 1/14), Individual #421 (10/13, and 12/13), Individual #448 (9/13 to 10/13, 12/13 to 2/14), Individual #409 (9/13 to 10/13, and 12/13), Individual #159 (12/13 to 2/14), and Individual #13 (8/13 to 9/13, and 11/13 to 1/14); and ○ Revised staffing schedules. ▪ **Interviews with**: ○ Tristan James, QIDP Director; Jamaun Willis, Director of Education and Training; and Jim Sibley, DADS Consultant, on 2/24/14; ○ Dr. Stacey Thompson, Director of Behavioral Health Services; Dr. Kimberly Testa, Assistant Director of Behavioral Health Services; Dr. George Zukotynski, DADS Coordinator of Behavioral Health Services; and Erin Mitchell, Behavioral Health Services Administrative Assistant, on 2/25/14; ○ Direct Support Professionals, on 2/26/14; ○ Anthony Miller, Behavioral Health Services Assistant, on 2/27/14; and ○ Jamaun Willis, Director of Education and Training; Jim Sibley, DADS Consultant; Heather Blackwell; and Debra Woodruff, Program Compliance Coordinator, on 2/27/14. ▪ **Observations of**: ○ Residence 729, Residence 732 Dove, Residence 732 Phoenix, Residence 779 Falcon, Residence 779 Hummingbird, Residence 779 Roadrunner, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; ○ Computer Center; ○ Day Program 501, Day Program 731, and Day Program 732; ○ Day Program/Vocational Center 533, Day Program/Vocational Center 730, Day Program/Vocational Center 775, and Day Program/Vocational Center 779; ○ Work Center 527, Work Center 532, and Work Center 544; ○ IMRT meeting, on 2/24/14; ○ Behavior Therapy Committee meeting, on 2/24/14; ○ Behavioral Health Services Department meeting, on 2/24/14; ○ Pre-treatment Sedation Committee meeting, on 2/25/14; ○ Restraint Reduction Committee meeting, on 2/26/14; ○ Human Rights Committee meeting, on 2/27/14; and

	o ISP Meeting for Individual #40.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, updated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: a) activities engaged in to conduct the self-assessment; b) the results of the self-assessment; and c) a self-rating. For Section K, in conducting its self-assessment: ▪ The Facility used monitoring tools. Based on a review of the Facility Self-Assessment, the monitoring templates and guidelines, a sample of completed monitoring tools, as well as interviews with staff: o The monitoring tools the Facility used to conduct its self-assessment included the Section K Monitoring Tool. o This monitoring tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as review of documents. o The Self-Assessment identified the sample(s) sizes, including 14 individuals who had a Positive Behavior Support Plan. This sample was followed to evaluate compliance within the following subsections: K.4, K.5, K.6, K.7, K.9, K.10, and K.11. o A Behavioral Health Services Specialist, whose job responsibilities included clinical services and compliance monitoring, completed the monitoring tool samples provided to the Monitoring Team. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources. o Staff rosters were reviewed and analyzed with regard to demonstrable competence in Applied Behavior Analysis. o Minutes from internal and external peer review meetings were reviewed. o Staff training curricula and in-service databases were reviewed. ▪ The Facility consistently presented data in a meaningful way. ▪ The Facility rated itself as being out of compliance with 11 subsections of Section K. This was consistent with the Monitoring Team's findings, with the exception of K.2, for which the Monitoring Team found the Facility was in substantial compliance. The Facility identified substantial compliance with subsection K.3 and sub-section K.11. The Monitoring Team agreed with the Facility's rating for subsection K.11. Reasons for a noncompliance rating for subsection K.3 are provided in the body of the report.
	Summary of Monitor's Assessment: Several positive changes were observed within the Behavioral Health Services Department. Although no BCBAs were currently on staff, the majority of the Behavioral Health Specialists were pursuing certification. The Department had initiated a contract with a local BCBA to ensure that supervision requirements could be met. Staff attendance at the Behavior Therapy Committee was quite good, which was a promising practice

	because this internal peer review offered an excellent opportunity for increased training and development of skills. The primary focus of the meeting a member of the Monitoring Team observed was protective mechanical restraint for self-injurious behavior (PMR-SIB). The discussion regarding its use, fading strategies, risks, and continued oversight reflected a very caring and thoughtful approach to treatment. This committee was well established to provide internal peer review. Documentation showed that external peer review had occurred in five of the six previous months through phone conferencing with staff from three other State Supported Living Centers, but follow-up to recommendations made was not consistently documented. Plans had been developed to introduce a third tier of peer review to address particularly challenging cases, which would be a positive addition. Staff also had focused their attention on addressing many of the problems observed with data collection. Suggestions for improving data accuracy and reliability were being considered. Weekly review of data within the Behavioral Health Services Department had been initiated with plans to begin monthly review with supervisory staff from the homes. One suggestion would be to include key direct support professionals in this meeting. Other promising practices included regular scheduling of professional staff in the homes and day programs, clear expectations for timely completion of all paperwork, and staff training that included role-play and on-the-job performance checks and feedback. Although there were many positive changes presented and discussed, the Facility will need to ensure consistent implementation of plans for improvement. A number of the issues that existed during previous reviews continued to exist, and focus on these efforts to improve them was positive and necessary.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. At the time of the visit, no Behavioral Health Services Department members were credentialed as Board Certified Behavior Analysts. Documentation the Department provided revealed that two Behavioral Health Specialists had completed all coursework, one had taken two courses, five were currently enrolled, and six were not enrolled. The Department Director had plans to begin coursework this summer and the Assistant Director was currently enrolled in the fourth course in the series. It was noteworthy that two of the three Lead Behavioral Health Specialists had not yet begun coursework leading to certification. The third had completed coursework and supervision requirements, yet it was reported that she had tendered her resignation and would be leaving the Facility shortly after the Monitoring Team's visit. Also concerning	Noncompliance

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	reasonable safety, security, and freedom from undue use of restraint.	was the status of the Department Educator. Although he had completed two courses, his current enrollment in coursework was not clearly specified. The Department should identify lead staff, including Department Educators, who are actively involved in obtaining certification in Applied Behavior Analysis. As Assistant Behavioral Health Specialists are very involved in staff training, the Department also should provide support to these staff members who are interested in pursuing certification as assistant behavior analysts. For the reasons noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The Facility recently had hired a new Director of Behavioral Health Services. Dr. Stacey Thompson held a Psy.D. in School Psychology and had over five years experience in the field of human services. She was provisionally licensed to practice psychology in the State of Texas. She was currently completing a post-doctoral internship to obtain full licensure. Dr. Thompson was not a Board Certified Behavior Analyst, although she planned to pursue certification. As Dr. Thompson held an advanced degree in psychology and had over five years of experience, she met the requirements of Settlement Agreement. The Facility was found to be in substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The Facility continued to engage in internal and external peer review processes. Weekly meetings of the Behavior Therapy Committee continued. Templates were used to evaluate the quality of assessments and corresponding treatment plans, including Positive Behavior Support Plans and Crisis Intervention Plans. Written feedback was provided to the responsible Behavioral Health Specialist with expected revisions outlined. The Facility provided evidence that regular meetings of the BTC had occurred between 8/19/13 and 12/30/13. Observation of the BTC meeting held during the week of the Monitoring Team's onsite visit revealed participation by many members of the Department. The case under review was presented skillfully and thoughtfully, and was followed by a robust discussion. This committee continued to function well in providing internal peer review for annual assessments and plans. The Monitoring Team had requested meeting minutes from the External Peer Review Committee (EPRC) over the six-month period prior to the visit. The Facility provided minutes for five meetings held between 9/13 and 2/14. The following summarizes the findings: ▪ Participants were identified in only two of the five meetings (40%). The minutes for the meeting held on 10/11/13 included a draft cover sheet that listed staff from the four SSLCs that comprise the committee. A copy of an email was enclosed with the minutes from the meeting held on 12/13/13. This indicated that staff from all four facilities participated.	Noncompliance

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		▪ Documentation provided indicated that at least one individual from AUSSLC was reviewed at each of the meetings of the EPRC. ▪ Although the parties had agreed that EPRC meetings were to be held each month, there was no documentation provided for 11/13. It was unclear whether or not a meeting had been held. However, external peer review meetings were to occur at least monthly, but had only occurred in five out of six months (83%). ▪ For three of the five meetings reviewed (60%), there was documentation regarding the discussion and feedback provided by EPRC members. Perhaps the most thorough review was documented in the meetings held on 2/24/14 regarding Individual #421, and 1/17/14 regarding Individual #202. ▪ Specific follow-up activities with identified completion dates were included in the minutes from the 10/11/13 only (20%). Staff should note the participants in all EPRC meetings, and document the discussion and recommendations that follow. Identification of follow-up activities, including responsible staff and expected and actual completion dates, is also necessary. Although the Facility had not yet initiated a peer review process that would allow for ongoing review of identified cases, plans were in place to address this need. A draft description of the Austin Case Specific Internal Peer Review was provided at the meeting of the BTC the week of the Monitoring Team's visit. As defined in the draft, the purpose of this review was: "…to focus in on a subset of the approved PBSPs to improve their effectiveness along with enhancing skill level of staff practicing applied behavior analysis." Plans selected for review were expected to be those with low efficacy, cases where there was an observed increase in harm or the use of restraint within a quarter, or others as referred by professional staff. This will offer a positive addition to the peer review process currently in place. Until there is evidence of consistent meeting of the EPRC, documentation of follow-up to the committee's recommendations, and an ongoing process for reviewing difficult cases, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A request was made for three months of psychology progress notes for the 12 individuals in the sample. In response, the Facility provided the following: a note indicating that progress notes had not been completed for Individual #302 since 9/13; monthly progress notes dated from 10/13 through 12/13 for three individuals; monthly progress notes dated from 11/13 through 1/14 for four individuals; and two months of progress notes for four individuals. This resulted in a review of 29 monthly progress notes for 11	Noncompliance

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	pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	individuals in the sample. A summary of findings is provided below: ▪ Behaviors targeted for reduction were identified and graphed in all of the progress reports (100%). In the graphs included in the reports for five individuals, a change in data collection was identified. For three of these individuals, it was clearly noted that in November 2012, staff began recording partial interval data within hour blocks of time. In May 2013, data systems were changed to a frequency count. As these different measurement systems provide very different information regarding behavioral occurrence, it is misleading to label these graphs "frequency." ▪ In 26 of the 29 reports (90%), replacement behaviors were identified and graphed. The reports for Individual #159 included an indication as to whether she had remained stable, progressed, or regressed on her use of her replacement behavior, but no data were presented. ▪ For both targeted problem behavior and replacement behavior, graphs depicted monthly frequency. ▪ Twenty-one of the 29 reports (72%) included information regarding monitoring of PBSP implementation. This was reported in the text, in a graphic display, or both. The method used to determine treatment integrity was not clearly identified, although observation of staff working with the individual was implied. In the 1/14 progress note for Individual #159, there was evidence that staff had also checked on data completion. ▪ Each progress note (100%) ended with a section regarding recommendations. Individual specific concerns are provided below: o Recommendations were identical over a three-month period for Individual #246. While several were appropriately repeated (e.g., continue behavioral and psychiatric services), one should have been completed soon after it was identified. A revision could have been made to the PBSP to combine and redefine targeted behaviors so that direct support professionals could more easily track behaviors. o Similarly, recommendations for Individual #159 were repeated across the three-month period of 11/13 to 1/14. These included reviewing brief changing procedures with staff to determine whether it could be modified, and reviewing July data with the team. While both of these might be very appropriate, it is suggested that they should have been accomplished when first identified. Data sheets for targeted problem behaviors identified in the PBSP for 12 individuals were reviewed. For seven of these individuals, data was provided between 12/13 and 2/14. For five individuals, data was provided between 10/13 and 12/13. A summary of the findings is presented below: ▪ The frequencies of occurrence within one-hour blocks of time throughout a 24-	

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		hour period were collected on all targeted problem behaviors. ▪ For every individual in the sample, there were days with missing data. In spite of the absence of data, daily frequencies of occurrence were tallied. A review of graphs in the monthly progress notes did not reveal any indication that data were missing, and, therefore, rates of targeted problem behavior might have been underreported. ▪ On all data sheets, there were columns for staff to note whether or not the replacement behavior had occurred within each hour block of time. As with the targeted problem behavior, there were days during which data was not recorded on replacement behavior. For six of the individuals in the sample (50%), the data sheets indicated the absence of any occurrence of the replacement behavior(s) in over 50% of the days in the three-month period. This was concerning as the replacement behavior was identified to serve as the functional equivalent of the targeted problem behaviors. ▪ For three individuals, the accuracy of the replacement behavior data was questionable. On 12/4/13, Individual #159 was noted to have displayed her replacement behavior only between the hours of 10:00 p.m. and 6:00 a.m. Similarly, Individual #153 was noted to have engaged with leisure materials between the hours of 10:00 p.m. and 6:00 a.m. on 11/19/13 and 12/1/13. Lastly, Individual #421 was noted to have asked for a break or asked for an activity between the hours of 10:00 p.m. and 6:00 a.m. on 10/9/13. In every case, it would appear that the individual should have been sleeping or encouraged to return to sleep. During the week of the Monitoring Team's visit, there were several occasions when problem behaviors were observed. A request was made for the data sheets from the week of the visit used to track the frequency of targeted problem behaviors. A summary of findings is provided below. ▪ Data were recorded within the hour that problem behaviors were observed for three individuals. These included the following: o On 2/25/14 at 10:40 a.m., Individual #159 was observed displaying aggressive behavior in her day program. She also was observed to display this behavior in her home on 2/26/14 at 4:45 p.m. In both instances, there was a record of her behavior. o Individual #429 was observed displaying aggression in her day program on 2/25/14 at 10:41 a.m. There was a record of aggression on her data sheet. o Individual #445 was observed to be very agitated in her day program on 2/26/14 at 9:30. Her self-injurious behavior was documented on her data sheet. ▪ For other individuals, the behaviors that were observed were not recorded.	

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		These included the following: o Individual #280 was observed trying to bite the hand of a staff member at 10:31 a.m. on 2/25/14. This behavior was not recorded. o Individual #105 kicked the member of the Monitoring Team as she visited his home on 2/26/14 at 8:26 a.m. This behavior was not recorded. o Individual #215 was observed repeatedly hitting himself as he left his day program on 2/26/14 at 10:50 a.m. These responses were not recorded. o Individual #302 was observed sitting on a fire escape on 2/27/14 at 8:10 a.m. The Facility reported that there was no data sheet for this day. No further explanation was provided. ▪ The Facility reported that three individuals did not have a PBSP, and, therefore, there were no data sheets. This was concerning, because the behaviors that were observed were potentially harmful to the individual or others. Individual #308 was observed in her day program biting pieces of a magazine. She then bit a piece of plastic from the toothbrushes used to teach vocational skills. Individual #168 was observed taking off her shirt in her day program site. Individual #36 hit the member of the Monitoring Team as she observed in his home. Each of these behaviors can pose a risk to the individual or others, and, therefore, the need for a PBSP should be assessed and/or a PBSP developed. While touring the Facility, a review was conducted of 10 Individual Books (I-Books). In every case, there was evidence that data was not being recorded in a timely manner. In all but one case, at least two hours had passed since data had been recorded. For Individual #13, one and one half hours had passed since the last recording. It is critical that staff record the presence or absence of targeted problem behaviors within the hour interval when the behavior occurred/did not occur or shortly thereafter. It should be noted that the Department of Behavioral Health Services had recognized the problems with data accuracy and reliability. The Department meeting that was observed the week of the Monitoring Team's onsite visit reflected a lively discussion regarding data and approaches to ensure improvement. A plan was in place for Department staff to provide weekly reports regarding the timeliness of data recording in preparation for monthly meetings with Residential Supervisors. This was a positive step in resolving many of the issues that have been raised in this and previous reports. Comments provided in past reports remain relevant. Although the Behavioral Services Department had initiated steps to assess the accuracy of data collection, it remained apparent that clinical decisions were being made based upon data that was very likely inaccurate and unreliable. Behavioral Services staff should work closely with direct	

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		support professionals to ensure that data collection systems are manageable and completed with integrity. Continued training, oversight, and assessment of inter-observer agreement will be necessary. Based on observation and review of documents, the Facility remained out of compliance with this section of the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As observed during the Monitoring Team's previous reviews, screening for psychopathology, emotional, and behavioral issues was completed either through the psychiatric clinic's completion of a psychiatric assessment or the completion of the Reiss Screen for Maladaptive Behavior to screen for the need for a psychiatric assessment. The Reiss screenings were used to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss Screening process is discussed above with regard to Section J.7 of the Settlement Agreement. The Behavioral Health Assessment (BHA) or Psychological Evaluation (PE) was reviewed for the 12 individuals in the sample. Information regarding a functional behavior assessment was included in each of these documents. The functional behavior assessment is completed to determine the variables that contribute to the occurrence of problem behavior, to determine the hypothetical function of the problem behavior, and to help guide the development of the behavior support plan. A summary of the review findings is provided below: ▪ The reports were labeled Psychological Evaluation for four individuals in the sample. Completion dates were between 10/22/12 and 1/13/14. It is suggested that the report for Individual #425 should be relabeled Behavioral Health Assessment, because this was the term identified in the Department policy updated in 12/13. The remaining eight Behavioral Health Assessment Reports were completed between 10/4/13 and 2/7/14. ▪ For eight of the 12 individuals in the sample (67%), the report was completed prior to the ISP date. Seven of these were completed within three to twenty days before the annual meeting. It is suggested that the report for Individual #159 should have been updated, because it had been completed almost one full year before her most recent ISP meeting. ▪ The reports for four individuals (33%) were completed on the same day or up to 50 days after the ISP meeting. ▪ Eleven of the 12 assessments (92%) identified both indirect and descriptive methods of determining behavioral function. The exception was the evaluation for Individual #246 that reviewed observations completed in late 2012 and early 2013, and an undated functional analysis. There was no indication that an	Noncompliance

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		indirect assessment had been completed. ▪ Specific instruments used for indirect assessment were the Questions About Behavioral Functioning (QABF), the Functional Analysis Screening Tool (FAST), the Motivation Assessment Scale (MAS), and/or the Functional Assessment Interview Form (FAIF). Of the 11 assessments in which these tools were reviewed, only four (36%) included a date of completion that reflected information gathered within one month of the report. As these screening tools and questionnaires can be administered quickly, staff should update them annually. ▪ While all of the reports indicated that direct observations had been completed, only three (25%) provided a clear summary of the events that were observed. The report for Individual #246 referenced outdated observations. A review of videotapes was included in the report for Individual #263. On a positive note, the report for Individual #13 provided a clear report of multiple observations conducted in both her home and work environments. It is suggested that this report serve as a model for future behavioral assessments. ▪ All of the assessments (100%) identified setting events, antecedent stimuli, and consequences to the targeted problem behaviors. Summaries of variables likely maintaining the problem behavior were also provided. Where appropriate, medical and/or psychiatric variables were identified. ▪ All of the assessments (100%) included the identification of replacement behavior. Eight of these (67%) reflected replacement behaviors that were functionally equivalent and were described in observable terms. An example of a well-defined and poorly-defined replacement behavior is provided below: o Individual #13 was to learn appropriate ways to seek attention, escape tasks or activities, and access preferred items. Each of these was operationally defined with clear examples provided. o The identified replacement behavior for Individual #159 was to learn to appropriately escape settings. However, her communicative method was not operationalized. ▪ Graphs depicting the frequency of targeted problem behaviors were included in all of the reports (100%). However, in six reports (50%), a change from a partial interval recording system to an event recording system was noted. As these two measurement systems present very different information about behavior occurrence, a frequency label on the vertical axis was misleading. The author of the report for Individual #448 even noted that an increase in her targeted behavior might have been a result of the change in data collection. Further concerns regarding graphic presentation of data was noted in the report for Individual #263, because it was acknowledged that there were several months with incomplete data. ▪ Individual preferences were reported in each of the reports. However, none of	

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		the reports suggested that formal assessment of preferences had been conducted recently. As individual preferences can change over time, these should be completed frequently and certainly when changes are observed in the individual. Individual specific concerns are noted below: o Identification of individual preferences was noted to be difficult for Individual #263, as she "…has not adhered to contingent reinforcement programs." The meaning of this statement was unclear. o The report for Individual #406 repeatedly noted that he might find the pressure applied during restraint to be reinforcing. In the same report, it was noted that there was no data to support this hypothesis. ▪ Only one of the 12 reports (8%) was signed. Although the Facility had made progress in ensuring standard presentation of annual Behavioral Health Assessments, these were not consistently updated or completed within expected timeframes. Further, the quality of these assessments varied across individuals. Continued emphasis should be placed on observation of the individual in his/her home, work, and leisure environments, with thoughtful suggestions for prevention strategies and functionally equivalent replacement behaviors. Annual assessments will need to be completed for each individual by his/her ISP meeting. For these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. A review was conducted of the most recent BHA or PE the Facility provided for each of the 12 individuals in the sample. The Facility's master list of assessments was also reviewed. It should be noted that only nine of the individuals in the sample were included in the alphabetical list of individuals with a behavioral health or psychological assessment. Of these nine, the date of completion matched the date on the list in only two cases (i.e., Individual #263 and Individual #13). The table below lists the date of the assessment provided to the Monitoring Team, the most recent assessment of cognitive abilities and adaptive behavior, and the most recent Inventory for Client and Agency Planning (ICAP), required every three years. The most recent date is provided whether this was found in the individual's most current assessment/evaluation or on the master list. An asterisk indicates a lack of correspondence between these two documents.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Individual</th><th>BHA/PE</th><th>Cognitive</th><th>Adaptive</th><th>I-CAP</th></tr>
<tr><td>Individual #263</td><td>11/13/13</td><td>7/27/89</td><td>3/30/12*</td><td>10/19/11</td></tr>
<tr><td>Individual #406</td><td>12/19/13</td><td>6/00*</td><td>“N/A”</td><td>1/30/13</td></tr>
<tr><td>Individual #78</td><td>11/7/13</td><td>4/9/90</td><td>10/21/13</td><td>4/18/13</td></tr>
<tr><td>Individual #246</td><td>9/12/13</td><td>3/26/79</td><td>7/19/12</td><td>8/30/13</td></tr>
<tr><td>Individual #153</td><td>9/20/13</td><td>7/6/89</td><td>8/16/11</td><td>6/15/11</td></tr>
<tr><td>Individual #421</td><td>10/17/13</td><td>1/9/12</td><td>11/1/13*</td><td>5/17/10</td></tr>
<tr><td>Individual #448</td><td>10/4/13</td><td>1/27/98</td><td>12/22/11</td><td>4/10/13</td></tr>
<tr><td>Individual #302</td><td>11/4/13</td><td>5/13/93*</td><td>10/18/12*</td><td>10/15/13</td></tr>
<tr><td>Individual #409</td><td>12/16/13</td><td>6/29/05</td><td>7/19/11*</td><td>6/30/10</td></tr>
<tr><td>Individual #159</td><td>10/22/12</td><td>2/23/90</td><td>5/26/11</td><td>5/29/09</td></tr>
<tr><td>Individual #13</td><td>11/19/13</td><td>2/27/89</td><td>1/9/14</td><td>11/21/12</td></tr>
<tr><td>Individual #425</td><td>1/3/14</td><td>5/23/91</td><td>5/23/91*</td><td>1/16/13</td></tr>
</table>

According to these records, 11 of 12 individuals (92%) had a current BHA or PE, one of 12 individuals (8%) had a cognitive assessment completed within the last five years, 11 of 12 individuals (92%) had an adaptive behavior assessment completed within the last five years, and nine of 12 individuals (75%) had an I-CAP completed within the last three years. It should be noted that the master list indicated that Individual #159 had a BHA completed in 10/13, but this was not provided to the Monitoring Team. It was unclear why an assessment of adaptive behavior was noted to be “not applicable” for Individual #406.

For 11 of the 12 individuals in the sample, there was evidence that an assessment of psychopathology had been completed within one to two years of the current BHA or PE. The one exception was Individual #302. Assessments used included the Reiss Screen for Maladaptive Behavior; the Diagnostic Assessment for the Severely Handicapped (Revised); the Assessment for Dual Diagnosis; the Anxiety, Depression and Mood Scale; and/or the Psychopathology Inventory for Mentally Retarded Adults.

Until the Facility can ensure that all required assessments are current and based on complete and accurate clinical and behavioral data, it will remain out of compliance with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual’s admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.

Since the last visit by the Monitoring Team, no individuals had been admitted to AUSSLC.</td><td>Noncompliance</td></tr>
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	psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	A review was conducted of the most recent BHA or PE the Facility provided for each of the 12 individuals in the sample. As noted in Section K.6, improvements had been made in completing annual behavioral health assessments and in updating standardized assessments of adaptive behavior. However, ICAPs were not consistently completed every three years, nor were measures of cognitive abilities current within five years. For these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. According to the information the Facility provided, four individuals were scheduled to participate in weekly counseling sessions with the Facility's therapist. Counseling plans were provided for three of these individuals. The exception was Individual #122. No plan was provided, and it was unclear whether he was receiving services at the time of the visit. A summary of findings for three individuals with plans and accompanying progress notes is provided below: ▪ Counseling treatment plans were dated between 4/9/12 and 9/5/13. The plan for Individual #291 had not been updated for over one year and included objectives that were scheduled for completion by 11/12. The plans for Individual #158 and Individual #7 had been developed within the previous year and contained objectives to be met by a designated date in 2014. ▪ All of the plans included objectives that described observable behaviors with mastery criteria. Staff are cautioned to carefully review mastery criteria, because Individual #7 was to attend 100% or greater of his sessions, which might be unrealistic. Missing in each of the objectives were the conditions under which the behavior was to occur. ▪ Progress was reported across three consecutive months for each of the individuals. Individual-specific concerns were noted and are reviewed below: o Individual #291 had one objective, which was to attend 75% of his counseling sessions each month. Over a three-month period, he attended only three of the scheduled seven counseling sessions (43%). Weekly sessions were not scheduled for two of these three months, response to treatment included identical information in October and November, and there appeared to be no clear plan for addressing his missed appointments. o Individual #158 had three objectives. During the months of October and November, these were "deferred until counseling session transition complete." This individual attended two scheduled sessions in October and the one scheduled session in November. It was reported that he did	Noncompliance

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		not attend any sessions in December, but the number of scheduled sessions was not identified. Progress notes from October and November recommended weekly sessions, but clearly this had not occurred. o In the October progress note for Individual #7, it was noted that the team had discussed "developing a behavior contract to earn cooking class privileges." Caution is recommended, because habilitation services should be provided non-contingently. The services the community-based therapist offered were described as art therapy. Neither short-term nor long-term goals adhered to guidelines for behavioral objectives. Progress notes from 11/1/13 through 1/17/14 did not offer data-based analysis of the efficacy of treatment. Inclusion of individuals in counseling remained unclear. For example, the BHA for Individual #421 noted that in August of 2013, the Facility administration had recommended ongoing counseling. There was no indication that a referral had been made or that services had been initiated. There are several components that must be addressed before the Facility will achieve substantial compliance with this provision of the Settlement Agreement. Referrals should be tracked and responded to in a timely manner, counseling plans should be current and include behavioral objectives that identify the conditions under which observable behavior will occur with measurable mastery criteria, and progress notes should reflect data-based assessment of treatment efficacy. Lastly, it will be important that evidence-based approaches are utilized in the provision of counseling services.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Positive Behavior Support Plan was provided for each of the 12 individuals in the sample. These were reviewed to determine whether essential elements were included in each plan. A summary of this review is provided below. ▪ All of the plans (100%) included the date of PST Approval. (As the term PST is no longer used, it is recommended that these forms be changed to IDT Approval, or Interdisciplinary Team Approval). Eight of these plans (67%) also identified dates on which the plan had been revised. Approval or revision dates were between 5/30/12 and 2/19/14. Although policy indicated that plans should be developed or revised each year, the PBSPs for Individual #263 and Individual #159 were from 2012. There might have been more current plans as the	Noncompliance

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	approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Behavioral Health Assessment (11/13/13) for Individual #263 noted that her plan had been updated to include appropriate attention seeking behavior. The Facility should carefully review all material provided to the Monitoring Team to ensure that all documents are current. ▪ A rationale for the PBSP was provided in all of the reports (100%). ▪ Operational definitions of targeted problem behaviors were included in all of the PBSPs (100%). There were several problems, however, including: o The PBSP for Individual #246 identified screaming, yelling, or crying under both aggressive and disruptive behaviors. This could result in double recording of these behaviors or other confusion regarding recording. It also was noted that in the latest revision, self-induced emesis was added as a monitored behavior. This was not identified or defined in the PBSP. o Consequences for self-injury and property destruction were included in the PBSP for Individual #406, but neither of these behaviors were identified or defined under targeted problem behavior. o In the Administrative Review section of the PBSP for Individual #421 there were data provided for leaving a designated area. This behavior was not identified or defined in the Staff Instructions section of the plan. o In the prevention section of the PBSP for Individual #302, refusal to take his medication and disrobing were both noted. Neither of these behaviors were included as a targeted problem behavior. o Self-injury and property destruction were addressed in the consequence section of the PBSP for Individual #159. These were not identified or defined as targeted problem behaviors. ▪ All of the PBSPs (100%) identified the potential function of the targeted problem behaviors. ▪ Operational definitions of alternative or replacement behaviors were included in 11 of the 12 PBSPs (92%). The exception was the plan for Individual #246. ▪ Strategies for teaching alternative or replacement behaviors were identified in all of the plans (100%). However, specific schedules for teaching these behaviors were identified in only four of the 12 plans (25%). The plan for Individual #153 and Individual #13 indicated that a teaching opportunity should be provided once per hour for at least one of their identified replacement/alternative behaviors. The two other plans, for Individual #78, and Individual #246 identified one to two opportunities per shift. As has been noted in the past, frequent opportunities should be scheduled to ensure that learning occurs. ▪ Preventative strategies were included in all of the 12 PBSPs (100%). The breath and quality of these strategies varied across plans. Individual-specific comments are provided below:	

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		o An example of a PBSP that included thoughtful preventative strategies was the plan for Individual #263. These included particular sensitivity to her visual problems, consistency in routines and preparing her for changes in these, and offering choices as appropriate. o In the Behavioral Health Assessment for Individual #78, it was noted that she wore a body suit under her clothing. This should be included in her PBSP, and it should be reviewed as a possible rights restriction. o The Bathing Compliance Data Sheets for Individual #302 were provided for the three-month period of 10/13 through 12/13. As indicated by the recorded data, this gentleman bathed or showered only 11 of 92 days. When the Monitoring Team requested the plan to address his refusal to participate in a necessary hygiene routine, the Facility noted this was addressed in his PBSP. A review of this document revealed an inadequate plan that focused on giving him time to cooperate, repeating requests to participate, informing him of the benefits of participating in the activity, and engaging in training tasks if he refused participation. If he did cooperate with daily programming, he was to be praised. A note in his Functional Skills Assessment reported that praise was not an effective reinforcer. Clearly, the data would suggest that these strategies had not been effective in teaching the individual to complete daily hygiene activities. The Facility should address this matter with a carefully designed plan to ensure proper hygiene. o Prevention strategies for Individual #409 included his choosing to wear a padded helmet to "self-soothe." The only guidelines included in the PBSP were for staff to help him adjust the helmet following his request, and no prompting of him to wear the helmet. As this is a very restrictive approach, the following guidelines are recommended: a) track the duration of his wearing the helmet and the conditions under which he chooses to do so; b) include parameters regarding the length of time he may wear the helmet; c) identify situations in which the helmet cannot be worn (e.g., while in bed); d) provide instructions for checking the condition of the helmet; and e) perhaps most importantly, develop plans for fading his use of the helmet. o In the prevention section of the PBSP for Individual #159, it was noted that an antecedent to her problem behavior was "application of mechanical restraints." There was no indication that restraints were used with this woman, therefore, it was unclear why this would be identified as an antecedent to problem behavior. o Schedules of reinforcement were identified in nine of the 12 PBSPs (75%). Four of these plans advised staff to provide reinforcement following the absence of targeted problem behavior for one hour.	

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		Attention was to be provided once every five minutes to Individual #421, and every 30 minutes to Individual #448, Individual #159, and Individual #425. Individual #302 was to receive a soda every time he cooperated during medication administration. It is suggested that all plans should include a structured and dense schedule of differential reinforcement, either for the absence of targeted problem behavior, for displaying lower rates of the targeted problem behavior, or for displaying incompatible or alternative behavior. ▪ Consequences for targeted problem behaviors were identified in all of the PBSPs (100%). Nine of the 12 PBSPs (75%) included instructions to staff to tell the person to stop displaying the behavior. It is recommended that Behavioral Health Services staff ensure that appropriate language and clear directions are provided in each plan. Individual specific examples are provided below: o Staff were to intervene if Individual #409 "placed his hand near his rectum with the intent to insert his finger, smear or obtain fecal matter." It is unclear how staff were able to determine his intent. It is suggested that any placement of his hand near his rectum should result in consequences. o Instructions in the PBSP for Individual #13 included "do not bribe (individual) to show good behavior." Staff should avoid any reference to bribery within the PBSP. Bribery involves enticement to engage in illegal activities. Reinforcement is an appropriate and essential component of any PBSP and should not be confused with bribery. ▪ Potential reinforcers were listed in five of the 12 PBSPs (42%). There was no evidence of the completion of structured preference assessments to identify potential reinforcers. ▪ Baseline or comparison data were provided in six of the 12 PBSPs (50%). ▪ Instructions for data collection were included in all of the plans (100%). ▪ None of the PBSPs were signed (0%). ▪ The Facility provided a master list of dates that required consents were obtained for current PBSPs. Only five of the 12 individuals were included on this list. For Individual #78, Individual #153, and Individual #159, consents were obtained within nine days of the plan's team approval or revision. Consent for the PBSP for Individual #13 occurred almost two months after the most recent revision, and consent for the PBSP for Individual #425 was obtained almost one month before the team had approved the plan. As dates of implementation were not included on the PBSPs, it was not possible to determine whether these were implemented in a timely manner. The department was in the process of revising their form for tracking consent of PBSPs and crisis plans. It would be advisable to include the date(s) that in-service training was provided to the staff who work directly with the individual.	

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		Based upon the review of the Positive Behavior Support Plans for the 12 individuals in the sample, the Facility remained out of compliance with this provision of the Settlement Agreement. A focus for the future should be the development of plans with adequate schedules of teaching identified replacement behaviors, enriched and specific schedules of reinforcement for appropriate and alternative behaviors, and expanded prevention strategies. Consents should be carefully tracked with the identified implementation date recorded.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Facility provided the Monitoring Team with copies of Positive Behavior Support Plan Treatment Integrity Forms that had been completed on 10 of the 12 individuals in the sample. The form guided the observer to score environmental setups, antecedents, behaviors to increase and staff response, and behaviors to decrease and staff response every minute for 10 minutes. Written positive and corrective feedback was then provided. This was followed by comments/concerns and recommendations for the future. The observer and the staff member who was working with the individual were to sign the form. A review of these documents is provided below: ▪ For this sample of 10 individuals, the Behavioral Health Associates had completed 36 treatment integrity checks between 8/13 and 2/14. It should be noted that if the form was not complete, it was excluded from this review. ▪ This represented between two and six monthly integrity checks for each of the 10 individuals. ▪ Treatment integrity measures ranged between 5% and 100%, with a mean of 92.7%. This represented very good implementation of the individual's PBSP. All of the integrity assessments revealed 100% implementation for seven of the 10 individuals in the sample. ▪ Behavioral Health Services staff are encouraged to give specific positive feedback whenever possible to ensure that this check on plan implementation does not become punishing to direct support professionals. This also provides a good opportunity to solicit feedback from staff regarding the components of the PBSP. ▪ All of the forms were consistent with the exception of the 2/14 check completed for Individual #159. It was unclear whether the Facility was in the process of revising the forms. The Facility should keep the form adapted from Reid and Parsons (2002), because this provides a clear outline of expected interventions. As noted above with regard to Section K.4, for 11 of 12 individuals in the sample, graphs	Noncompliance

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		included in their psychology progress notes depicted the total monthly occurrence of targeted behaviors. Axes were labeled (broadly), and data points and paths were displayed. Labels were not always appropriate to the data (inconsistency between partial interval and frequency data noted above). Condition change lines were used to depict changes in health status (e.g., hospitalization), environmental changes, medication changes, program changes (e.g., high school graduation), PBSP changes (e.g., introduction of a reinforcement program), and changes in level of supervision. As has been noted in every report, concerns remained regarding the accuracy of reported data. Inter-observer agreement measures were not being collected or reported. Further, monthly data display can mask critical changes in behavior that result from changes in intervention, changes in medication, including subtle changes to dosing, and changed related to health issues. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned and unplanned changes. Although there was evidence of ongoing assessment of treatment integrity and monthly review of progress, the Facility remained out of compliance with this provision of the Settlement Agreement. Data collection remained compromised, monthly assessment of inter-observer agreement and treatment integrity was not yet fully implemented, and graphing conventions did not allow for adequate review of progress.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	As reported by the Facility, PBSPs were assessed for readability during the annual internal peer review process. The Behavior Therapy Committee utilized the Flesch-Kincaid readability test to determine grade level of all plans. The direct support professionals who were interviewed during the Monitoring Team's visit reported that PBSPs were clearly written and understood by staff. The Monitoring Team also found the 12 PBSPs reviewed for this report to be clearly written. One suggestion is to ensure that the most current PBSP is included in the individual's I-Book. Staff reported that on occasion in-service training was provided on revisions to a PBSP, but the written updated plan was not always available on site. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	Substantial Compliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Interview with staff from the Behavioral Health Services Department revealed a three-tiered staff training program. Didactic training provided staff with a foundational understanding of department services and Positive Behavior Support Plans. Newly hired staff then met with Behavioral Health Assistants who would provide written tests on	Noncompliance

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	the specific PBSPs for which they are responsible and on the implementation of those plans.	individual-specific PBSPs. During this same meeting, understanding of PBSPs would be assessed through role-play. Finally, the Behavioral Health Specialist would provide on-the-job training while conducting treatment integrity checks, described in Section K.10 of this report. Although the Facility was making good progress towards ensuring competency-based training of all relevant staff, by their own analysis training was not yet adequate following revisions or annual updates. For this reason, the Facility remained out of compliance with this provision of the Settlement Agreement. To move towards substantial compliance, the Facility should: 1. Continue to complete competency-based training for every staff member on the PBSPs (i.e., role playing). 2. Because an on-the-job (in vivo) component also should be implemented, the Facility should describe it in its policy and show that it implements it regarding: a. Staff on-the-job (in vivo) integrity checks of implementation (who, what percentage, how often, etc.); this should include new staff and current staff. b. Which PBSPs must all staff working with the individual have demonstrated on-the-job (in vivo) integrity checks (e.g., high risk, dangerous violence). c. Demonstration of competence for challenging behaviors that occur very infrequently. d. Timely on-the-job training for all revisions to an individual' PSBP.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. At the time of the visit, 280 individuals were in residence at the Facility. Employed within the Behavioral Health Services department were a Director, an Assistant Director, and 14 Behavioral Health Specialists. In addition to having clinical caseloads, one Behavioral Health Specialist provided counseling services, one supervised staff training, and one tracked the Department's compliance with the Settlement Agreement. The Department also employed six assistants who supported clinical care. At the time of the visit, there were two vacant assistant positions. Once all assistant positions were filled, there would be one assistant for every two Behavioral Health Specialists. One promising practice was the scheduling of department staff to be present in the homes and day programs of the individuals on their caseloads. From Monday through Friday, staff were assigned specific times in the morning and afternoon to be in the	Noncompliance

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		environments accessed by the individuals. This allowed for greater observation of the individuals and enhanced the ability of Behavioral Health Services staff to work collegially with the direct support professionals. The Department is commended for the introduction of Corrective Action Plans for staff members. These were designed to ensure that staff completed all required documentation in a timely manner. Although the Department employed a sufficient number of professionals to maintain an average ratio of one for every 30 individuals, the Facility remained out of compliance with this provision as none of the staff had demonstrated competency in Applied Behavior Analysis as evidenced by certification.	

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director, if new since the Monitoring Team's last visit; o Name and degrees of all PCPs new to the Facility since last Monitoring Team's visit; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing Cardiopulmonary Resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since the last Monitoring Team on-site review, copy of Continuing Medical Education (CME) for each PCP, list of CME credits according to topics reviewed, and list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since last Monitoring Team's visit; o Minutes of Infection Control (IC) committee meetings during the prior six months; o Communication concerning Skin Integrity Committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o For each PCP, two most recently completed quarterly medical reviews, and prior quarterly medical reviews, from each assigned residence: Individual #372, Individual #328, Individual #426, Individual #439, Individual #417, Individual #117, Individual #266, Individual #290, Individual #184, and Individual #119; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, with separate reports/data of external medical peer review audits from internal medical peer review audits (i.e., both general medical and medical management audits), including information concerning number of corrective action plans, and QA Department follow-up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory. Submitted requested information included location at time of death, whether Do Not Resuscitate (DNR), whether receiving hospice services, ambulatory status, and whether supplemental oxygen prescribed as part of routine care. Date of any Ethics Committee meeting that reviewed the individual's terminal course, if applicable, for

	Individual #318; o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations made prior to last Monitoring Team's visit which had follow-up closure or action steps completed); o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (e.g., clinical/administrative) that remain incomplete/outstanding; o Two most recent annual, medical assessments and physical examinations and prior annual assessment and examination per PCP caseload, for the following individuals: Individual #389, Individual #337, Individual #81, Individual #286, Individual #84, Individual #97, Individual #117, Individual #172, Individual #303, and Individual #142; o Specialty clinic schedule per month for past six months (including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow-up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of all outside consultations for medical purposes for the past six months, categorized by specialty including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow–up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still pending; o List of individuals: a) with tracheostomies, b) with fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location), c) with injuries requiring visit to ER or hospitalization since the Monitoring Team's last on-site review, and d) with pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether taken to ER or hospitalized, since the Monitoring Team's last on-site review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of reason for colonoscopy (i.e., preventive versus evaluation of active problem), with reason if not up-to-date; o For those women over 40, date of last mammogram and reason listed if not up-to-date (i.e., guardian refusal, etc.); o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth;

	o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last Dual Energy X-ray Absorptiometry (DEXA) scan or statement if not completed, copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake and Vitamin D intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test; o For those going to the ER and not hospitalized, copy of IPN from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility record orders, IPN/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations): Individual #109 12/18/13, Individual #22 12/18/13, Individual #333 12/15/13, Individual #268 12/9/13, Individual #48 12/9/13, Individual #4 12/7/13, Individual #306 12/6/13, Individual #385 12/4/13, Individual #333 12/4/13, and Individual #210 12/2/13; o For those admitted to hospital, copy of IPN from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, IPN/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, for the five most recent hospitalizations that have returned for at least 30 days (in order to allow completion of recommendations): Individual #333, Individual #172, Individual #302, Individual #140, and Individual #142; o For these same five most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter, by category of infection last two quarters; o Summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms/pneumonia data from Avatar database for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia, b)

	decubitus ulcers, c) UTIs, and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: a) malignancy, b) cardiovascular disease, c) diabetes mellitus, d) sepsis, e) bowel obstruction or bowel perforation and f) pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including name of individual, residence, diagnosis (i.e., type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #268, Individual #448, Individual #453, Individual #195, and Individual #363; o List of individuals seen by neurologist, with dates on which appointments were completed and reason, since the Monitoring Team's last visit, date of prior visit to the neurologist for these same individuals; o List of those with status epilepticus since the last monitoring visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged/new onset seizure since last Monitoring Team's visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals with diagnosis of seizure disorder on zero, one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, and Felbamate); o Since the Monitoring Team's last visit, any Ethics Committee meeting minutes, with attendance rosters, concerning DNR decisions/changes, or other concerns addressed by this committee; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (i.e., on campus and off-site), list of appointments that were completed and ones not completed (with reasons); o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o Five most recent nutritional assessments for individuals with osteoporosis: Individual #457, Individual #357, Individual #181, Individual #61, and Individual #337; o For concerns identified needing closure at morning medical meetings for period of 30-60 days prior to the Monitoring Team's visit, any documents providing evidence of closure (e.g., minutes of medical staff meeting, copy of ISPA addressing concern, etc.);

	○ Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; ○ ISPAs addressing missed appointments or refusals for the past three months (for mammograms, colonoscopies and off-site and on-site consultation appointments); ○ List of missed medical appointments with reasons past six months; ○ Presentation Book for Section L; ○ DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; ○ For women age 21 to 65, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), if pelvic not done, the reason/indication, and if pap smear not done including the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; ○ For the self-assessment process: list of monitoring/audit tools used: for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review; ○ For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; ○ For each of the following individuals, copies from the active record: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews: Individual #210, Individual #321, Individual #147, Individual #13, and Individual #45; and ○ For the most recent six individuals who had acute respiratory distress sent to the ER or hospitalized, dysphagia and GERD evaluations completed: Individual #433, Individual #426, Individual #398, Individual #457, Individual #50, and Individual #381; ○ Minutes of the medical morning meeting with handouts during the Monitoring Team's visit: 2/25/14, 2/26/14, and 2/27/14. ▪ **Interviews with**: ○ Chrishanthi Perera, MD, Medical Director; ○ Archie Smith, MD, Staff Physician; ○ Alfredo Cisneros, MD, Staff Physician; ○ Ashton Wickramasinghe, MD, Staff Physician; ○ Vivian Pugh, MD, Staff Physician; and ○ Flor Lopez, RN, Medical Program Compliance Nurse.

	▪ **Observations of**: o Morning Medical Meeting, on 2/25/14, 2/26/14, and 2/27/14; and o Individual #398, Individual #22, Individual #323, individual #117, Individual #188, Individual #363, Individual #72, Individual #390, Individual #191, Individual #434, Individual #100, Individual #51, Individual #426, Individual #81, Individual #45, Individual #286, Individual #14, Individual #107, Individual #423, Individual #341, Individual #235, Individual #287, and Individual #439.
	Facility Self-Assessment: For Section L, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: external and internal medical peer review general medical quality improvement audits, external and internal medical peer review medical management audits, and internal Medical Department audits of specific diagnoses/concerns. o These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement, but needed expansion given that the Monitoring Team identified additional areas needing improvement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews. o The Self-Assessment identified the samples sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o Instructions/guidelines of the monitoring/audit tools were not provided in reference to the audits. o The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse, Facility physicians, and external physician. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be incomplete and outdated, especially the preventive care databases. ▪ The Facility presented some data in a meaningful/useful way, but some problems were noted. Specifically, the Facility: o Presented findings consistently based on specific, measurable indicators. o Did not have a monitoring tool in place to measure the content/quality of the annual medical assessment. o Did not have a tool that was reliable in tracking timeliness of quarterly medical reviews. ▪ The Facility rated itself as being in noncompliance with Section L. This was consistent with the Monitoring Team's findings.

	▪ The Facility data identified several areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to increase the sample size of the external medical peer review audits, and the need to provide trend analysis of medical peer review data.
	Summary of Monitor's Assessment: A strength of the Medical Department was the Medical Director's leadership. Under the leadership of the Medical Director, the medical team of Primary Care Practitioners (PCPs) provided quality care in a number of areas, as well as quality documentation of clinical care. Critical clinical discussions occurred at each morning medical meeting, and included participation from a variety of other disciplines. The morning meeting had an appropriate structure/format and was efficiently run. Minutes reflected the critical discussions. ISPAs were tracked to closure. Annual medical assessments had been behind schedule in completion, and a corrective action plan was implemented with rapid improvement in this area. Caseloads were of an appropriate size per PCP. PCPs had in-depth knowledge of the individuals on their clinical caseloads. Tracking of on-site and off-campus appointments appeared thorough. A task force on aspiration pneumonia had had significant impact on several clinical departments. Clinically, the significant potential contribution of gastroesophageal reflux disease (GERD) to aspiration pneumonia appeared to be identified in the template used to review each instance of pneumonia. Evaluations of acute respiratory distress often included evaluations of GERD, and GERD diagnoses were appropriately evaluated and treated. Areas needing improvement included the many databases on which the Medical Department relied for information to make continued advances in health care. Some preventive care databases appeared out-of-date and unhelpful, and might not have accurately reflected the clinical care at the Facility. Facility computer/information technology support/database entry and management support might be needed to address the issues. The lack of QA Department follow-through in monitoring results of external and internal peer review corrective action plans needed focus. Although the formal process set forth expectations for a strong component of QA monitoring to ensure follow-up on the results of these peer review audits, at AUSSLC, no monitoring had occurred in the prior six months. The annual medical assessments were now up-to-date, but the content varied across PCPs, and this needed review. The quality of the quarterly medical reviews was exemplary, but there was no information available to provide evidence of timely completion via an information management system. Ethics Committee closure items needed documentation of follow-through to completion. The Medical Department had not begun to develop a policy and procedure manual. Components of quality medical care were reflected in the discussions of the morning medical meetings, and in the improved documentation in the active records, concerning acute changes in health status and chronic care. Continued progress will require strengthening of other clinical and nonclinical departments critical to the services the Medical Department provided.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and DNR Orders. <u>Staffing and Administration</u> For the census of 281 as of 1/30/14, there were five physicians responsible for this population. The Medical Director had a caseload of 14. Other PCPs had caseloads ranging from 64 to 71. There was no vacancy in the Department. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was undated, but scanned on 1/30/14. For the physicians in the Department, five out of five (100%) were current in CPR. Of the five PCPs in the Medical Department, a list of CME credits was submitted for four of these PCPs. This varied from five to 72.75 hours. The topics covered included: medical ethics, pneumonia, palliative care, pain management, albuminuria in type II diabetes mellitus, prevention of stroke, diagnosis of adrenal insufficiency, hyperkalemia, alopecia, inborn errors of metabolism, topics in pulmonary medicine, integrative nutrition, MRSA sepsis, and cardiac risk assessment. The majority of the topics that were covered included areas of importance to primary care and the individuals residing at AUSSLC. Topics were not specific to developmental disabilities. One PCP did not complete CME during this time period. <u>Physician and other Departmental Participation In Team Process</u> For the three morning medical meetings observed, there was a signed attendance roster in three of three meetings. This information was not available in the minutes. Membership was listed, but attendance was not listed. This might have been tracked through other means. The Medical Director chaired the meeting each morning. For the three morning medical meetings observed, there were three hospitalizations (i.e., Individual #381, Individual #186, and Individual #59), and four admissions to the Infirmary and two medical observations (i.e., Individual #264, Individual #182, Individual #381, Individual #333, Individual 324, and Individual #432). Based on the Monitoring Team's observations and review of documentation: ▪ **IDT follow-up with ISPA:** For zero of three hospitalized individuals, critical clinical questions were raised followed by a request for the IDT to meet to review the case for preventive measures, with	Noncompliance

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	monitoring plan.	subsequent development of an ISPA. However, based on other documentation, hospitalizations required a post-hospital ISPA, and were tracked to completion by the morning medical meeting. ▪ **IDT follow-up with ISPA:** For zero of four Infirmary admissions, critical clinical questions were raised followed by a request for the IDT to meet to review the case for preventive measures, with subsequent development of an ISPA. However, based on other documentation, Infirmary admissions required an ISPA, and were tracked to completion by the morning medical meeting. ▪ **IDT follow-up with ISPA:** For zero of four ER visits critical clinical questions were raised followed by a request for the IDT to meet to review the case for preventive measures, with subsequent development of an ISPA, if indicated. However, based on other documentation, ER visits required an ISPA and were tracked to completion by the morning medical meeting. ▪ **Assignment of follow-up to meeting participant:** There was one critical clinical question raised/identified needing closure. It was followed by assignment of the concern for further review by one or more morning medical meeting attendees concerning steps to be taken to prevent a recurrence. ▪ **Assignment of open record review:** As a subset of those hospitalized, for those with aspiration pneumonia, reactive airway disease, recurrent pneumonia with undetermined etiology, respiratory failure, or sepsis with undetermined etiology, there were no new assignments requesting an open record review for the prior 30 days of the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation, need for consultation, review of medication and medication side effects, etc. ▪ **For previously assigned open record reviews:** One was presented during the three morning meetings. ▪ **Closure discussions:** There was one prior concern with assignments for follow-up presented at the medical morning meetings. ▪ **Follow-up requested ISPAs reviewed:** There were no brief summaries of ISPAs that had been assigned to IDTs in responding to concerns referred by the medical morning meeting. According to the weekly report schedule, these were discussed on the Friday of each week, and the Monitoring Team did not observe the Friday meeting. ▪ **Infection control updates:** During the three medical morning meetings, there was one infection control update presented. ▪ **Summaries of completed consultations:** During the three medical morning meetings, there were no summaries presented of completed consultations from the prior day. According to the weekly report schedule, the on-campus specialty clinic nurse presented consults that were referred to the IDT. This was done twice a month at the morning meeting. There was no information regarding whether consults not needing IDT involvement were reviewed for significant findings at the morning medical meeting. ▪ **Dental Department updates:** The Dental Department provided brief updates/information during two of three medical morning meetings. ▪ **PT/OT/ST and PNMT updates:** The PT, OT, ST, and PNMT presented updates during one of three	

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		medical morning meetings. ▪ **Skin integrity updates:** Skin integrity reports/updates were provided at one of three medical morning meetings. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at zero of three medical morning meetings. ▪ **Hospital Liaison Nurse updates:** The Hospital Liaison Nurse reported an update for three of three hospitalizations during the meetings the Monitoring Team member observed. ▪ **On-call PCP participation:** For the three morning medical meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in three of three meetings. ▪ **Attending PCP participation:** The attending PCP for the individual (when not the on-call PCP) participated in the discussions in health status changes/on-call concerns in three of three meetings. The strengths noted at the medical morning meeting included the following: ▪ The morning medical meeting was organized and efficient. ▪ Attendance was multidisciplinary and discussion was interdisciplinary. ▪ Minutes were created and reflected on a screen as the meeting discussion progressed. ▪ Minutes reflected areas of concern in preventing aspiration pneumonia. There was a dedicated section listing the prior 24 hours of seizure activity, gastrostomy tube (G-tube) concerns, and emesis. There was also a report of missed appointments with reasons. ▪ The PCPs appeared to know the individuals on their caseloads well. Past history, current status and clinical findings, and plans were part of discussion for each individual with acute illness. ▪ Critical clinical interdisciplinary discussion occurred for each new occurrence of individuals going to the ER, admitted to the hospital or admitted to the Infirmary within the prior 24 hours. The minutes captured these critical discussions succinctly. Weakness and concerns include the following: ▪ It would be helpful if significant consult/test results of individuals were discussed with input from the PCP as to any next step. This is an important aspect of critical clinical discussions. ▪ A tabulation of information at the end of the minutes would provide brief tracking information, such as number of ISPAs received in prior 24 hours, number of ISPAs outstanding, number and type of consultation reports received in prior 24 hours, number of closure concerns outstanding, number of look-back reviews outstanding, etc. These would be single line with ongoing statistic for each item. It was likely ongoing tracking was occurring, but was not reflected in the minutes. This would demonstrate the activity of the morning medical meeting and the Medical Department, as well as provide a measure of accountability to IDTs, members assigned closure concerns, etc. It appeared the tracking of look-back reviews occurred, but this information did not appear in the minutes. ▪ It would be helpful to have a list of those in attendance at each meeting, rather than a list of membership. One could not determine who specifically attended each meeting. Overall, this was a valuable addition to the Facility process of integrated clinical services, and demonstrated critical clinical decision making in a timely manner. One obtained valuable information concerning the	

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		critical clinical issues at AUSSLC that day, and the steps in place to provide ongoing healthcare and safety. Attendees obtained a snapshot of the acute health concerns, as well as the steps being taken to resolve them. Routine Care A list of dates of the last two annual medical assessments and physical exams were submitted. In the information the Facility initially submitted, information was not available for one PCP. Information of the caseloads for four PCPs was available and a total of 217 names were submitted. For seven individuals, there was no information or misinformation suggesting a typographical error or data entry error. For the remaining 210 individuals, there were dates of prior and current annual medical assessments listed. Of these, 161 of 210 (77%) of the recent annual medical assessments were completed within 365 days of the prior assessment. Of these, 170 of 210 (81%) of the recent annual physical exams were completed within 365 days of the prior assessment. These documents also were reviewed to determine if they were current and completed in 2013 or 2014. Documents dated earlier than 1/1/2013 were considered outdated. Two hundred three of 210 (97%) annual medical assessments were current. Two hundred four of 210 (97%) of annual physical exams were current. During the Monitoring Team's onsite visit, this information was updated to include the caseloads of all five PCPs. The eligible number of individuals was the 210 indicated above as well as the 66 of the additional PCP caseload. This was a total of 276 individuals, which was four less individuals than the census at the time of the Monitoring Team's onsite review. One hundred ninety two of 276 (70%) of the annual medical assessments were completed within 365 days of the prior annual medical assessment. Two hundred thirty four of 276 (85%) of the recent annual physical exams were completed within 365 days of the prior assessment. Documents were reviewed to determine if they were current and completed in 2013 or 2014. Documents dated earlier than 1/1/2013 were considered outdated. Two hundred sixty nine of 276 (97%) annual medical assessments were current. 269 of 276 (97%) annual physical exams were current. It appeared the prior delay in completing these documents had been resolved, in part due to a corrective action plan the Facility implemented when this concern was identified. A corrective action plan had been submitted to the QA/QI Council as of 1/17/14 to improve the timely completion rate of the annual medical assessments. This included adding a contract physician to complete the annual medical assessments, and providing guidance to one of the PCPs in setting a weekly goal of completing annual medical assessments. A tracking system for completed annual medical assessments was in place, and the Medical Program Compliance Nurse was to provide a weekly report to the Medical Director for any overdue annual medical assessments. The timeframe for completion was 2/17/14. It appeared that this system had a positive impact, given that 97 percent of the annual medical assessments and physical exams were current. As an ongoing monitoring system, monthly reports were to be sent specifically to each PCP, listing the status of annual medical assessments. A monthly report also was to be sent to the Medical Director for review. For ten individuals, a copy of the two most recent annual medical summaries and physical examination evaluations, as well as the prior annual medical summary and physical examination evaluation were	

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		submitted for review. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 10 individuals, compliance was nine out of 10 (90%). For the 10 most recent annual medical assessments, there was a section dedicated to the interval history of the past year included as part of the document in four of 10 (40%) reviews. For some assessments, it appeared the information was scattered in the document, because a listing of events/consults/abnormal labs, changes in medication, and other significant clinical concerns during the prior year was not found in one place for several of the documents. For others, the interval history was clear, providing a succinct summary of all significant clinical events and findings in one location in the document. Given the depth of detail provided in the medical history spanning decades of health issues, it was helpful to have a dedicated section to review the most recent one year of events separate from the more remote history, because it gave an indication of the current health and challenges of the individual. For the 10 most recent annual medical assessments, the major active problems listed had plans of care addressing each of the significant current diagnoses in six of 10 (60%) assessments. There was variability in location of parts of the plans. Some assessments appeared to focus on a plan when discussing the individual diagnosis, in which significant diagnoses were followed by documentation of ongoing or current needs, but there was no listing of these plans in a dedicated section. Others had a clear listing, in bullet form, of the plans for the individual, covering each significant diagnosis. Some provided a summary, but did not mention all significant concerns in this summary. For the 10 most recent annual medical assessment, seven of 10 (70%) addressed smoking history. Family history was adequate/helpful in four of 10 (40%). A discussion of readiness/requirements for transition to the community was included in nine of 10 (90%). It is recommended the content and quality of the annual medical assessment be reviewed as part of focused monitoring. Differences in interpretation of completion of this lengthy document needed further discussion among the PCPs to develop a standardized approach and consensus for each section of this time-intensive form. It was noted that the Action Plan included a 10 percent sample of annual medical assessments as part of a monthly quality review, but it was scheduled to begin 4/1/14. As part of the annual medical assessment, any need for pre-treatment sedation for specific medical exams, tests, and procedures was to be documented. The appropriately completed consent form was to be available for Legally Authorized Representative (LAR) consent at the time of the annual ISP, or if the LAR was not available, a verbal consent process was to be utilized. This process was implemented in December 2013. A document entitled: "Process for Obtaining Medical Consent for Pre-Treatment Sedation" provided detailed guidance of the process.	

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		As part of the monitoring review process, the Monitoring Team selected the medical records of a reduced sample of five individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on identifying individuals with various diagnoses/health care issues, and selecting a sample of individuals from each category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This sample was selected to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included the preventive care flow sheet, physician orders for the prior one year, IPNs for the prior one year, the most recent three quarterly medical reviews, most recent PBSP, last annual ISP and subsequent addendums, labs, x-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one year, the integrated risk rating form, the most recent health care management plan/risk action plan/ integrated health care plan, the most recent annual medical assessment and physical exam, DNR forms if applicable, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From five medical records reviewed: ▪ Four of five (80%) annual medical assessments had been completed in the prior 365 days. ▪ Four of five (80%) annual physical exams had been completed in the prior 365 days. For the one individual with an overdue annual physical exam, there was documentation of attempts to complete the exam, but the individual refused. There were numerous ISPAs concerning refusals of care. ▪ Active problem lists appeared to be thorough in five of five (100%). ▪ Five of five (100%) annual medical assessments included a smoking history and/or substance abuse history. ▪ A family history was documented (or attempts at obtaining this information) in three of five (60%) charts. ▪ Five of five (100%) had information discussing requirements for transition. These five medical records also were reviewed to determine whether the physician IPNs used the SOAP format for acute illness documentation. In five of five (100%), the SOAP format was used. ▪ Five of five (100%) of SOAP IPNs included the date. ▪ Five of five (100%) of SOAP IPNs included the time. ▪ Five of five (100%) of applicable SOAP IPNs recorded vital signs or referenced vital signs from another IPN. The Medical Department was unable to provide a list of quarterly medical reviews (and annuals if completed in a month in which a quarterly was due) that were completed each quarter for all individuals over the prior year. This will be a needed area of focus to allow the Facility to determine timeliness of completion. The two most recently completed quarterly medical reviews were requested for each PCP, along with the	

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prior quarterly medical review for these same individuals. Twenty quarterly medical reviews for 10 individuals were submitted.

- A template format was used in 20 of 20 quarterly medical reviews.
- Twenty of 20 (100%) included the date of the quarterly review completion.
- Four of 20 included the signature of the PCP. The copies submitted might have been obtained from the computer rather than the active record.
- Major diagnoses were listed in 20 of 20 (100%) medical quarterly reviews.
- Nineteen of 20 (95%) medical quarterly reviews provided complete information. One review only included the active problem list without completing the remainder of the template.
- The last three monthly weights or equivalent information were recorded in 18 of 20 (90%) medical quarterly reviews.
- There were brief comments/entries listing numbers of seizures per quarter (if applicable) in 12 of 12 (100%) medical quarterly reviews.
- There was documentation of whether there were changes in medication in 19 of 20 medical quarterly reviews.
- Important/abnormal labs and drug levels/radiographic test results were documented in 12 of 20 medical quarterly reviews.
- Two quarterly medical reviews indicated the occurrence of an ER visit. Two of two included reasons for the ER visit. Zero of two included treatment provided in the ER.
- Two quarterly medical reviews included documentation of hospitalization. Two of two included reasons for the hospitalization. Zero of two included treatment during the hospitalization.
- Nineteen of 19 individuals had documentation of consultations completed, listing the specialty.

In relation to the quality of the quarterly medical reviews, the Facility had achieved substantial compliance. The timeliness of quarterly assessments could not be determined.

<u>Access to Specialists</u>

Based on data the Facility submitted, the following chart indicates the off-site appointments scheduled for the six months prior to the Monitoring Team's visit, the off-site appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments:

Specialty	Initial Appointment Scheduled	Initial Appointment Completed	Number of Appointments Rescheduled*	Follow-up Appointment Completed	Pending Number Individuals Needing Completion of Appointment as of 12/31/13
Allergy	1	1	0	0	0
Cardiology	35	20	(5R) 5	(1R) 4	3
Dentist	2	1	0	1	0

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		Dermatology	24	20	(3R) 3	0	1	
		Endocrine	6	4	0	0	2	
		Epileptologist	7	6	0	0	1	
		Pedorthic	1	1	0	0	0	
		Gastroenterology	4	2	0	1	0	
		Gynecology	5	3	0	1	1	
		Nephrology	20	15	0	3	1	
		EEG lab	4	4	0	0	0	
		Sleep disorder	4	1	(1R) 1	0	2	
		Neurosurgery	1	1	0	0	0	
		Oncology/ Hematology	30	23	0	4	2	
		Ophthalmologist	13	10	(2R) 2	(2R) 1	0	
		Orthopedic	12	11	0	1	0	
		Otolaryngology	7	6	0	0	1	
		Physical medicine	9	7	0	0	1	
		Plastic surgery	1	1	0	0	0	
		Podiatry	6	4	0	2	0	
		Proctology	4	2	0	1	0	
		Pulmonology	6	3	0	1	0	
		Reclast	16	14	(1R) 1	(1R) 1	0	
		Rheumatology	2	2	0	0	0	
		Urology	35	32	0	2	0	
		Mammogram	62	28	(14R) 12	5	5	
		DEXA	56	21	(12R) 9	(3R) 4	7	
		Radiology	79	50	(3R) 3	(3R) 10	8	
		Colonoscopy	23	21	1	1	0	
		Various procedures	34	25	(2R) 2	(1R) 4	2	
		Total	**509**	**339 (67%)**	**(43R) 39**	**(11R) 47**	**37**	
		*Number of refused appointments are in parentheses (R). The number of non-refused missed appointments is listed outside of parentheses. Additional information tracked individuals until completion of appointment. The Medical Department						

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		indicated 63 follow-up appointments had been completed (through available February 2014 data) when the initial appointment had been missed. As a number of individuals serially missed an initial appointment (which would artificially increase the number of initial missed appointments and pending appointments), the Monitoring Team member removed repeated missed/refused appointments to determine the number of actual remaining incomplete appointments. The total of missed appointments was 46. Two had typographical errors and could not be further interpreted. For the remaining 44 appointments, 29 were completed or cancelled, because the clinical reasons no longer existed for completing the appointment. Fifteen remained pending and had been scheduled after December 31, 2013. This was a 494/509 = 97 percent completion rate. Onsite, specialty clinics were held to meet the needs of the individuals for the six months prior to the Monitoring Team's visit. Based on data the Facility provided:	

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed	Follow-up to Initial Appointment Scheduled
Orthopedics	7/1/13	4	3 (1R)	1
Surgery	7/8/13	7	7	0
Eye Clinic	7/12/13	14	13	1
Optometry	7/17/13	24	20 (1R)	4
Podiatry	7/17/13	37	31	6
Orthopedics	7/22/13	4	3	0
Surgery	7/22/13	1	1	0
Neurology	7/26/13	22	21 (1R)	0
ENT	8/1/13	8	8	0
GYN	8/9/13	6	4	2
Orthopedics	8/12/13	3	3	0
Surgery	8/12/13	4	4	0
GI	8/13/13	11	10 (1R)	1
ENT	8/15/13	10	9	1
Eye Clinic	8/16/13	15	13	2
Optometry	8/21/13	20	19	1
Podiatry	8/21/13	22	16 (1R)	6
Neurology	8/23/13	24	22 (1R)	2
Surgery	8/26/13	6	6	0
ENT	8/29/13	12	11 (1R)	1
Surgery	9/9/13	4	4	0
Orthopedics	9/9/13	1	1	0
ENT	9/12/13	15	15	0

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		Eye Clinic	9/13/13	10	7 (3R)	3	
		Optometry	9/18/13	21	19	2	
		Podiatry	9/18/13	30	24 (1R)	6	
		Gynecology	9/20/13	10	7 (3R)	3	
		Surgery	9/23/13	5	5	0	
		Neurology	9/27/13	26	25(1R)	1	
		Orthopedics	9/30/13	5	3 (2R)	2	
		Surgery	10/7/13	4	4	0	
		GI	10/8/13	11	10 (1R)	1	
		ENT	10/10/13	5	5	0	
		Gynecology	10/11/13	22	16 (2R)	5	
		Podiatry	10/16/13	19	16 (1R)	3	
		Orthopedics	10/21/13	5	3 (1R)	2	
		Surgery	10/21/13	7	7	0	
		ENT	10/24/13	6	6	0	
		Neurology	11/1/13	22	22	0	
		ENT	11/7/13	6	5	1	
		Eye Clinic	11/8/13	12	10	2	
		Optometry	11/14/13	29	28	1	
		Orthopedics	11/18/13	3	1 (2R)	2	
		Podiatry	11/20/13	18	11(1R)	7	
		ENT	11/21/13	5	5	0	
		Neurology	11/22/13	23	23	0	
		Surgery	11/25/13	6	6	0	
		Surgery	12/2/13	3	3	0	
		ENT	12/5/13	4	2	2	
		Orthopedics	12/9/13	4	2 (2R)	0	
		Gastroenterology	12/10/13	17	16 (1R)	1	
		Podiatry	12/11/13	18	13 (2R)	0	
		Eye Clinic	12/13/13	6	5	1	
		Surgery	12/17/13	2	0	0	
		Optometry	12/18/13	33	32	1	
		ENT	12/19/13	11	11	0	
		Neurology	12/20/13	19	17	2	
		Total		**701**	**613 (30R)**	**76/88**	
		Show rate for appointments: 613/701 = 87 percent (appointments scheduled included follow-up appointments made for missed appointments).					

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		Appointments made for missed appointments: 76/88 = 86 percent. Data provided indicated that, as of February 2014, eight refused appointments remained incomplete and four non-refused appointments remained incomplete. The completion rate (i.e., indicating evidence of tracking until either appointment was completed or the appointment was cancelled as no longer clinically applicable) was 689/701 = 98 percent. The data appeared to be detailed. An important statistic not easily determined was the number of individuals remaining with an initial appointment not completed. This could not be readily determined from the above chart , because several individuals missed several follow-up appointments (i.e., the number of individuals missing appointments was less than the number of missed appointments). The Facility was able to subsequently provide this information (as noted in the February 2014 updated information in the prior paragraph) during the Monitoring Team's onsite review The Provision Action Information indicated that a task force had been created to address missed on-campus and off-campus appointments. Meetings occurred on 9/26/13, 10/28/13, 11/26/13, and 12/20/13. The current system appeared to track appointments, missed appointments, and follow-up appointments. The data appeared thorough and readily available, and it appeared the Facility was taking action to ensure follow-up occurred for missed appointments. The Facility is considered to be in substantial compliance with this clinical area. The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Section L.2 and L.3. In addition, the Monitoring Team's findings with regard to follow–up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> ▪ Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in five of five (100%) records reviewed. ▪ Preventive care flow sheets were up-to-date (at least at the time of annual medical assessment) in four out of five (80%) records reviewed. For one individual, the document had been updated in 2009, with a single test recorded more recently. ▪ In five of five (100%) records, current vision screening was documented within the prior 24 months. ▪ In five of five (100%) records reviewed, audiological screening occurred in the prior three years. ▪ The influenza vaccination had been given to four of five (80%) individuals in a timely manner during 2013. From submitted documents, there was no information one individual received this vaccination in 2013, although it was recorded for 2012. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date and immunity status), and whether it was given if indicated, was recorded in four of the five (80%) active records reviewed. ▪ Whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or was being tracked for completion), was recorded in five of the five (100%) active records reviewed. ▪ A Tdap had been given to five of five (100%) individuals.	

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		▪ A pneumococcal vaccination had been given to five of five (100%) individuals. ▪ For individuals age 60 or over, a zoster vaccine had been given to three of three (100%) individuals. A document was submitted entitled "Preventative Care as of 2/4/2014 mammograms" for individuals residing at AUSSLC. The DADS SSLC policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed. A total of 145 names were submitted. One hundred forty two were women age 40 or greater. Three men were listed and these names were removed. Of the 142 women listed, there were 18 women over the age of 70. These were not included in the compliance analysis. Of the 124 women between the ages of 40 and 70, 64 of 124 (52%) were considered up-to-date (i.e., dates of mammogram from 1/1/13 through the date of the document 2/4/14). Reasons for not being current were not provided. It was noted there were occasional names listed twice, and the extent of the duplicate names was not determined. The Facility is encouraged to review the database, to ensure duplicate entries do not occur, that current information is entered into the database, and that reasons for noncompliance with mammogram completion are documented for each individual. From the sample of five medical records reviews, there were two females between the ages of 40 and 70. Of these, one female was eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Zero of one (0%) was up-to-date on mammogram testing. A list of women aged 21 to 65 was submitted, along with the date of last pelvic exam, date of last pap smear, a history of hysterectomy with reason, and reason for non-completion of the gynecologic exam, if applicable. One hundred one names were listed. Of these, five families refused/did not provide consent, 13 had physical limitations, five had a hysterectomy (four listed unknown reasons, one listed a benign reason), and 11 were too agitated to comply with the exam. This indicated there were 67 women eligible for screening gynecological examination. The "SSLC Preventive Health Care Guidelines August 30, 2011" was used in reviewing compliance (i.e., every three years from age 21 to 65 as long as last three test results were normal). The database indicated 41 had a gynecological exam in 2013, two had this exam in 2012, and two had this exam in 2011. Fourteen were listed with completion of a most recent gynecologic exam from 2011 and prior. Seven had no dates of any gynecological exam listed. Pelvic exams and/or pap smears completed in the past three years was used as a compliance measurement for those without contraindications. Forty-five of 67 (67% compliance) women completed this exam in the last three years. Tracking was not available prior to 2013. From the sample of five active records reviewed, there were two females between the ages of 21 and 65. ▪ One of two females had documentation of reasons for not completing cervical cancer screening within the prior three or five years. ▪ Of the remaining females, zero of one (0%) female had documentation of cervical cancer screening within the prior three or five years. ▪ One of one (100%) documented a pelvic exam in the prior three years. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last	

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		colonoscopy, with the reason for the colonoscopy (i.e., screen or diagnostic testing for signs and symptoms). A total of 207 names were submitted. Of these, nine were over the age of 75. Eleven individuals had clinical contraindications or family/guardian refusals of consent. Therefore, the eligible population included 187 individuals. Of these, 166 completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. This was a compliance rate of 166/187 = 89 percent. Of the five active records reviewed, there were four individuals from the age of 50 to 75. Three of four (75%) had a colonoscopy completed in the past 10 years. The Facility submitted two lists for individuals with osteoporosis/osteopenia. For one list, there was no title or date of completion. Medications were listed along with diagnosis. There were a total of 151 names listed. One hundred thirty seven were listed specifically with a diagnosis of osteoporosis. Five had a diagnosis of osteopenia, and nine were listed as "osteoporosis prevention" or "osteoporosis prophylaxis." Of the 137 with osteoporosis, there were six with both a diagnosis of osteoporosis and osteopenia. These were included in the 137 for medications prescribed: ▪ One hundred four of 137 were prescribed calcium supplements. ▪ Eighty-seven of 137 were prescribed Vitamin D supplements. ▪ Ninety-eight of 137 were prescribed additional medication to treat osteoporosis. Sixty-eight of 137 were prescribed a bisphosphonate. Twenty-nine of 137 were prescribed Prolia. One of 137 was prescribed Miacalcin. A second list was submitted entitled "Preventive Care as of 2/4/2014 – DEXA." This listed 233 individuals with two DEXA scan dates: DEXA scans completed and when the next DEXA scan was due. The submitted data was confusing, because the next appointment date was often in the past (2011 or 2013), and there was no information to indicate whether the DEXA had been completed for these "next appointment dates." A single T-score was submitted in each case. This could have referred to the T-score from the DEXAs completed or could have referred to the T-score from the DEXAs that were listed under "next appointment" and that date had passed (i.e., 2011 to 2013). Of the 233 names listed, 98 included a diagnosis of osteopenia, and 18 were listed as "preventative" (referring to the DEXA test). The remaining 135 were diagnosed with osteoporosis. It was noted that there were 23 with a diagnosis of osteopenia with a T-score greater/higher than -1.0 (which is usually interpreted as the cut off value for osteopenia. For example, a more positive score than -1.0 and approaching 0 or in the plus range is considered normal). These 23 had a diagnosis of osteopenia, but with a T-score indicating normal bone density. It was noted that there were 28 with a diagnosis of osteoporosis with a T-score greater/higher than -2.5 (which is usually interpreted as the cut off value for osteoporosis. For example, a score of -2.5 or more negative is considered osteoporosis and a score more positive is considered osteopenia if less than -1.0 or normal if greater than -1.0). Other variables were not part of the database submitted. Some individuals might have had improvement from medication and the scores reflected this, and some diagnoses might have been based on other information such as fragility history, FRAX (fracture risk assessment score), etc. However, the two lists needed to be reviewed and potentially revised in order to provide information useful in guiding the PCPs. It was not clear if the DEXAs were up-to-date. It was not indicated whether those not prescribed calcium and Vitamin D supplementation	

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		were receiving the appropriate amount through diet or nutritional supplements. That only 98 of 137 were prescribed specific medication to optimize treatment for osteoporosis needed further review. It could not be determined if some were on a drug holiday, were found not appropriate for additional medication, were waiting on dental clearance, or whether the database was incomplete, etc. For men with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted no data for any laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. For women with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted no data for any laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Five Nutrition Services Comprehensive Assessments were reviewed that most recently had been completed for those with a diagnosis of osteoporosis. The assessments were reviewed for content concerning calculation of daily calcium and Vitamin D in the diet and supplements. Several organizations have provided guidance in dietary intake of these nutrients. The Monitoring Team member used the National Osteoporosis Foundation as guidance in reviewing the amount of calcium and Vitamin D offered to the individuals. The National Osteoporosis Foundation recommends that men ages 50 to 70 consume 1000 mg per day of calcium, and women age 51 and older and men age 71 and older consume 1200 mg per day of calcium. Calcium supplements are recommended when an adequate dietary intake is not achieved. The average daily dietary calcium intake in adults was estimated at 600 to 700 mg per day, indicating many adults would need about 400 to 600 mg of additional calcium daily. The National Osteoporosis Foundation also advised against daily intake exceeding 1200 to 1500 mg as there was no evidence of additional benefit to bone health/strength, and excessive amounts had potential risks. The Institute of Medicine indicated that calcium intake from all sources in excess of 2000 mg might increase the risk of harm. It is important to determine the daily dietary intake of calcium in order to provide the appropriate amount of supplementation. Recommended intake of Vitamin D, according to this organization, was 800 to 1000 International Unit (IU) for those over age 50. *The Committee to Review Dietary Reference Intakes for Vitamin D and Calcium,* National Research Council/Institute of Medicine (2011) indicated Vitamin D intake should be 600 IU daily until age 70, and then 800 IU at age 71 and older. Discussion in assessments of diet and Vitamin D levels and supplementation would allow a determination of the recommended daily amount offered. Vitamin D levels often determine effectiveness of Vitamin D intake and absorption, with adjustment in supplements based on these lab values. A review of these nutritional assessments provided the following information in guiding the PCPs to prescribe the appropriate level of supplementation of calcium and Vitamin D. ▪ Zero of five included the daily amount of calcium available in the offered diet.	

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		▪ Zero of five included the daily amount of Vitamin D in the offered diet. ▪ Three of five individuals were prescribed a multivitamin. Zero of three assessments included the amount of calcium in the daily multivitamin/mineral supplement when prescribed. Zero of three included the amount of Vitamin D in the daily multivitamin/mineral supplement when prescribed. ▪ Five of five included the total daily supplementation of calcium other than in a multivitamin/mineral supplement. The range of supplementation was 1228 mg per day to 1500 mg per day. ▪ Five of five included the total daily supplementation of Vitamin D other than in a multivitamin/mineral supplement. ▪ Zero of five calculated the total daily intake of calcium in the diet and supplements. ▪ Zero of five calculated the total daily intake of Vitamin D in the diet and supplements. It was noted that the supplements of calcium alone provided the daily requirement of calcium. Given that the amount of calcium from diet or the multivitamin/mineral supplement was not provided, the total daily intake could not be calculated to determine the appropriateness of treatment consistent with the National Osteoporosis Foundation guidelines. Other professional organizations might have recommendations with additional/alternative guidance. As there are other clinical factors to consider in prescribing these nutrients, it is recommended that this area be reviewed to determine the appropriate optimal dosage of calcium for each individual with osteopenia or osteoporosis. The nutritional services comprehensive assessment provided a breadth of information, including current diagnosis, current medication, current diet order, anthropometric assessment, biochemical data, and oral health status. Four of five provided some indication of the dietary intake of the individual (i.e., ate all, variable intake, good acceptance of diet, etc.). It also included a summary of estimated daily nutrient needs. However, for three of five, the specific offered diet did not record information as to calories per day. Mentioned was regular diet or maintenance diet, but no specific calorie amount or range was listed. Although the estimated daily nutrient needs were listed, the assessments did not list the amounts of these components (e.g., protein, fiber, calcium, Vitamin D) in the offered diet, whether they met the daily requirements or whether the appropriate amount of supplement was prescribed or should be reviewed. Such information would guide the PCP in prescribing the optimal dose of any supplementation needed. From the sample of five medical records reviewed, three had a diagnosis of osteopenia or osteoporosis. Three had completed a DEXA scan. Two of these DEXA scans were completed in the prior three years. ▪ Of these, three of three (100%) had a DEXA scan/T-score recorded. ▪ Of these, three of three (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these, three of three (100%) had been prescribed supplemental calcium and Vitamin D. ▪ Of these, three had additional medications prescribed to treat osteoporosis. <u>Down Syndrome and Hypothyroidism</u> A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 11 individuals were identified with a diagnosis of Down syndrome. As of the scan date of 1/30/14, 11 of 11	

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(100%) had a thyroid test completed within the prior 12 months. The Facility was considered to be in substantial compliance with this clinical area.

Acute and Emergency Care

Documentation was provided for Emergency Room visits from August 2013 through January 2014. The following table lists the analysis of this raw data by month, the number of ER visits for the month, and the most frequent/common categories of diagnosis for the visits, based on the submitted documentation. The Facility categorized this information:

Month	ER Visits	Trauma	GI	Respiratory	Neur-ology	Infection	Cardi-ology	Bleeding	Other
August 2013	19	0	0	0	0	0	3	3	13
September 2013	17	1	0	0	0	0	2	2	12
October 2013	17	0	1	1	0	0	2	1	12
November 2013	12	0	0	0	0	0	1	1	10
December 2013	15	1	2	0	0	0	2	0	10
January 2014	13	0	0	0	0	0	0	5	8
Total	**93**	**2**	**3**	**1**	**0**	**0**	**10**	**12**	**65**

The active record was reviewed for 10 individuals who had most recently gone to the ER and returned. These individuals are listed in the documents reviewed section. There was limited information for one individual submitted. For this one individual, the record had been checked out by another entity and was not available as of 1/31/14 for copying. The following information was based on the nine individuals for whom requested documentation was submitted. The following summarizes the results of this review:

- Information was submitted indicating that the ER was notified prior to the arrival of the individual with appropriate medical background information provided for four of nine (44%) individuals.
- Prior to the transfer to the ER, a PCP was on-site for four of these transfers. In four of four (100%) records, the PCP had written an IPN that included the date and time.
    - For three of four (75%) PCP transfer IPNs, there was reference to vital signs or vital signs were recorded in proximity to the PCP transfer IPN.
    - For four of four (100%) PCP transfer IPNs, reason for the transfer was documented.
    - In four of the four (100%) PCP transfer IPNs, the SOAP format was utilized.
- A copy of the ER report was available in nine of nine (100%).
- Of the 10 ER visits, diagnostic categories included: trauma (four), infection (two), gastrointestinal

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(two), and vascular (one).

- When the individual returned to the Facility after evaluation at the ER, nine of the nine (100%) active records had a PCP IPN.
- Nine of nine (100%) post-ER visit PCP IPNs included date and time.
- Nine of nine (100%) post-ER visit PCP IPNs referenced vital signs or vital signs were recorded in proximity to the IPN.
- Nine of nine (100%) post-ER visit PCP IPNs utilized a SOAP format.
- A summary of ER information and findings was included in nine of nine (100%) PCP IPNs.
- For nine of nine (100%), treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER.

The Facility provided information concerning the number of hospitalizations per month, with the main diagnosis listed per admission. The following lists this information, broken down by month. The most frequent diagnoses are listed. Facility staff provided this data:

Month	Admissions	Respiratory	Neurology	GU	GI	Bleeding	Infection	Other
August 2013	21	2	0	0	0	1	0	18
September 2013	17	0	2	0	0	0	0	15
October 2013	20	0	4	0	0	0	0	16
November 2013	23	0	2	0	0	0	0	21
December 2013	15	1	2	0	0	0	0	12
January 2014	18	2	0	0	1	1	0	97
Total	**114**	**5**	**10**	**0**	**1**	**1**	**0**	**97**

Additionally, five active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review:

- Five individuals returned to the Facility. No individual died while in the hospital.
- Three of five (60%) had PCP IPNs post hospitalization. For two individuals, no PCP IPNs were submitted post hospitalization. It could not be determined whether the PCP IPNs were written but documentation was not submitted, or whether the PCP did not complete IPNs. It appeared this information was not submitted and the request was not completed.
- Of the three post-hospital PCP IPNs submitted, three of three (100%) included vital signs, attempted vital signs, or there were adjacent IPNs with vital signs recorded.
- Three of three (100%) post-hospital PCP IPNs included date and time.

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- Three of three (100%) post-hospital PCP IPNs had an adequate summary of hospital events and findings.
- Three of three (100%) post-hospital PCP IPNs used the SOAP format.
- Five of five (100%) active records of the hospitalized individuals included a copy of the hospital admission history and physical.
- Five of five (100%) active records included a copy of the hospital discharge summary.
- Five of five (100%) included Hospital Liaison nurse notes for the individuals.
- For three of three (100%) individuals that returned to the Facility in which IPNs were provided, additional PCP IPNs were included as part of the follow-up.
- Of the five hospitalizations, major organ system categories included the following: Infection (two), metabolic concerns (two), and orthopedic (one).

AUSSLC had an Infirmary. Documentation was provided for Infirmary admissions from August 2013 through January 2014. The following lists the month, the number of Infirmary admissions for the month, and the most frequent/common category of diagnosis for the admissions, based on submitted data. For the following chart, he Facility determined the category for each Infirmary admission:

Month	Admiss-ions	Trauma	GI	Respi-ratory	Infec-tion	Fever	Met/end*	Neur-ology	Dental / Post-op	Other
August 2013	45	3	2	1	0	0	0	2	0	37
September 2013	38	0	2	0	0	1	0	4	0	31
October 2013	44	0	3	3	0	0	0	5	0	33
November 2013	52	0	3	3	0	3	0	6	0	37
December 2013	74	1	3	5	0	0	0	5	1	59
January 2014	68	0	3	2	0	1	0	1	7	54
Total	**321**	**4**	**16**	**14**	**0**	**5**	**0**	**23**	**8**	**251**

*- met/end = metabolic/endocrine

It was noted in the submitted data for ER visits, hospitalizations, and Infirmary admissions, that the "other" category was the major diagnostic category, and several major categories of illness had few entries. The Monitoring Team member was provided a copy of the Infirmary admissions and categorized admissions according to the most common categories. The above chart was given to staff during the onsite review, and

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		Facility staff completed the list and submitted it back to the Monitoring Team. The list below was adjusted to remove fever and add cardiovascular. However, the differences in numbers in most categories indicate the need to develop clear guidance in determining the organ system or diagnostic category as it is entered. This information will be useful in guiding the Medical Department, once the data is accurate, in determining categories of illness or health impairment. A category for genitourinary concerns (GU) was added due to the number of admissions involving this organ system. The infection category excluded respiratory or genitourinary infections, as these are best identified in their respective organ system rather than the general term "infection." Tracking categories of illness is an initial step in focusing time and research into causative factors. The Facility may need to change the categories to include the most common diagnostic categories over time, especially if some are affected by seasons. The categorizations based on diagnoses will need continuous guidance from the Medical Department to assist in creating a quality database. This should include physician support to the staff completing this information.	

Month	Admissions	Trauma	GI	Respi-ratory	Infec-tion	Met/ end	Neur-ology	GU	Cardio	Other
August 2013	45	3	9	11	3	2	6	4	2	5
September 2013	39	7	9	0	4	2	5	5	4	3
October 2013	46	2	7	8	6	2	8	7	3	3
November 2013	52	2	10	8	5	2	5	4	2	14
December 2013	74	3	5	8	10	8	5	4	2	29

This revision of applicable diagnoses for each category resulted in more detailed information. It also focused on the number of "other," which increased in November and December. In both of these months, the Dental Department used the Infirmary for post-anesthesia monitoring and post-procedure care. For December, orthopedics appeared as a significant "other" category. The prior data, although time-consuming for staff to calculate, did not provide the needed detail to determine any trend or changes. This information should be available on an ongoing basis and the Medical Department should use it, and not just provide it in response to a document request from the Monitoring Team.

For those that were discharged from the Infirmary, the length of stay was recorded as follows:

- The number staying one day or less was 144.
- The number staying two days was 31.
- The number staying three days was 26.
- The number staying four days was 14.
- The number staying five days was 18.

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		▪ The number staying six days was 16. ▪ The number staying seven to 10 days was 21. ▪ The number staying 11 to 20 days was 20. ▪ The number staying 21 to 30 days was two. ▪ The number staying 31 to 60 days was one. ▪ The number staying 61 or more days was zero. *Pneumonia* Data was submitted that had been entered into the Avatar database. The actual copy of the tracking forms, which was requested, was not submitted. As a result, information for the following was not submitted: location (i.e., on-site or off-site/hospital) of diagnosis of pneumonia; whether chest x-ray completed, and if so, confirmed a pneumonia; results of any blood cultures; whether taking food by mouth (PO) with or without textured diet or thickened liquids; whether fed by enteral feeding tube; and rate of feedings if by tube (i.e., bolus, intermittent, continuous). The incidence per month from the Avatar database was as follows:	

Month	# of Pneumonia Cases	# of Aspiration Pneumonia Cases	# of Bacterial Pneumonia Cases
July 2013	5	3	2
August 2013	10	7	3
September 2013	3	1	2
October 2013	5	2	3
November 2013	9	6	3
December 2013	2	1	1
Total	**34**	**20**	**14**

From the Avatar data, the Facility was able to break down the cases of aspiration pneumonia by age. Eleven of 20 cases occurred in the fifth decade. Immunization status was reviewed with those with bacterial/viral pneumonia. It was documented that of the 14 cases of bacterial pneumonia, only one individual had received the pneumococcal vaccination in the prior 10 years. For the others, the pneumococcal vaccine had not been given, or more than 10 years had lapsed. For those with aspiration pneumonia, the data provided information as to whether the individual was fed orally or by feeding tube. Thirteen of 20 utilized a feeding tube and seven were fed orally. For those with bacterial/viral pneumonia, eight of 14 utilized a feeding tube and five of 14 were fed orally. For one individual, this information was not provided.

An additional submitted document entitled: "pneumonia and oral feedings 7/1/13 to 12/31/13" listed 11 individuals with PO intake. The reason for the lack of agreement with the Avatar data was not determined. Of the 11 individuals listed with PO intake, five required thickened liquids, and 10 required textured solid food (i.e., pureed, chopped, etc.). Five had a swallow study completed in 2013. Six had a swallow study prior

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		to 2013 (from 1997 to 2012). From a separate document entitled "Absolute numbers of new cases for pneumonia – 2013 Pneumonia cases," the numbers were not identical to the Avatar information. For July 2013, there were four pneumonias; for August 2013, 10 pneumonias; for September 2013, there were two pneumonias; for October 2013, there were three pneumonias; for November 2013, there were nine pneumonias; and for December 2013, there were two pneumonias. There was agreement with the Avatar data for August 2013, November 2013, and December 2013. It is recommended that the Facility continue to review the various databases to determine reasons for discrepancies and resolve the differences in the databases. From the document entitled "Individuals who have been newly diagnosed with pneumonia," the numbers of pneumonia cases differed from the above other databases. The information submitted indicated the following numbers of pneumonia cases: August 2013 (five pneumonias – all were aspiration pneumonia), September 2013 (one pneumonia), October 2013 (one pneumonia), November 2013 (five pneumonias of which three were aspiration pneumonia), and December 2013 (one aspiration pneumonia). Data in this database included all of 2013. It was noted that the Facility recorded 33 cases of pneumonia from January through June 2013. The Facility recorded 15 cases from July through December 2013. Considering the differences in information for the pneumonia data across several databases, the degree of accuracy of this database could not be determined. However, it did indicate the need for a focus on accurate and consistent database management. From this one database, it could not be determined if this was a cyclical pattern at AUSSLC or the improvement in the second half of the year was an outcome of an improved aggressive approach to pneumonia prevention. There continued to be various databases concerning pneumonia cases at AUSSLC, despite review of the process for pneumonia database management (i.e., as discussed in further detail below). The Facility is encouraged to continue to review the several databases concerning pneumonia to ensure they are complete, accurate, and in agreement. An untitled document, dated 9/4/13, provided a summary of data from 9/1/12 through 8/31/13. A Pneumonia Task Force (with interdisciplinary composition) was created due to the high incidence of pneumonias relative to other SSLCs. At that time, several assignments were made to departments, including meal time coordination to address oral intake (by 9/15/13), habilitation therapies review of supports for those with a history of aspiration and taking food and fluid by mouth, a habilitation therapies and nursing review of those with enteral feeding tubes (by 9/12/13), development of a protocol to be used by PCPs in reviewing diagnoses of pneumonia at the time of hospital discharge (by 8/31/13), a database entry protocol (by 8/31/13), and weekly review of mealtime coordination by both units and administration (by 9/23/13). Meeting minutes of the 10/23/13 Pneumonia Task Force were submitted, indicating ongoing efforts to address many specific clinical and documentation concerns. Of note, there was concern for double reporting of pneumonia cases. The form "Tool for Confirming Pneumonia Diagnosis" provided a template with information to be documented, including diagnostic tests completed, signs and symptoms, and lab values,	

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		with a final statement of PCP confirmation or not of pneumonia. A second page of this tool provided specific information with focus on aspiration pneumonia. The data on this second page included the type of pneumonia, whether there was a history of prior pneumonia, immunization status, risks for aspiration (i.e., feeding tube, feeding formula rate, oral hygiene), and evaluation of dysphagia (i.e., date of modified barium swallow study), or GERD (i.e., date of gastric emptying study, EGD). There was also a section determining specific acute conditions immediately prior to the onset of pneumonia (i.e., seizure, emesis, etc.), and acute and chronic mechanical conditions (i.e., position of feeding tube, gastric residual, etc.). This provided a methodical root cause analysis of each pneumonia/aspiration pneumonia. This tool was created in November 2013, and revised in February 2014. The Look-Back Tool protocol was to include an interview with the direct support professionals. Data was provided from July through December 2013, and was reviewed at the 1/15/14 Pneumonia Task Force meeting, according to the agenda (no minutes were provided to confirm discussion of this data). Several graphs were submitted for this time period. One graph documented the pneumovax immunization status with bacterial/viral/other pneumonia diagnoses. Six of seven individuals with pneumonia from October 2013 through December 2013 had not received this immunization, or the last immunization was greater than 10 years prior to onset of the pneumonia. During this same time period, seven of nine aspiration pneumonias were diagnosed in those with feeding tubes versus oral intake. This information provided guidance for clinical interventions. The data to be collected and forms to be completed appeared to encompass the major areas that should be reviewed for each pneumonia case. This had significant implications in potential to prevent recurrent pneumonia by ensuring major contributors to pneumonia were reviewed and core diagnostic tests and procedures considered. The challenge will be implementing this protocol and monitoring to ensure compliance, as well as tracking the impact with complete and accurate data. It was noted a Urinary Tract Infection (UTI) and emesis subcommittee were to be formed to address these conditions. *Respiratory Distress* For six individuals most recently sent to the ER or hospitalized for acute respiratory distress, the Facility submitted any evaluations to rule in or rule out dysphagia and GERD. Supporting documentation was provided. ▪ Five of six had Esophagogastroduodenoscopy (EGD) documentation submitted. The most recent EGDs per individual dated from 2009 through 2013. ▪ Five of six had MBSS documentation. For an additional one of six, it is likely that an MBSS was completed in the remote past. ▪ Two of six had evidence of a gastric emptying study. ▪ Four of six indicated fundoplication or repair/revision of a slipped fundoplication. ▪ Four of six had an enteral feeding tube. ▪ One of six had a tracheostomy. ▪ Six of six had various consultants involved in evaluation and treatment of GERD or dysphagia or	

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		both. ▪ Four of six were prescribed medication for GERD. ▪ One of six had additional testing for food allergies. These chronic conditions are an ongoing challenge, often associated with a slow or silent worsening of these diagnoses, at some point necessitating consultations, and review for surgical and other medical options. These six cases demonstrated a quality review of these conditions with an appropriate aggressive approach to evaluating and treating dysphagia, GERD, and gastroparesis in the most recent six individuals with acute respiratory distress. The Facility provided evidence of substantial compliance in this clinical area for these chronic conditions. *Sepsis* From a document entitled "Individuals who have been newly diagnosed with sepsis for past year," one individual was diagnosed with sepsis in the time period from August 2013 through December 2013. AUSSLC submitted minutes for the Infection Control Committee. There were no meetings in July or August 2013. Minutes were submitted for 9/19/13, 10/28/13, and 12/17/13. On 11/20/13, there was an additional meeting with focus on C difficile infections. This reviewed both clinical and administrative steps to reduce C difficile infections. A "C difficile training" document was submitted. It included contents of a training program held during three shifts on two days (1/29/14 and 1/31/14). There was an action plan to reduce the occurrence of this infection, including timely communication with home personnel, housekeeping, food services, and nursing, along with the various department roles in terminal cleaning to prevent spread of infection. <u>Trauma</u> During the time period from August 2013 through December 2013, there were five fractures. There were no events in which more than one fracture occurred. The fracture sites included the following: ▪ Three upper extremity: right wrist, right 5th finger, left 4th finger; and ▪ Two lower extremity: right tibial plateau, and left hip. During the time period from August 2013 through December 2013, 26 individuals went to the ER or were hospitalized for injuries. The five individuals with fractures were included in this total. Two of the individuals with fractures were admitted to the hospital. The breakdown of injuries per month requiring ER or hospitalization were as follows:	

Month	Number of Injuries Requiring ER Visit or Hospitalization	Month	Number of Injuries Requiring ER Visit or Hospitalization
August 2013	6	September 2013	9
October 2013	3	November 2013	4

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December 2013	4		

Chronic Conditions and Specific Diagnostic Categories

GERD
As part of the review of five records, GERD was reviewed.

- Of the five, five were diagnosed with GERD. Not each case would have had the listed test or procedure, but the following provides evidence of the spectrum of treatment at the Facility.
- Two had an EGD with results available or discussed in the IPN/ISP.
- One had a fundoplication.
- Three had a feeding tube.
- Four had appropriate medication prescribed.
- Zero had a tracheostomy.
- Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in five of five reviews.

Tracheostomies
Three individuals currently had tracheostomies.

Newly Diagnosed Chronic Conditions
Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus type II. No individuals were newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year.

Pica
An updated and complete list of pica or ingestion of inedible objects was submitted for the time period of August 2013 through December 2013. This included five events involving three individuals. No pica incident required an ER visit or hospitalization during this period of time.

Month	# of Pica Events	# of Individuals	ER Visit	Hospitalization	Procedure/surgery
August 2013	3	2	0	0	0
September 2013	0	0	0	0	0
October 2013	1	1	0	0	0
November 2013	1	1	0	0	0
December	0	0	0	0	0

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2013					
January 2014	0	0	0	0	0
Total	**5**	**4**	**0**	**0**	**0**

Chronic Constipation
Two hundred thirty six individuals had a diagnosis of constipation or received treatment for constipation at least weekly. A document entitled: "Absolute numbers of new cases of bowel obstruction" listed the number of bowel obstructions per month:

Month	Number of Bowel Obstructions	Month	Number of Bowel Obstructions
July 2013	2	October 2013	0
August 2013	1	November 2013	0
September 2013	0	December 2013	0
Total	**3**		

Enteral Feeding Tubes
The Facility submitted information that there were no individuals identified as having jejunostomy tubes or gastro-jejunostomy tubes.

Skin Integrity
The Facility indicated a Skin Integrity Committee did not exist at AUSSLC.

A document entitled "absolute numbers of new cases for decubitus ulcers" provided the number of new cases per month at AUSSLC:

Month	Number of Decubiti	Month	Number or Decubiti
July 2013	0	October 2013	0
August 2013	0	November 2013	1
September 2013	2	December 2013	2
Total	**5**		

A report of individuals with skin integrity concerns was provided weekly at the morning medical meeting.

Seizure Management
A list was submitted indicating that approximately 136 individuals had a diagnosis of a seizure disorder as of 1/31/14.

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		The Facility submitted information concerning antiepileptic medication usage. As of a scanning date of 1/31/14, 133 individuals were prescribed antiepileptic medication. However, from a document submitted entitled: "A list of all individuals being treated for seizure disorders," only 43 individuals were listed. It is recommended the database for seizures be reviewed (i.e., number of individuals, management, etc.), because this second list appeared incomplete. Of these, 58 of 133 (44%) were prescribed one antiepileptic medication, 38 (29%) were prescribed two antiepileptic medications, 20 (15%) were prescribed three antiepileptic medications, 13 (10%) were prescribed four antiepileptic medications, and four (3%) were prescribed five antiepileptic medications. Additionally, three individuals with a diagnosis of seizures were on no antiepileptic medications. Forty-three individuals were considered to have a refractory seizure disorder. Twelve of 43 had a vagus nerve stimulator (VNS) implant. There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS. In the prior six months, two individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. There were two individuals with status epilepticus in the prior six months. Both were sent to the ER. A list was submitted indicating the percentage of individuals prescribed older antiepileptic medications. Information submitted indicated that 28 of 133 (21%) individuals were prescribed one or more of the following: Dilantin, Primidone, Phenobarbital, and Felbamate. The Facility did not submit a further breakdown of the data into the number/percentages of individuals on each of these medications. Additionally, 25 individuals had a VNS implant. From a document entitled "VNS list," six of the 25 were marked as N/A (not applicable) under the date of replacement. The reasons were not given, but might have indicated the individual was not using or no longer had a VNS. Requested documents included seizure management (e.g., neurologist's notes) for the past six months for five individuals. The Facility submitted neurology consultation notes documenting seizure management for three individuals. For one individual, ENT notes were submitted rather than neurology clinic notes. For a second individual, neurology clinic notes were submitted for an individual with dementia, but without a diagnosis of seizures. These individuals are listed in the documents reviewed section. The following provides a summary of the review of the three submitted records for individuals with a seizure disorder: ▪ For two of the three (67%) individuals, the notes indicated a description of the seizures. Reference was made to attachments, which might have provided a description of the seizures in one of three, but these were not submitted. ▪ For three of the three (100%) individuals, the notes documented frequency of seizures. ▪ For three of the three (100%) individuals, the notes or referenced information included a review of current medications for seizures and dosages. ▪ For three of three (100%) individuals, notes or referenced information included recent blood levels	

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		of antiepileptic medications. ▪ For three of three (100%) individuals, notes included recommendations. <u>Do Not Resuscitate Orders</u> A total of 16 individuals at the Facility had DNR orders in place. The dates of the DNRs were submitted. DNR orders were initiated for three individuals in 2013, for six individuals in 2012, for two individuals in 2011, for zero individuals in 2010, for three individuals in 2009, and for two individuals in years prior to 2009. For 16 of 16 (100%), adequate clinical justification was provided for the DNR. Clinical justification included the following: seven individuals had dementia, four had compromised respiratory function, one had a cardiac diagnosis, two had cancer, one had severe kidney disease, and one had anatomic abnormalities with severe osteoporosis, which would cause CPR to be ineffective. Additional information was provided concerning DNR decisions in the prior six months. One individual had been on a DNR, and this was changed to a full code status, because the individual had recovered from an illness considered terminal earlier in 2013. A detailed ISPA document discussing lifting of the DNR was submitted. Two other individuals had a DNR instituted in the prior six months. The Ethics Committee consult request reviewed the conditions considered terminal. These appeared appropriate. A copy of the signed "Out of Hospital (OOH) DNR order" form was submitted. The Facility Ethics Committee met on the following dates to discuss specific individuals to review DNR status: 8/12/13, 8/26/13, 9/26/13, 10/25/13, and 11/7/13. Four meetings involved a discussion of DNR status for three individuals. One meeting reviewed the risk/benefits of psychiatric medication. Minutes of the Facility Ethics Committee included the following components: ▪ Five of five (100%) meeting minutes documented date and time. ▪ Five of five (100%) meeting minutes included the name(s) of individuals for discussion of DNR. ▪ Four of five (80%) meeting minutes listed names of attendees. ▪ Five of five (100%) meeting minutes included a signature sheet. ▪ Five of five (100%) included meeting minutes that included a synopsis of the proceedings and critical review of information. ▪ In four of four (100%) applicable cases, meeting minutes included a summary of discussion with family/guardian. ▪ Five of five (100%) meeting minutes included discussion by the physician. ▪ Five of five (100%) meeting minutes included a recap with recommended action steps outlined. ▪ In two of two (100%) applicable cases meeting minutes included documentation of any DNR documents signed based on the decision of the Ethics Committee. ▪ In zero of three (0%) meeting minutes, for meetings assigning follow-up, subsequent documentation of closure of those assignments was submitted. These closures included sending an OOH –DNR form for guardian/parent signature (the DNR roster submitted did not include the individual's name, indicating lack of closure of the DNR discussion), a formal consult to a psych-pharmacologist had no evidence of closure submitted, and a hospice referral had no evidence of closure.	

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		Mock Code Drills and Emergency Response Systems Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Non-facility Physician Case Reviews During the prior six months, the Facility completed one non-facility physician audit review (Round #8). This occurred from 10/24/13 to 10/25/13. The following represents a synopsis of the information: ▪ For this external medical peer review, PCP compliance in essential areas ranged from 81 to 100 percent. For areas considered non-essential, compliance ranged from 86 to 96 percent. It was noted that two PCPs had 100 percent compliance in essential areas. One Facility physician was not represented in the random sample. This was due to the fact that data being used for the random sampling did not reflect current changes in individuals moving between residences. As a result, the random sample did not include any individuals on one physician's caseload. ▪ The external audit review process information indicated the number of records chosen for review. A total of 12 records were reviewed. Three records were reviewed for the general medical quality assurance audit. Nine records were reviewed for the medical management audit (i.e., three records each for UTI, seizures, and constipation). ▪ The external audit review process information indicated how the sample was obtained. ▪ Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: (4) Is the Annual Physical Exam complete, including the past medical history, family history, and a plan of care? (9) Has the MMR (Measles-Mumps-Rubella vaccine) been given? (14) Has the Varicella (titer or vaccine) been given? (15) Has the Zostavax (if >60) been given? (19) Have the appropriate preventive screenings for colonoscopies been provided? The QA Department did not provide a list of most commonly missed clinical indicators/questions. The above was obtained by matching the audit question to a graph, which provided compliance for all medical records by question. ▪ From the external peer review audit, there were no corrective action plans generated. Although requested, the QA Department was unable to provide any documentation that corrective action plans had been distributed, and serially followed up to determine if the corrective actions had been completed for Round #8. ▪ The most recent available information the QA Department submitted concerning the external medical management audit was from 4/18/13. Although the QA Department did not have the results of an external peer review medical management audit subsequent to that date for Round #8, the Medical Department supplied the information through the pre-visit document request. The data was not dated, but the data had different values from the 4/18/13 information the QA Department submitted. This data was interpreted as being derived from the Round #8, October 2013 medical	Noncompliance

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		management audit. The three areas of clinical focus were: constipation, seizures, and UTI. For all records reviewed, compliance for constipation was 92 percent, for seizures was 80 percent, and for UTIs was 100 percent. Compliance of all external medical management audit questions per PCP ranged from 80 to 100 percent. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: Constipation: (3) Is there evidence that the PCP documented follow up effectiveness of the treatment plan including side effects?; and Seizures: (6) If individuals' seizures are stable has the PCP considered and documented the need to continue the same seizure medications versus a reduction in the medication? ▪ From the external medical management audit for Round #8, there were no corrective action plans generated and distributed to the PCPs for resolution. There was no evidence the QA Department tracked these corrective action plans to resolution. ▪ The external reviewer had provided the Facility with a summary of the review. ▪ On 10/25/13, a Medical Provider Exit Interview was conducted. ▪ The exit interview identified strengths such as the following: overall documentation had improved, annual medical assessments were on time and more thorough, quarterlies were completed on time, quarterly drug reviews were completed on time, immunization documentation had improved, acute care documentation had improved, SOAP format was used more frequently and documentation had improved, and the quality of medical care provided for constipation and UTIs had improved. ▪ The exit interview identified areas needing improvement such as the following: the annual medical assessment needed better documentation of family history, the latest State office form for the preventive care flow sheet was not being used, seizure documentation addressing risk and benefits of tapering medication needed to be addressed in the annual medical assessments and quarterlies, and all medications needed to match the diagnoses. ▪ Additionally the Monitoring Team member noted that compliance rates were calculated as an average of all PCP scores. Additionally, each PCP was tracked for compliance. ▪ There was no information concerning follow-up of any frequently missed questions, which might indicate need for training, systems changes, etc. Without the corrective action plans, it was difficult for the Medical Department to review findings with the PCPs. There did not appear to be a separate medical staff meeting that generated minutes documenting a discussion of the results of the external peer review results. There were no Medical Department staff meeting minutes submitted that documented implementation of steps to correct the deficiencies noted in the external peer review audits. There were no Medical Department staff meeting minutes submitted that documented a discussion of systemic improvements to be developed and implemented to reduce deficiencies noted in the external peer review findings. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days from the Monitoring Team's visit. Since the time of the Monitoring Team's last visit, one death had occurred:	

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		▪ The age at death was over the age of 65. ▪ The cause of death was determined to be aspiration pneumonia. ▪ An autopsy was not performed. ▪ DNR status (Resuscitative Status II) was ordered while residing at AUSSLC, and the individual was on DNR status at the hospital. ▪ The individual died in a hospital setting. ▪ The individual had been hospitalized previously in the six months prior to death. ▪ The individual had a feeding tube, and had a fundoplication. ▪ The individual was not enrolled in hospice. ▪ The individual was non-ambulatory. Since August 1, 2013, one clinical death review investigation and one administrative death review were completed. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death review. The administrative death review recorded the final list of recommendations for the death review process of the individual. The one administrative death review had one recommendation. This recommendation was extensive and had positive effects on several departments (i.e., medical, nursing, habilitation, residential, etc.). The Facility submitted follow-up documentation for one of one (100%) recommendation.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends;	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. <u>Medical Department Internal QA System</u> The data from one internal medical peer review was provided. This peer review occurred on 1/27/14. The audit questions were identical to those used in the external medical peer review audit. According to submitted QA data, compliance for PCPs in essential areas ranged from 74 to 100 percent. Compliance for PCPs in non-essential areas ranged from 92 to 99 percent. Separately, information obtained from document requests indicated that compliance for PCPs in essential areas ranged from 74 to 80 percent. Compliance in nonessential areas ranged from 88 to 95 percent. It was noted that from this latter information, only three PCPs were listed as having scores from the internal audit. The reason for not including two other PCPs in the data was not provided. Separately, compliance for all PCPs in essential and nonessential areas of an internal medical peer review audit was submitted. This was undated, and results were not identical to the results of the 1/27/14 audit results already mentioned. This might have represented the same audit with different calculated results, or might have represented an internal medical peer review audit of 10/18/13, if one occurred at the same time as the external medical peer review audit. The information in this additional "internal audit" was not dated. It listed each PCP individually, compliance with essential and nonessential areas, and each question that remained noncompliant in the general medical audit. This information also was listed as results from Round #8. It is recommended that data and reports be clearly identified by date of completion so as to ensure	Noncompliance

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	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	correct interpretation of findings. Areas that appeared to need improvement included answers to the following audit probe questions: (1) Was the Active problem list dated and signed when it was last reviewed? (4) Is the Annual Physical Exam complete, including past medical history, family history, and a plan of care? (6) Are drug and/or food allergies, intolerances, or reactions appropriately documented? (8) If the individual uses tobacco products, was there documentation for recommendation for cessation of tobacco use? (9) Has the Measles-Mumps-Rubella immunization been given? (14) Has the varicella (titer or vaccine) been given? (15) Has the Zostavax (if >60) been given? (17) Have the appropriate preventive screenings for mammograms been provided? (26) Was the preventive care flow sheet updated at the time of the last annual assessment? (30) Do the Medication Orders for acute conditions include indication and duration for all the medications prescribed? (34) Are all diagnostic test results and consults initialed and dated? and (42) Did the provider indicate resolution and closure of acute problems in the integrated progress note? For the internal medical peer review audit, there were no corrective action plans identified. There was no information submitted concerning tracking these corrective action plans to closure by the QA Department. The QA Department submitted information for the most recent internal medical management audit. Information was dated 4/20/13. It did not appear the QA Department had updated information. From the Monitoring Team's pre-visit document requests, information was submitted from a more recent internal medical management audit, which might have been completed 1/27/14. Utilizing the same audit questions from the external medical management peer review for the following clinical concerns, compliance among PCPs ranged from 81 to 100 percent. Information for four of five PCPs was included in the audit results. Medical compliance by diagnosis for all PCPs was as follows: Constipation (97%), Seizures (78%), and UTI (80%). Areas that appeared to need improvement included answers to the following audit probe questions: Constipation (3) Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects? Seizures (4) Quarterly review of seizures documented by the PCP with recommendations? (6) If individuals' seizures are stable has the PCP considered and documented the need to continue the same seizure medications versus a reduction in the medication? and UTI (3) Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN of that individual's response? For the internal medical management peer review audit, there were no corrective action plans identified. There was no information submitted concerning tracking these corrective action plans to closure. <u>Inter-rater reliability</u> The QA Department did not provide the inter-rater reliability data for the past six months. <u>Medical Department Initiatives based on internal medical peer review findings.</u>	

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		▪ For the internal medical peer review findings, there was no evidence the Medical Department completed medical staff meetings to discuss results. ▪ There was no submitted documentation providing evidence that minutes of the medical staff meetings identified and discussed areas needing improvement. ▪ There was no evidence that minutes of the medical staff meetings documented development of a plan of improvement. ▪ There was no evidence that minutes of the medical staff meeting documented implementation of a systemic plan of correction for the Facility. ▪ The Medical Department response would have benefited from distribution of corrective action plans with serial follow up to determine closure and whether closure occurred promptly or was delayed. <u>Medical Department Internal Reviews/Initiatives and Improvement Projects</u> The Medical Department implemented the following additional processes for internal peer reviews: ▪ Quality indicators were identified for clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. These are discussed in more detail with regard to Section H.4.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Since the last Monitoring Team's visit, the following policies/procedures/protocols were approved and/or implemented: "SSLC Procedure: Guidelines for Prevention and Monitoring of Clostridium difficile infections," dated July 2013. The Facility indicated the Medical Department did not have a policy and procedure manual. It is recommended that sections be developed to reflect the ongoing activities of the Department, especially new or unique initiatives that had been successful and will be ongoing. When the policy and procedure manual is being written, these policies, procedures, and protocols will then already be in place. Aspects to be included in a Medical Department manual would include the following areas (the list is not all-inclusive, but should reflect the operations of the Medical Department and the needs of the Facility): ▪ Staffing and administration - caseloads, categories of topics for CME, CPR certification, etc.; ▪ Organizational procedure and role of the morning medical meeting; ▪ Routine care and documentation standards; ▪ Updating diagnoses using ICD and DSM nomenclature; ▪ Preventive care; ▪ Acute care; ▪ Utilization of clinical guidelines and national standards as part of practice pattern; ▪ Tracking missed appointments;	Noncompliance

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	Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	▪ External peer review; ▪ Internal peer review and inter-rater reliability; ▪ Role of QA/QI Department in monitoring/guiding the Medical Department; ▪ Internal QI monitoring initiatives; ▪ Mortality review recommendations; ▪ Role of Ethics Committees; and ▪ Others as indicated.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC's Self-Assessment; o AUSSLC At-Risk Individuals list; o AUSSLC's Nursing Department Presentation Book; o AUSSLC's nursing staffing data; o AUSSLC's Action Plans for Nursing; o AUSSLC's lists of individuals who were seen in the emergency room, and hospital; o Medical records for the following individuals: Individual #6, Individual #430, Individual #93, Individual #270, Individual #341, Individual #72, Individual #206, Individual #357, Individual #452, Individual #13, Individual #364, Individual #219, Individual #115, Individual #232, Individual #360, Individual #155, Individual# 450, Individual #405, Individual #268, Individual #34, Individual #390, Individual #204, Individual #363, Individual #398, and Individual #423; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Medical Emergency Response Drills monthly data; o Risk Management monthly checks of the Emergency Equipment; o Emergency Response Drills raw data; o Infection Control Committee meeting minutes for 1/14/14; o Medication Administration Observation raw data; o Medication Variance data by month; o Unexplained Returned Medication data; o Returned Medication data by home; o Pharmacy Narcotic Count form; and o Entrance Presentation information. ▪ **Interviews with**: o Charletta Klein, RN, Acting Chief Nurse Executive; o Maryann Clark, RN, Chief Nurse Executive from El Paso SSLC; o Sharon Price, Interim Nurse Operations Officer, Physical Nutritional Management Nurse; o J. Mike Fitch, Assistant Director of Programs; o Linda Richardson RN, Nurse Manager; o Debbie Carnico, RN, Hospital Nurse Liaison; o Melissa Ann Klopf Sawyer, RN, Quality Assurance Nurse; o Chrishanthi Perera, Medical Director; o Kenda Pittman, PharmD, Director of Pharmacy; o Jennifer Mears, Employee Resources; o Valeria Kiefer, RN, MSN, State Office Coordinator for Nursing Services;

	o Guy Campbell, PharmD/Clinical Pharmacist; o Jamie Blaylock, RN, Acting Infection Control Nurse; o Juan Rios, Data Analyst; o Ernest Coleman, Risk Manager; o Cecilia Ragland, Training Specialist, CTD; o George Schock, State Office Discipline Coordinator for Incident Management, and AUSSLC Interim Director of Incident Review and Management; o Silvia Valdez, State Office o Eugenia Andrews, State Office Director of Operations; and o Laura Cazabon-Braly, Facility Director. ▪ **Observations of**: o Medication Administration in the Infirmary; and o Medication Variance Committee meeting on 2/24/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section M, in conducting its self-assessment: ▪ The Facility essentially did not use monitoring/auditing tools. At the time of the review, the Facility had little to no data addressing Section M and reported that they were in the process of reviewing and restructuring the Nursing Department as a necessary priority before any type of consistent monitoring activities were resumed. When these activities are re-implemented, the Facility should review all the requirements of the Settlement Agreement for the different subsections of Section M, and prioritize the ones for which monitoring should be phased in. Although ultimately, the Facility should have the capacity to self-assess all of the requirements of Section M of the Settlement Agreement, it will be important to develop priorities for monitoring so as to not overwhelm the system with data for which there is not adequate time or resources to fully analyze and respond to results. Based on a review of the Facility's Self-Assessment: o Since the last review, the Nursing Department continued to experience significant staffing challenges and turnover in most of the key nursing leadership positions, including a complete turnover regarding the staff overseeing Section M. Consequently, since the last review, the department had made no progress in conducting a self-assessment and reported that most of the auditing that was previously conducted had been stopped in January 2014. Also, the continual chronic turnover regarding the Chief Nurse Executive position as well as other key nursing positions had resulted in a lack of consistent leadership and appropriate clinical direction regarding nursing's role and responsibilities in conducting nursing assessments in alignment with nursing protocols, developing and implementing the Integrated Health Care Plans, and implementing the required nursing documentation. From discussions with the Facility staff, it was clear to the Monitoring Team that there was a significant lack of overall knowledge regarding the status of a number of nursing systems. The Facility is encouraged to review the Monitoring Team's

	report to identify indicators that are relevant to making compliance determinations in each subsection of Section M, especially regarding the quality of the nursing supports and documentation. It was unclear why the Facility included some of the specific information in the Self-Assessment, because it appeared that it was not related to the specific provision. Some examples are provided below with regard to specific subsections. o In developing and/or re-implementing monitoring tools for this area, the Facility should develop adequate instructions to address the methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews, resulting in inaccurate data. In addition, specific definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. o Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples are pulled (e.g., everyone with a comprehensive nursing assessment, individuals identified with high-risk ratings, etc.) should be included with all of the data presented in the Self-Assessment. This is necessary to facilitate the interpretation of the relevance of the data. Adequate sample sizes should be used to ensure the data representative of the actual practices being monitored. o Regarding the monitoring for Section M, in order for the Facility to generate accurate data reflecting the clinical quality of the supports provided and documentation maintained, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s), such as determining compliance regarding the quality and adequacy of the nursing assessments. The Facility should develop specific criteria by which to evaluate quality in alignment with specific standards of practice such as the use of nursing protocols. o As noted above, adequate inter-rater reliability should be established for the final Section M monitoring tools. The Facility rated itself as being in substantial compliance with none of the subsections of Section M. This was consistent with the Monitoring Team's findings due to the lack of systems in place addressing many of the requirements for each provision, as well as the problems found regarding the quality aspect of the supports provided and documentation reviewed.
	Summary of Monitor's Assessment: Since the last review, nursing staffing continued to be a significant challenge for the Facility, with turnover in a number of staff nursing positions as well as some turnover in the key leadership nursing positions. Due to these staffing issues, the Facility had to continue to use

	Agency nurses to cover positions, and continued to do so at the time of the review. Some of the changes regarding the Nursing Department and nursing positions since the last review included the following: ▪ In October 2013, the Chief Nurse Executive position was vacated and in November 2013, a nurse from a private consulting firm became the Acting CNE; ▪ In January 2014, the Program Compliance Nurse position was vacated, and reportedly was filled in March 2014; ▪ In January 2014, the Case Manager Supervisor position was vacated; ▪ In December 2013, the Infection Control Nurse position was vacated; ▪ Since January 2014, the current Nurse Operations Officer had been on leave; and ▪ In January 2014, one Nurse Educator position was vacated, and a new Nurse Educator was hired in January 2014. At the time of the review, the information the Facility provided indicated that the Nursing Department had a total of 136 allotted positions with 19 vacancies. The nursing vacancies included seven Registered Nurse positions and 12 Licensed Vocational Nurse positions. Interviews with the Acting CNE indicated that since the last review, due to staffing issues, there had been significant periods of time where very few monitoring activities had been conducted resulting in little to no data generated. Consequently, due to the significant lack of data contained in the Facility's Self-Assessment as well as available during the review, the Monitoring Team was not able to accurately ascertain what specific activities the Facility was conducting to address most areas of Section M of the Settlement Agreement. Overall, the numerous and 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 vacated, had resulted in a Nursing Department that was not functioning in a manner that supported individuals' nursing needs, including the needs of individuals most at-risk for health and mental health issues. The Monitoring Team continued to identify significant concerns with regard to nursing supports provided to individuals with acute changes in status, as well as individuals with chronic health conditions, and also identified numerous problems with the documentation of nursing supports. Consequently, the Facility essentially had made no progress regarding the overall requirements of the Settlement Agreement for Section M. However, based on interviews with some State Office staff and the Facility Director during the review, there appeared to be some aggressive and very promising strategies in development to address the structure of the Nursing Department and the responsibilities that had been assigned to the different nursing positions. Hopefully, these efforts will ultimately address the problematic issues that have existed and currently existed in the Nursing Department.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information addressing nursing documentation regarding restraints is included above with regard to Section C. In assessing its progress, AUSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ Since the last review, vacancies in Nursing Administration and the high turnover rates within the nursing department had proven to be a great hindrance regarding the leadership, stability and the department's ability to effectively improve its standard of practice. The Facility Director reported that the Facility was in the process of restructuring its available nursing positions and reviewing staffing patterns to ensure staffing assignments were based on acuity levels and individuals' needs. However, at the time of the review, the Acting Chief Nurse Executive (CNE) reported that the Facility did not have a tool in place to measure acuity nor were there any policies guiding criteria for minimum staffing levels for nursing, ▪ In addition, the Facility indicated that in order to reduce the number of agency nurses utilized, the number of sick call-ins and abuse of leave time was currently being reviewed with any resulting corrective action in accordance with the SSLC Human Resources policy. No other information addressing this issue was provided in the Self-Assessment. ▪ Also, the Facility indicated that as of January 23, 2014, there were 16 Registered Nurse Case Managers (RNCMs) whose caseloads were 19 individuals. The Facility indicated that in the event of a RNCM vacancy, the reassignment of caseloads occurred to ensure continuity of services. ▪ At the time of the review, the Facility reported that the Statewide Nursing QA process had not been implemented. However, its implementation was anticipated in April 2014. ▪ The Facility' Self-Assessment indicated that from July through December 2013,	Noncompliance

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		the Nursing Department utilized the following monitoring tools: Comprehensive Nursing Review, Infection Control, Real Time Acute Illness, and Urgent Care/ER/ Hospital. However, the Self-Assessment indicated that resulting data demonstrated inconsistent implementation and utilization of the monitoring tools. ▪ Although the Facility indicated that nursing did utilize a selection of protocol audits as a means of self-monitoring, and that documentation protocols had been fully implemented, the Facility reported that there was not a database in place at the time of the review to summarize the findings of these audits, or any data analysis reports available to identify trends. Consequently, the Facility had no status update regarding this area. In addition, the Monitoring Team's findings noted throughout Section M indicated that clearly the use of nursing protocols had not been fully implemented. ▪ In addition, the Facility indicated that the Hospitalization/Transfer/Discharge process had been fully implemented and audits of this process were being conducted. However, interviews with Nursing staff, including the Hospital Liaison indicated that the data generated from the Urgent Care/ER/ Hospitalizations monitoring tool was submitted to the QA Department, but was not reviewed with nursing staff nor was any type of analysis report generated. Thus, the data had not been reviewed or used to identity trends or problematic issues needing corrective actions. <u>Self -rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance due to significant lack of adequate auditing and data collection within the Nursing Department. Processes are not in place which would ensure that AUSSLC is competent and compliant with expected response to changes in health status across the areas of nursing assessment, nursing care plans, infection control and emergency response. While two areas maintained acceptable monitoring (Infection Control and Hospitalization/ER/Discharges) and data collection; overall a data driven analysis process and subsequent development of action plans is not currently unavailable. The Action Plan for M.1 will address future goals and improvement strategies for this provision." Unfortunately, the Monitoring Team did not find that Infection Control and Hospitalization/ER/Discharges were being adequately monitored as the Facility indicated in its Self-Assessment rating. For example, although information regarding Infection Control from the Self-Assessment was not placed under the appropriate provision, the Facility indicated the following, which did not support that this area was being acceptably monitored: ▪ Monitoring of infection control audits was reviewed for September and October	

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		2013, and also for January 2014. The Facility reported vacancies in the Infection Control Nurse position were a barrier to consistent monitoring. ▪ There were no audits being completed for hand washing. The Facility reported that vacancies in the Infection Control Nurse position were a barrier. Infection Control Committee minutes, dated 1/14/14, indicated hand washing continued to be enforced. However, there was no formal data available regarding the process or the monitoring results. ▪ There was no evidence of infection control environmental rounds being conducted for the time period of July 1, 2013 through December 2013. ▪ The Infection Control Committee continued to meet per policy and the required members were in attendance, as noted in the Infection Control Committee minutes dated 1/14/14. Current infection control topics were discussed, however, no tracking or trending data was presented. ▪ The status of the Infection Control database was unknown. ▪ The status regarding PPD administration compliance was unknown. ▪ There was no data available pertaining to the Antibiograms. Consequently, due to the significant lack of data contained in the Facility's Self-Assessment as well as available during the review related to the requirements for Section M, the Monitoring Team was not able to accurately ascertain what specific activities the Facility was conducting to address most areas of Section M of the Settlement Agreement. Interviews with the Acting CNE indicated that since the last review due to staffing issues, there had been significant periods of time where very few monitoring activities had been conducted resulting in little to no data generated. Regarding the little data that was contained in the Self-Assessment for Section M, it was evident that there continued to be significant problematic issues regarding the format, the organization, the presentation, and the interpretation and analysis of the Facility's data. As noted in previous reports, the Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and then provide training to the nursing staff regarding how to analyze their data to identify problematic trends. <u>Staffing</u> Since the last review, AUSSLC had continued to experience significant changes regarding key leadership positions in the Nursing Department as well as staff nursing positions, which included: ▪ In October 2013, the Chief Nurse Executive position was vacated, and in November 2013, a nurse from a private consulting firm became the Acting CNE; ▪ In January 2014, the Program Compliance Nurse position was vacated and reportedly was filled in March 2014; ▪ In January 2014, the Case Manager Supervisor position was vacated;	

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		▪ In December 2013, the Infection Control Nurse position was vacated; ▪ The current Nurse Operations Officer had been on leave since January 2014; and ▪ In January 2014, one Nurse Educator position was vacated, and a new Nurse Educator was hired in January 2014. In addition, at the time of the review, the information the Acting CNE provided indicated that the Nursing Department had a total of 136 allotted positions with 19 vacancies. The nursing vacancies included seven RN positions and 12 LVN positions. From a review of the Facility's nursing staffing data and discussions with the Acting CNE, since the last review, the Nursing Department had experienced significant staffing challenges that continued to regularly warrant the use of Agency nurses. However, the recent addition of a nurse scheduler to oversee the daily nursing coverage, monitor call-ins, and very simply track which nurse was working on which unit from shift to shift had made a significant positive difference in the oversight of the nursing work schedule. In addition, from the Monitoring Team's interviews with some State Office staff and the Facility Director during this review, there appeared to be some aggressive and very promising strategies in development to address the structure of the Nursing Department, and the responsibilities that had been assigned to the different nursing positions. It is the hope of the Monitoring Team that these actions will ultimately address the ongoing problematic issues that have existed in the Nursing Department. Overall, the numerous and 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 vacated, had resulted in a Nursing Department that was not functioning in a manner that supported individuals' nursing needs, including the needs of individuals most at-risk for health and mental health issues. The Monitoring Team continued to identify significant concerns with regard to nursing supports provided to individuals with acute changes in status, as well as individuals with chronic health conditions, and also identified numerous problems with the documentation of nursing supports. Consequently, the Facility essentially had made no progress regarding the overall requirements of the Settlement Agreement for Section M. <u>Quality Enhancement Efforts</u> Interviews with the Facility's Quality Assurance Nurse indicated that she had not been involved in conducting any nursing monitoring activities since the last review, and thus, had not been involved in establishing inter-rater reliability for any of the nursing monitoring tools. In addition, the Acting CNE reported that at least since January 2014, most nursing monitoring activities were not being conducted, and those that might have been previously did not have any associated data available for review.	

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		Assessment and Documentation of Individuals with Acute Changes in Status A review of five individuals' IPNs (i.e., Individual #390, Individual #204, Individual #363, Individual #398, and Individual #423) who had been transferred to a community hospital found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in alignment with the nursing protocols in none (0%) of the cases. ▪ The documentation indicated that the licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. Due to the lack of ongoing clinically appropriate nursing assessments, changes in status were often only identified when the individual was already acutely ill. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments as dictated by the symptoms in alignment with nursing protocols in none (0%) of the cases. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in alignment with the individuals' overall medical status in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in alignment with the nursing protocols addressing the specific health issue in none (0%) of the cases. ▪ The documentation indicated that all acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these five individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past reviews. This was due to the lack of a structured system driving the type of nursing assessments that should have been conducted for the health issues and the associated documentation of those assessments. This structure was available through the nursing protocols, but a review of the documentation clearly indicated that nurses were not using the protocols to guide their assessments and/or documentation. The result of the lack of regular nursing assessments conducted for existing medical issues was the consistent lack of recognition that the symptoms the individuals were experiencing were signs of changes in status. The lack of consistent nursing assessments found in the documentation made it largely impossible to accurately determine exactly when changes in status were initially occurring. Although some IPNs were found that contained adequate nursing assessments, the lack of consistency of these nursing assessments rendered the overall care of the individuals	

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		inadequate in addressing their specific needs. Although the Facility reported that the nursing protocols had been "fully implemented," there was no indication they had been implemented, because nurses were not consistently using them to guide nursing assessments and documentation. Due to the number of individuals with complex medical needs at AUSSLC, this area should be considered a high priority for Facility review, and the development and implementation of specific action plans addressing the continuing problematic issues that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a very limited review of records while on site, it was noted that very few documents were missing from the active records. However, the Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services <u>Infection Control (IC)</u> Since the last review, there had again been turnover regarding the Infection Control Nurse position. Although the Facility had appointed a nurse as the Acting Infection Control Nurse in January 2014, an interview with this nurse indicated that her role in the position was very limited, and mainly related to facilitating administration of the influenza vaccines, and assisting with basic training of staff for an outbreak of C-diff in Castner and symptoms of a stomach virus. However, she reported that any formal duties of the Infection Control position, such as constructing timelines for outbreaks, maintaining databases, or monitoring care plans related to contagious illnesses, were not part of her role. Consequently, since the last review, many of the Infection Control systems that were essential to the overall IC program had not been developed and implemented. This resulted in this crucial clinical area being severely fragmented. Some of the problematic areas the Monitoring Team noted included the following: ▪ The Facility had continued to not utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues. Specifically, the Facility had not been using the Drug Utilization Discrepancy Reports to identify any discrepancies regarding the infection control data to ensure that the data were reliable. Discussions with the Acting Infection Control Nurse and the Acting CNE indicated that any available IC data regarding acute infections that occurred at least since the last review would	

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		not be reliable. ▪ At the time of the review, the Acting CNE indicated that it was doubtful that the Immunization database was completed and up-to-date. The Acting IC Nurse indicated that she had not been involved in gathering any historical immunization data and entering it into the immunization database. Consequenlty, the Facility could not determine which individuals' immuniztion status had been researched and updated, as appropriate. Thus, at the time of the review there was no indication of progress regarding the tracking, trending, and analysis of these data. ▪ Although the Infection Control Committee met in January 2014, there was little to no information included in the minutes, dated 1/14/14, indicating that data regarding infection control issues were being aggregated and analyzed along with any other available monitoring data addressing IC issues, such as actual infection rates. Such analysis was necessary in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. ▪ The Facility reported that since the last review, the Real Time IC audits had not been conducted consistently. The Monitoring Team could not interpret the data addressing these audits that was provided in the Facility's Self-Assessment. ▪ At the time of the review, Infection Control was not conducting any Environmental Surveillance Surveys. ▪ Regarding nursing care plans addressing infectious illness, during the previous review, nurses that were interviewed were not aware of the specific individuals who had been exposed to Tuberculosis (TB). Consequently, no nursing care plans were found to be in place addressing the needed nursing assessments in order to appropriately monitor the individuals for any active symptoms of the disease, as well as assess these individuals while they were being treated with INH, a medication used to treat individuals exposed to TB. During the current review, when the Monitoring Team asked nursing staff about the status of these individuals since they had been receiving INH treatment, nursing staff indicated that no one in the Facility was receiving this type of treatment. In fact, the Medical Director confirmed that four individuals (i.e., Individual# 450, Individual #405, Individual #268, and Individual #34) currently were being treated with INH for TB exposure. A review of the nursing care plans for these four individuals found that two of the four (50%) had a care plan addressing this significant clinical issue. Individual #268 and Individual #347 did not have care plans addressing this issue. Of the two care plans reviewed, neither (0%) was found to be clinically adequate. It was extremely concerning that after six months since the last review, there were no clinically appropriate nursing care plans in place.	

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		At the time of the review, the Facility indicated that since turnover had occurred in the Infection Control position, there had been no consistency in the monitoring and tracking of Infection Control issues, rendering any Infection Control data unreliable. The chronic turnover in this position had resulted in a substantial breakdown in communication regarding Infection control systems and procedures. <u>Mock Code Drills and Emergency Response Systems</u> ▪ Although the Facility's Self-Assessment indicated that Emergency Mock Drills were being conducted as required, at the time of the review, the number of passed and failed drills per month could not be produced. According to Facility Staff, including the Interim Director of Incident Review and Management, these data had not been aggregated. Although Facility staff reported that the Risk Management Meeting minutes would contain information regarding Mock Drills, it would not be aggregated by percent of pass and failed drills by month, or analyzed and trended in this manner. Thus, the Facility was not able to provide a sufficient update regarding Mock Drills at the time of the review. ▪ However, documentation provided after the review indicated that from September 2013 through February 2014, the pass rate was 83%, 90%, 85%, 100%, 91%, and 56%, respectively. Although the Facility aggregated this information for the Monitoring Team, it was troubling that the Facility clearly was not reviewing this information in order to identify trends and problematic issues regarding systems and staff performance regarding emergency procedures. ▪ Consistent with the findings from the past reviews, the Facility had not been conducting drills of alternative scenarios. ▪ On a positive note, the Monitoring Team's review of the Facility's raw data verified that the required daily emergency equipment checks Risk Management staff and nursing staff completed were consistently being conducted. ▪ The Facility indicated that data and data analysis addressing actual medical emergencies (6200) with any associated plans of correction was not available. ▪ There were no indications that problematic trends were being identified and tracked regarding both actual emergencies as well as from the Mock Code Drills. ▪ There was no indication that Emergency Equipment Competency Checklists were being regularly conducted at least every quarter for each nurse. ▪ As noted from past reviews, there was no clinical review of the Mock Code Drills as well as the actual medical emergencies that occurred at the Facility. Consequently, the status of the Facility's emergency systems was not being reviewed, discussed, or tracked by any clinical staff. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.	

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M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. AUSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that from July 2013 through January 31, 2014, 62% of the nurses had completed the RN physical assessment competency training, and between 93% and 98% had completed the Mosby physical assessment study courses. However, the Facility's Self-Assessment also indicated that since the last review, monitoring regarding the Nursing Comprehensive Assessments had been not been conducted consistently and no data was available for review. ▪ In addition, the Facility indicated that a review of the Nursing Discharge Summary indicated that a process was in place for the facility Placement Coordinator to review of all discipline discharge assessments. A tracking system was in place to ensure assessments were completed. However, the Self-Assessment stated that: "it was unclear if the nursing department conducts a review process of the discharge summaries prior to submission to the Placement Coordinator." It was unclear to the Monitoring Team why the Facility was not able to ascertain if this process existed and what further actions were to be taken to address the documentation related to discharge/transitions. ▪ Unfortunately, the Monitoring Team could not accurately interpret the data provided in the Self-Assessment regarding "SSLC required documentation" and the timeliness of annual nursing assessments. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance. The rating is due to an inadequate system/process to review and evaluate the quality of the comprehensive nursing assessments for correct analysis of the assessment data and the development of appropriate nursing interventions associated with identified risk. Recommendations to select an educational/mentoring/monitoring component for the RNCMs [Registered Nurse Case Managers] would be of benefit to assist in establishing quality and compliance baselines and to develop corrective actions and goals for the RNCMs. Monitoring of facility RN's assessments in response to acute illness/injury and/or changes in health status will require additional attention. The Action Plan for M.2 will address future goals and improvement strategies for this provision."	Noncompliance

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		Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below were based on specific findings related to the significant problems with the quality of the content of the Comprehensive Nursing Assessments. At the time of the review, the Acting CNE reported that due to the number of continuing challenging staffing issues in the Department, there had been essentially no progress made in addressing the requirements for this provision of the Settlement Agreement. In addition, the Action Plan the Facility submitted for Section M.2 did not include any steps to address the ongoing problematic issues regarding the quality of the nursing services and related documentation. As noted during all the previous reviews, it was very troubling to the Monitoring Team that thus far, AUSSLC had not developed a clear understanding of what constituted a clinically appropriate Comprehensive Nursing Assessment or developed and implemented a competency-based curriculum addressing the quality of the documentation that should be contained in the Comprehensive Nursing Assessments. Due to the ongoing lack of implementation of the nursing protocols, there continued to be a lack of appropriate clinical nursing assessments being conducted for the individuals on an ongoing, day-to-day basis. This resulted in an absence of clinical objective data generated to even analyze for the Comprehensive Nursing Assessments to provide baseline data and/or provide information about whether individuals were better, had remained stable, or had declined with regard to their health status. Consequently, the Monitoring Team continued to find the Facility's Comprehensive Nursing Assessments to be clinically inadequate, and in fact, they contained less relevant clinical information than found in past reviews. The Quarterly/Annual Nursing Assessments for 10 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls: ▪ Of the 10 individuals' nursing quarterly assessments reviewed, 10 (100%) were timely completed. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. ▪ There was an adequate assessment of the high and medium risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. In	

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		a number of the nursing quarterly assessment summaries reviewed, there was no mention of the medium and/or high health risk indicators. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. Consistent with the findings from the previous reviews, the Monitoring Team found that there had been no progress made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. From the Monitoring Team's review, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. From interviews with the Acting CNE, at the time of the review, it was unclear as to how AUSSLC's Nursing Department actually planned to address this issue. The consistent lack of progress found regarding the quality of the Comprehensive Nursing Assessments continued to be very concerning to the Monitoring Team due to the potential impact it had on the health and wellbeing of individuals residing at the Facility. As previously recommended by the Monitoring Team, appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. This area should be considered a priority for nursing. It is imperative that the nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health/mental health status. Regarding the nursing documentation for six individuals discharged/ transitioning to the community, a review of the nursing documentation and Nursing Discharge Assessment Summaries for six individuals including: Individual #364, Individual #219, Individual #115, Individual #232, Individual #360, and Individual #155 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. This was because none of the IPNs were included in response to the document request that stated: "For the past six months, nursing documentation for	

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		individuals who have transitioned to the community, including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. As noted consistently in previous reports, it is crucial that AUSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. The only reference to discharge/transition issues found in the Facility's Action Plan stated: "utilize revised comprehensive nursing review for annual, quarterly and discharge nursing assessment per policy guidelines and ISP schedule," which did not reflect the need to address the quality of the nursing documentation regarding this area. In addition, there was no mention of any needed training to address the quality of Discharge Summaries. Consequently, there was no improvement found in the nursing documentation for the individuals that had been transitioned to the community since the last review. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. AUSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that since the last review there had been inconsistent monitoring of the Integrated Health Care Plans, and that there was not a process in place to review policy compliance, development, implementation, and quality regarding acute care plans. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance. Processes are currently not in place to assure the quality and timeliness of the nursing care plan to address risk, acute and chronic health issues and changes to health status via the Integrated Health Care Plans (IHCP) and the acute health care plan (ACP). As a result, the ability to develop positive goals towards departmental improvement addressing adequate nursing	Noncompliance

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		response and nursing interventions is not in place. The Action Plan for M.3 will address future goals and improvement strategies." The records of 10 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls. Of the 10 individuals' Integrated Health Care Plans reviewed: ▪ Ten (100%) were found to have a care plan addressing their high or medium health/mental health risk indicator found on the Facility's At Risk List. These risks were not necessarily confirmed on the individuals' IRRFs, because five of the ten IRRFs did not include the actual risk ratings for each indicator (detailed findings are provided with regard to Section I). ▪ None (0%) of the nursing interventions contained in the 10 care plans indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. In addition, none of the nursing interventions listed in the care plans reviewed were in alignment with the nursing protocols addressing the specific health issues. ▪ None (0%) of the 10 care plans were found to be clinically adequate. There was no indication that any types of nursing assessments were to be conducted addressing specific existing health issue in alignment with the nursing protocols. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ None (0%) of the 10 plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 10 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 10 care plans, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. The overall lack of progress in this area since the last review was very concerning to the Monitoring Team. Specifically, some of the problematic issues identified in the Facility's previous care plans were found in the current IHCPs including: ▪ The rationale for several risk levels on the Integrated Risk Rating forms did not consistently include the needed clinical justification to support the designated level. In addition, half of the IRRFs reviewed (five of ten) did not include the risk rating for each of the health indicators. Consequently, it was often difficult for	

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		the Monitoring Team to determine the accuracy of some of the risk levels and the need for action steps addressing the health risks. ▪ Most of the goals listed in the IHCPs reviewed did not address the etiology of the health problem as an objective clinical area of focus to assist the team in developing action steps that were individualized. Consequently, many action steps found in the care plans did not address the underlying cause of the health issue and had no association with the goals listed. ▪ As noted above, none of the nursing action steps found in the IHCPs reviewed included the ongoing clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the IHCPs did not consistently include specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; noting consistently where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Unfortunately, many of the nursing action steps were noted to be meaningless in that they were often generic, not measurable, and non-specific to the individual's health care needs. ▪ At the time of the review, the IHCPs reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. ▪ The generic nature of many of the action steps contained in the IHCPs prohibited validation that the steps were actually being implemented. It is crucial that the Facility address the lack of clinically adequate care plans for the individuals under their care regardless of the staffing challenges and system changes experienced by the Facility. As previously recommended, the Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at AUSSLC. Regarding nursing care plans addressing infectious illness, at the time of the review, the Facility indicated that since turnover had occurred in the Infection Control position, there had been no consistency in the monitoring and tracking of Infection Control issues rendering any Infection Control data unreliable. The chronic turnover in this position had resulted in a substantial breakdown in communication regarding Infection control systems and procedures that at one time were in the process of being developed and implemented. For example, during the previous review, nurses that were interviewed were not aware of the specific individuals who had been exposed to Tuberculosis (TB). Consequently, no nursing care plans were found to be in place addressing the needed nursing assessments	

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		in order to appropriately monitor the individuals for any active symptoms of the disease, as well as assess these individuals while they were being treated with INH, a medication used to treat individuals exposed to TB. During the current review, the Monitoring Team found that when nursing was asked about the status of these individuals since they had been receiving INH treatment, nursing indicated that no one in the Facility was receiving this type of treatment when in fact, the Medical Director confirmed that four individuals (i.e., Individual# 450, Individual #405, Individual #268, and Individual #34) were currently being treated with INH for TB exposure. ▪ A review of the nursing care plans for these four individuals found that two of the four (50%) had a care plan addressing this significant clinical issue. Individual # 268 and Individual #347 did not have care plans addressing this issue. ▪ Of the two care plans reviewed, neither (0%) was found to be clinically adequate. It was extremely concerning that after six months since the last review, there were no clinically appropriate nursing care plans in place. Clearly, there had been no progress made regarding this provision of the Settlement Agreement. In order for progress to be made regarding this provision of the Settlement Agreement, the Integrated Health Care Plans/Nursing Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ Be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. With regard to this provision, AUSSLC's Self-Assessment indicated the following: ▪ The Facility reported that the following data table represented the status of training for nurses at the time of the review:	Noncompliance

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Name of Education *Denotes ongoing education	N	n	%
Documentation*	44	44	100
Physical Assessment*	74	46	62
Medication Admin for Nurses*	125	124	99
NEO for Nurses*	92	92	100
Infant-Child AED [Automatic External Defibrillator] Key	104	104	100
Mosby Physical Assessment Class*			
- November 2012	63	59	94
- March 2013	61	58	95
- May 2013	61	57	93
- July 2013	61	58	93
- October 2013	58	57	98
Name of Education	N	n	%
Communicable Illness Care Plans	111	99	89
Daily Med/Narc [Narcotics] Counts & ADRs [Adverse Drug Reactions]	111	99	89
G-Tube Insertion 6-13 Revision	111	99	89
Lab Specimen Labeling & Ordering	111	99	89
Medication Administration Guidelines-06-2013	111	99	89
New Med Admin Obs [Observation] Guidelines	111	99	89
Nsg [Nursing] Services Policy 010.3	111	99	89
Med Variance in Avatar	111	99	89
60 days No Float New Nurses	110	102	93
Furlough & Off Campus Med Admin Policy 5-13	110	102	93
Med Admin 8-13 Update	110	102	93
Nursing Department Staffing and Pull Policy May 2012	110	102	93
Medication Administration Guidelines-08-2013	110	102	93
SSLC Guidelines for Prevention and Monitoring of Clostridium difficile Infections-July 2013	110	102	93
Gastric tube - Balloon Check-09-01-2013	110	102	93
Pica and related behaviors	110	102	93

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Hospitalizations, Transfers and Discharges	110	102	93
Enteral Nutrition 9/13	110	102	93
Enteral Medication Administration 8/13	110	102	93

Although the Facility's data indicated that for most of the areas noted above, a majority of the nurses had received training regarding topics such as Documentation and Communicable Illness Care Plans, the training provided had little to no positive impact as noted from the Monitoring Team's findings throughout Section M. In addition, the information from the Facility's Self-Assessment indicated the Nurse Educator conducted random walk-throughs addressing areas such as ensuring nursing protocols were present and in use, and reviewing documentation on the enteral nutrition sheets and the emergency equipment check lists. However, no additional information was provided regarding what criteria was used to determine compliance regarding the walk-throughs. In addition, the Self-Assessment noted that no formal data was actually collected.

- In a positive step forward, in January 2014, the Facility had hired an additional Nurse Educator to focus on RN Case Managers' compliance and training needs.
- Although the Facility indicated that "real time" protocol auditing had been initiated, the Self-Assessment noted that: "data results were not readily available." Consequently, at the time of the review, the Facility could not provide a status update regarding this provision of the Settlement Agreement.

Self-rating:
Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance. Although the AUSSLC Nurse Educator maintained the majority of required training competencies, several areas of training delinquencies were noted. Additionally, AUSSLC Nursing Department could not provide data driven evidence all trainings and in-services were applied to clinical practice. The Action Plan for M.4 will present strategies to address departmental goals and action steps leading to improvement. "

Although the Monitoring Team found some mention of nursing protocols in a few of the IHCPs that were reviewed, all of the nursing assessments from the nursing protocols were included in the IHCPs for implementation only after an acute health event occurred, rather than proactively for individuals with existing high and medium health risks. This proactive use would be necessary to attempt to prevent the occurrence of an acute health event. Only using nursing protocols reactively means that an individual has to become ill in order to be provided regular nursing assessments in alignment with the protocols, and

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		only for as long as the acute event persists. Consequently, only implementing nursing protocols reactively does not result in improved clinical care focused on minimizing health risks. At the time of the review, the reactive use of nursing protocols found in some of the IHCPs reviewed did not result in an improvement in clinical care. The same significant problematic issues as was found during the previous reviews were found for the current review regarding nursing assessments, care plans, and the overall nursing care, as well as the associated documentation. Specifically, the problematic findings found in the nursing documentation reviewed for Sections M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility clearly was not implementing nursing protocols sufficiently to address the health status of the individuals served as required by this provision of the Settlement Agreement. In addition, the major concerns the Monitoring Team had regarding these consistent problematic issues, especially related to individuals with high/medium health risk indicators and their changes in status warranting hospital admissions were exemplified in a review of five individuals who had been hospitalized since the last review: Individual #390, Individual #204, Individual #363, Individual #398, and Individual #423 (specific details are provided with regard to Section M.1). A review of these individuals' records indicated the following: ▪ There was no indication that nursing was actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation; ▪ Clinically appropriate nursing assessments were not conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data had not been established to quickly recognize changes in health status; ▪ Timely communication had not occurred with practitioners/physicians or other disciplines regarding changes in status; and ▪ Appropriate and clinically adequate care plans had not been developed and implemented that outlined specific nursing interventions for specific health issues. A review of the Facility's Action Plan addressing this provision found that it essentially contained no actions that would actually support the consistent implementation of nursing protocols or the specific problematic issues that the Monitoring Team has repeatedly found regarding this requirement. In fact, one the actions steps found in the Facility's Action Plan regarding M.4 clearly was not specific to AUSSLC in that it stated:	

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		"Provide SSLC nurse educator training for newly selected EPSSLC Nurse Educator." These consistent problematic findings clearly showed that the Facility had not actually implemented the use of nursing protocols as required by the Settlement Agreement. Consistent with past reviews, the problematic findings from this review indicated that AUSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in substantial compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, AUSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ The Facility's Self-Assessment indicated that a review of the current At-Risk Policy was in the developmental stages at the time of the review. Thus, compliance could not be determined. ▪ The Monitoring Team's review of the information contained in the Facility's Self–Assessment found that most of the information provided did not address this provision and included no data indicating that any progress related to this provision had been made. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance. Recommend SSLC assistance with the development of an Infection Control Department to establish realistic goals towards the direction of compliance this would include development of appropriate databases, inclusion of data trend reports in the Infection Control Committee meetings and data driven action plans." Although the findings of the Monitoring Team noted below also indicated that the Facility was not in compliance with the requirements of this provision, it was unclear to the Monitoring Team why the Facility's self-rating for this area was based on the area of Infection Control rather than the At-Risk system. Consistent with past reviews, the documentation reviewed did not adequately address individuals' health/mental health risks in alignment with the requirements of this provision.	Noncompliance

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		A review of records for 10 individuals determined to be at risk (i.e., Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13 for falls) found that none (0%) included an adequate nursing risk assessment that included individual-specific information that clearly justified the risk ratings assigned. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 10 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, many of the Quarterly Comprehensive Nursing Assessments did not even mention the high and medium risk health indicators for the individuals in the assessment or the Summary Section. A review of these 10 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. As noted with regard to Section I, the Monitoring Team found that there was an increase in some of the specific clinical information for a few of the risk categories contained on the IRRF forms. However, overall for the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, falls, injuries, and/or fractures, there was a lack of individual-specific information from the current year as compared to the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. In addition, the Integrated Risk Rating forms the Facility provided did not consistently include the risk ratings for each of the risk categories and/or was incomplete for five of the 10 individuals reviewed including: Individual #430, Individual #270, Individual #72, Individual #206, and Individual #452. Consistent with the findings from previous reviews, no modifications had been made or specific procedure implemented to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments reviewed for the At-Risk individuals noted above did not adequately address their health risks, and in some cases, did not even include all the high/medium health risks in the Summary Section of the Comprehensive Nursing Assessments. In addition, based on a review of 10 records for individuals determined to be at risk (i.e., Individual #6, Individual #430, and Individual #93 for aspiration; Individual #270, and Individual #341 for constipation; Individual #72, and Individual #206 for urinary tract infections; Individual #357, and Individual #452 for weight issues; and Individual #13	

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		for falls), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ None (0%) of the IHCPs sufficiently addressed the health risk in accordance with applicable nursing protocols. Although some of the IHCPs included nursing protocols in response to an acute event, none were included for existing health issues, such as constipation or aspiration, where the implementation of nursing assessments in alignment with the nursing protocols would be implemented on a regular basis and not just in response to an acute event. ▪ Implemented a plan within fourteen days for each individual, as appropriate, in none (0%) of the cases reviewed. The 10 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage compliance with a healthy diet and encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the IHCP/Risk Action Plans into the ISPs in 0 of the 10 cases (0%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily, weekly, or "PRN" without the specific shift, day, or criteria included to ensure accountability. At the time of the review, nursing did not have a plan in place to address this critical area addressing the needs of At-Risk individuals. Consequently, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information	

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		contained in the IRRFs from nursing, and the quality of the interventions contained in the IHCPs had not been addressed. At the time of the review, the Facility indicated that they were not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In response to this requirement, AUSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ The Facility's Self-Assessment indicated that at the time of the review, the Nurse Educator indicated the Medication Administration Guidelines were fully implemented and that 99% (124 out of 125 nurses) had successfully completed the medication administration competency-based course. In addition, the Self-Assessment indicated that the previous Chief Nurse Executive had discontinued the quarterly medication observations. However, no further information was provided indicating if and when these observations were to be re-implemented. ▪ The Facility's Self-Assessment also indicated that the Nursing Operations Officer reported that the Nurse Managers were conducting random Medication Administration Record audits. However, a formal database was "not available" at the time of the review. It also was noted in the Self-Assessment that the Nurse Managers and the Pharmacy Department were completing medication room checks. However, the Self-Assessment noted that: "evidence of collaborative utilization of both audits was not found." No other information was provided regarding these issues. ▪ The Facility indicated that monthly Medication Variance Committee meetings were being held per policy. However, the Self-Assessment also indicated that "collaborative discussions and development of goal orientated action plans to ensure an effective process is in place to report and investigate potential medication variances was not evident." Consequently, information provided in the Facility's Self- Assessment along with nursing staff interviews while on site provided little information to the Monitoring Team regarding the overall status of this requirement. ▪ Although the Pharmacy had data regarding medication variances and the	Noncompliance

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		number of returned medications by month by home, and the data were analyzed and graphed, no information was included in the Self-Assessment for Section M.6 specifically addressing what trends were identified, what actions had been implemented, and what the effect was of the actions taken. Self-rating: Regarding the Facility's compliance rating, the Self-Assessment stated: "based on the findings from this assessment, this provision is not in substantial compliance. Establishment of an effective process to assure competence and compliance with the Medication Administration Guidelines is not evident. Additionally, an effective reporting and investigative process addressing potential and actual medication variances is not evident. Collaborative efforts on the part of Nursing, Medical and Pharmacy to improve the entire medication prescribing, dispensing and administration process will be required for substantial improvements to occur. The action plan for M.6 will begin to present positive goal orientated steps towards compliance." The Monitoring Team's findings supported the Facility's self-rating of noncompliance regarding this provision. However, it was unclear to the Monitoring Team from the significant lack of information contained in the Self-Assessment regarding the Facility's medication administration system what exactly the status was for this area. In addition, it was unclear to the Monitoring Team why at this juncture of the process the Nursing Department would have only informal monitoring systems in place addressing an area as crucial as the medication administration system where data should be formally collected, trended, and analyzed. Additional information would have been helpful in order to fully understand what processes were actually in place and what new actions the Facility had implemented since the last review. Also, the Nurse Educator that had provided some of the information for the Self-Assessment to the Acting CNE regarding this area had left the position three weeks prior to the review, and the new Nurse Educator had only been in the position for two weeks and was not yet familiar with many of the Nursing Education systems. In addition, the NOO, who also had provided some information regarding the medication system, was on leave at the time of the review. Consequently, it was not clear to the Monitoring Team what systems were actually in place and being consistently implemented addressing this essential requirement of the Settlement Agreement. From interviews with the Pharmacy Department, the following steps regarding the Facility's overall medication administration system had been initiated: ▪ At the time of the review, the Facility was conducting counts for all medications between each shift in order to promptly identify any shortages or excesses	

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		regarding the medications in each home. ▪ During the Medication Variance Committee meeting held during the week of the review, it was decided that a new position, Medication Variance Coordinator, would be created and implemented after the review in order to increase the reliability of the medication variance data. ▪ The Pharmacy had continued to participate in monthly Nurse Education meetings and New Employee Orientation. ▪ Since the last review, the medication variances had been entered in to the Avatar program. The Pharmacy had been working with data analysts in order to generate meaningful trending reports to facilitate systems improvements. Although the steps discussed above included some forward movement, at the time of the review, the Monitoring Team found that AUSSLC continued to have significant problematic issues regarding its overall medication administration system as noted below: ▪ As noted previously, medication administration observations had not been conducted as required since the last review. ▪ It was not clear to the Monitoring Team if the Nursing Department had conducted any Medication Room Audits since the last review, and if any findings from these audits had been reviewed and problematic issues addressed. ▪ In addition, during an observation of a Medication Variance Committee meeting, it was reported that nurses were checking the Medication Administration Records (MARs) between change of shift and when they found a MAR blank, they were allowing staff to fill in the MAR and not filling out a medication variance as would be appropriate since the blank represented a breach in the medication administration procedure. The MAR should be initialed at the time the medication is administered. Consequently, these documentation medication variances have not accurately reported. ▪ Although at the time of the review, the Facility had begun to address the type of medications that were being returned to the Pharmacy in order to identify any emerging clinical issues due to the unexplained returned medications, there was no formal process in place documenting what issues were being researched and what the resulting outcome and plan of action was to prevent issues from reoccurring. ▪ Interviews with the Acting CNE and Pharmacy Director indicated that the current medication variance data was not reliable. ▪ As noted during past reviews, the Facility had identified the lack of consistent nurses assigned to specific residences as well as the use of Agency nurses due to staffing issues as factors resulting in increases in medication variances. However, there was no indication that a plan or procedure was developed and	

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		implemented addressing these situations, especially with the consistent staffing challenges the Nursing Department experienced. ▪ Although the Facility was spending much time attempting to reconcile unexplained shortages and excesses of medications, the number of other actual medication variances suggested that AUSSLC continued to have a significant problem regarding the under-reporting of medication variances. A review of the medication variances (Category A-E) reported by the Facility indicated the following: ▪ September 2013 - 254 variances, (92 short/excess medications); ▪ October 2013 - 163 variances, (94 short/excess medications); ▪ November 2013 – 192 variances, (148 short/excess medications); ▪ December 2013 – 309 variances (137 short/excess medications); and ▪ January 2014 - 220 variances (123 short/excess medications). Based on observations of medication administration at the Infirmary, the following problematic issues were found. Specifically, the nurse did not: ▪ Follow proper procedures by allowing the medications to flow into G-Tubes by gravity. The nurse used the syringe to "push" the medications into the G-/tube for Individual #381, even after the Facility reported that bed-side competency-based training recently was provided regarding procedures for tubes; ▪ Listen to lung sounds when Individual #381 coughed in response to the medication being pushed into the tube; ▪ Know the reason why Individual #381 had a fundoplication, which was why she was in the Infirmary; ▪ Consistently tell the individuals what medication they were receiving; and ▪ Consistently provide instructions to the direct support professionals for positioning after medication administration. ▪ In addition, the Facility nurse conducting the observations did not correct the medication nurse when the medications were given incorrectly through the G-tube. Since the last review, the staffing challenges and inconsistency in Nursing Leadership had resulted in a significant lack of oversight and follow through regarding the processes and procedures related to the Facility's medication administration system. As previously recommended, the Facility should continue efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data. In addition, further collaboration should occur between the Pharmacy, Nursing,	

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		and the Medical Departments in constructing a format and structure to critically review the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate Pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of Pharmacy services, including for updated policies, highlights of the approved changes; o Any Pharmacy surveys completed since the last Monitoring Team's visit: plans of correction and/or internal auditing procedures and reports related to Pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluations (DUE) reports completed since last Monitoring Team's visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics (P&T) Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including whether calendar based on fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one year period; o For Quarterly Drug Regimen Reviews two most recent per residence that have been completed with physician signatures and dates, including for anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #40 10/3/13, Individual #40 1/9/14, Individual #291 10/3/13, Individual #291 1/9/14, Individual #332 8/1/13, Individual #332 11/6/13, Individual #119 8/1/13, Individual #119 11/6/13, Individual #325 8/5/13, Individual #325 11/7/13, Individual #112 8/5/13, Individual #112 11/7/13, Individual #248 8/7/13, Individual #248 11/12/13, Individual #140 8/7/13, Individual #140 11/12/13, Individual #321 9/4/13, Individual #321 12/5/13, Individual #335 9/4/113, Individual #335 12/4/13, Individual #394 10/1/13, Individual #394 1/2/14, Individual #371 10/2/13, Individual #371 1/2/14, Individual #149 9/10/13, Individual #149 12/6/13, Individual #98 9/10/13, Individual #98 12/6/13, Individual #184 10/11/13, Individual #184 1/16/14, Individual #92 7/24/13, Individual #92 10/18/13, Individual #306 7/24/13, Individual #306 10/18/13, Individual #204 7/19/13, Individual #204

	10/16/13, Individual #312 7/19/13, Individual #312 10/16/13, Individual #297 7/29/13, Individual #297 10/29/13, Individual #15 7/29/13, Individual #15 10/29/13, Individual #347 8/28/13, Individual #347 12/3/13, Individual #363 8/28/13, Individual #363 12/3/13, Individual #375 9/4/13, Individual #375 11/4/13, Individual #439 7/31/13, Individual #439 11/4/13, Individual #72 8/14/13, Individual #72 11/19/13, Individual #100 8/14/13, Individual #100 11/19/13, Individual #302 9/24/13, Individual #302 12/27/13, Individual #283 9/24/13, and Individual #283 12/27/13; o For 10 most recent QDRR in which recommendations were made and accepted, copies of physician orders: Individual #321, Individual #112, Individual #375, Individual #439, Individual #92, Individual #21, Individual #367, Individual #394, Individual #200, and Individual #235. For 10 most recent QDRR in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #160 and Individual #222; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team's visit; o Since the last review, copy of any internal Pharmacy department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team's visit; o For the past six months, any Adverse Drug Reaction (ADR) reports completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors/variances per month for prior 12 months by error type, nurse, residence, shift, individual, category of severity, error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between Pharmacy and Nursing Department concerning medication errors/variance (emails, memos, etc.) since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when QDRR are conducted by home/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual # 40 7/21/13 (1117 hr), Individual #98 7/21/13 (1233 hr), Individual #344 7/24/13 (1510 hr), Individual #30 8/6/13 (2315 hr), Individual #30 8/17/13 (1649 hr), Individual #421 8/31/13 (2331 hr), Individual #421 8/31/13 (1300 hr), Individual #421 9/6/13 (1517 hr),

	Individual #193 9/18/13 (1048 hr), Individual #193 9/18/13 (1400 hr), Individual #30 9/30/13 (1950 hr), Individual #246 10/11/13 (2235 hr), Individual #421 10/13/13 (1210 hr), Individual #159 10/13/13 (1620 hr), Individual #421 10/13/13 (0930 hr), Individual #283 10/16/13 (1445 hr), Individual #283 (1650 hr), Individual #159 10/30/13 (0550 hr), Individual #159 11/4/13 (1807 hr), Individual #109 12/11/13 (0849 hr), Individual #109 12/12/13 (1436 hr), Individual #109 12/12/13 (1120 hr), and Individual #109 12/13/13 (1628 hr); o Any trend analysis of chemical restraint use (i.e., graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o For 10 orders involving drug-drug interactions, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of Pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following 10 individuals: Individual #49, Individual #403, Individual #56, Individual #374, Individual #158, Individual #390, Individual #84 (two reports), Individual #140, Individual #168; o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of Pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #198, Individual #224, and Individual #29; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of Pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #390 (2 reports), Individual #122, Individual #158, and Individual #399; o For five new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy

	of Pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #268, Individual #374, Individual #307, Individual #158, and Individual #347; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/ information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of Pharmacy label indicating Pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #178, Individual #302, Individual #405, Individual #40, and Individual #13; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. When the data was collected periodically rather than continuously, the frequency of data collection was requested; and o Presentation Book for Section N. ▪ **Interviews with**: o Kenda Pittman, PharmD, Director of Pharmacy; and o Guy Campbell, PharmD. ▪ **Observations of**: o Medication Variance Committee Meeting, on 2/24/14; and o Pharmacy and Therapeutics Committee Meeting, on 2/26/14.
	Facility Self-Assessment: For Section N, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment are discussed below in further detail. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as record reviews, review of Quarterly Drug Regimen Reviews, and review of Pharmacy and Therapeutics Committee minutes. o The Self-Assessment identified the sample sizes, including the number of

	individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: Pharmacy staff. o Inter-rater reliability needed further development for several of the audits to confirm the reliability of the findings. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. Examples included QDRR statistics, QDRR delivery tracking, and QDRR recommendations tracking. The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in substantial compliance with the following subsections of Section N: N.1, N.2, N.3, N.4, N.5, N.6, and N.7. This was consistent with the Monitoring Team's findings for N.1, N.2, N.4, N.6, and N.7. This was not consistent with the Monitoring Team's findings for Sections N.3 and N.5. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to further define the cause of excess returned medications, and the need to continually reduce the number of medication errors. The Pharmacy Department indicated internal QA monitoring tools had been implemented. These results were documented in the Self-Assessment for Section N. ▪ Ten new orders were randomly selected each week and a number of clinical indicators were audited. The Facility Self-Assessment found substantial compliance with Section N.1. ▪ The Pharmacy Department created an internal audit to review content of the QDRRs. Areas reviewed included metabolic risk for atypical anti-psychotics, benzodiazepine use, anticholinergic use, polypharmacy, lab values, and completion of MOSES/DISCUS. The Pharmacy Director reviewed 10 QDRRs (random sample) per month. The data submitted from July through December 2013 appeared complete. A graph of findings from review of the QDRRs was provided with a date range of June 2012 through December 2013. It was noted that in 2013, there were no deficiencies in content of the QDRR found as part of the QDRR audits. ▪ Additionally, the Pharmacy Department had a spreadsheet that tracked sections (i.e., polypharmacy, benzodiazepine use, etc.) of the QDRR content and process (i.e., date of Pharmacy signature, date of PCP signature, date of psychiatry signature, etc.), dating from March 2013. From this information, a quarterly report was generated for "QDRR statistics." This included the number of QDRRs completed in the quarter, the percentage completed in a timely manner, the number of recommendations made, the percentage of recommendations with agreement by PCP, whether action was taken for the accepted recommendations, the timeliness of PCP review, and timeliness

	of psychiatry review. A review of findings of polypharmacy, benzodiazepine use, anticholinergic use, psychiatric indications of use, and a review of any trends were included in the quarterly report. Copies of the 2012-2013 Quarter 4 QDRR Statistics, and 2013-2014 Quarter 1 QDRR Statistics were submitted. ▪ The Records Department completed a five percent record review per month. This included documentation of the percentage of the records with QDRRs and whether they were current. For the months of November 2013, December 2013, and January 2014, compliance was 100 percent. ▪ The Self-Assessment indicated that the contents of the P&T Committee meeting was reviewed to determine completeness of reporting DUEs, corrective actions to be taken based on the DUEs, and follow-up of recommendations/action plans to closure. The meeting minutes of 8/29/13 and 11/14/13 were reviewed and initial report of the DUE and any follow-up to the DUE were considered complete.
	Summary of Monitor's Assessment: Several processes central to Pharmacy services demonstrated quality, and the numerous monitoring tools implemented to assure quality and identify problems at their inception further demonstrated this. Quality processes included new order processing, completion of Quarterly Drug Regimen Reviews, quality of recommendations based on these QDRRs, the process to identify and address adverse drug reactions, and the thoroughness of the drug utilization reviews. In the area of medication variances, the Pharmacy Department had implemented numerous steps to identify causes and provide systems approaches, as well as put a process in place to attempt to address concerns unique to an individual building. A challenge ahead was the continued search for causes of medication variances and development of a systems approach to reduce these events. This will require ongoing collaboration with the Nursing Department. The Pharmacy Department appeared to take every opportunity to provide additional training to nurses and other appropriate staff as the need arose. In addition, improvement was needed with regard to the Psychiatry Department's review of the use of stat medications.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated,	The Pharmacy Department staffing included the following: a Pharmacy Director, one Clinical Pharmacist (PharmD), three Staff Pharmacists (one PharmD, and two BS Pharm), and three Certified Pharmacy Technicians. The Pharmacy Department submitted a copy of the following updated policies: "Pharmacy Services," with approval date of June 28, 2013. There were no reported revisions of this policy in the prior six months. Although not related to compliance with the Settlement Agreement, since the Monitoring Team's last visit, the Pharmacy Department completed a State/Federal regulatory review/survey. The review was dated 12/13/13, and was completed as an internal audit by the Pharmacy Director for	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	AUSSLC. Compliance was 100 percent. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review for the 60 days prior to the Monitoring Team's visit. The following lists the number of patient intervention entries generated per month, according to the clinical category of the intervention:	

Category of intervention	November 2013	December 2013	January 2014	February 2014
Duplicate/unnecessary therapy	1	1	2	0
Patient care	0	2	2	0
Interaction/compatibility intervention	0	3	0	0
Order clarification/confirmation	0	2	6	1
Therapeutic consultation	0	1	0	0
Allergy/disease state contraindication	0	1	3	0
Adverse drug reaction	0	1	0	0
Antibiotic regimen change	0	2	0	0
Total per month	**1**	**13**	**13**	**1**

This information demonstrated the breadth of clinical areas reviewed and concerns identified by the Pharmacy Department in completing new orders.

The Pharmacy also had an internal QA monitoring system to review the quality of the single patient intervention entries. According to the Self-Assessment for Section N, 25 percent of these reports from July through December 2013 were reviewed for the following: name of pharmacist, date and time PCP contacted, name of PCP, medication name, description of recommendation, and documentation of outcome. Additionally, recommendations that resulted in an order were tracked to completion.

Another internal QA audit was the Lab Order Monitoring Report, which included all Intelligent Alerts. The report was reviewed for the time interval from 7/1/13 through 12/31/13 as a tracking tool to ensure required testing had occurred, orders occurred based on recommendations, and if not ordered, whether there was documentation of justification.

A sample of 28 new prescriptions was reviewed and the following summarizes the results:

- Ten new orders were submitted in which the Pharmacy found concerns with **drug-drug interactions** with the current drug regimen. Requested were copies of the following to verify appropriate processing by the Pharmacy Department: copy of new order, copy of

#	Provision	Assessment of Status	Compliance
		snap shot or label or MAR reflecting the order had been processed correctly, a copy of the patient intervention report or a copy located in a screen shot, and a copy of any change in order or other evidence that recommendation was followed by an order (i.e., for lab test, etc.). A copy of the new order was provided for 10 of 10 (100%) new orders. A copy of the snapshot or equivalent was provided for 10 of 10 (100%) new orders. A copy of the patient intervention report or equivalent was provided for 10 of 10 (100%) new orders. A change of order or additional order occurred in five cases. Evidence of this change was confirmed in five of five (100%) order changes or additional orders. ▪ Three new orders were submitted in which **allergies** were reviewed and determined by Pharmacy to be a concern. Requested were copies of the following to verify appropriate processing by the Pharmacy Department: copy of new order, copy of snap shot or label or MAR reflecting the order had been processed correctly, a copy of the patient intervention report or a copy located in a screen shot, and a copy of any change in order or other evidence that recommendation was followed by an order (i.e., for lab test, etc.). A copy of the order was submitted for three of three (100%) new orders. A copy of the snapshot or equivalent was submitted for three of three (100%) new orders. A patient intervention report or equivalent was submitted for three of three (100%) new orders. A change in order occurred in two of three. Evidence of change of order was submitted in two of two (100%) applicable orders. ▪ Five new orders were submitted in which **significant side effects** were reviewed by Pharmacy and determined to be a concern. Requested were copies of the following to verify appropriate processing by the Pharmacy Department: copy of new order, copy of snap shot or label or MAR reflecting the order had been processed correctly, a copy of the patient intervention report or a copy located in a screen shot, and a copy of any change in order or other evidence that recommendation was followed by an order (i.e., for lab test, etc.). A copy of the new order was submitted in five of five (100%) new orders. A copy of the snapshot or equivalent was submitted in five of five (100%) new orders. A copy of the patient intervention report or equivalent was submitted in five of five (100%) new orders. A copy of the change in order or other new order was submitted in three of three (100%) applicable orders. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by Pharmacy during initial review. Requested were copies of the following to verify appropriate processing by the Pharmacy Department: copy of new order, copy of snap shot or label or MAR reflecting the order had been processed correctly, a copy of the patient intervention report or a copy located in a screen shot, and a copy of any change in order or other evidence that recommendation was followed by an order (i.e., for lab test, etc.). A copy of the new order was submitted in five of five (100%) new orders. A copy of the snapshot or equivalent was submitted in five of five (100%) new orders. A copy of the patient intervention form or equivalent was submitted in five of five (100%) new orders. A copy of follow-up orders or test results was submitted in four of four (100%) applicable cases.	

#	Provision	Assessment of Status	Compliance
		▪ Five new orders were submitted in which Pharmacy had concerns about the potential need for **dosage adjustments**. Requested were copies of the following to verify appropriate processing by the Pharmacy Department: copy of new order, copy of snap shot or label or MAR reflecting the order had been processed correctly, a copy of the patient intervention report or a copy located in a screen shot, and a copy of any change in order or other evidence that recommendation was followed by an order (i.e., for lab test, etc.). A copy of the new order was submitted in five of five (100%) new orders. A copy of the snapshot or equivalent was submitted in five of five (100%) new orders. A copy of the patient intervention form or equivalent was submitted in five of five (100%) new orders. A copy of a change in order was submitted in two of two (100%) applicable cases. Additionally, a recent addition to the Pharmacy software system was the Intelligent Alerts warning system. This information was based on Federal Drug Administration (FDA) warnings and updated guidelines. From the submitted Provision Action Information, on 9/18/13, an Intelligent Alert was added for ketoconazole. An Intelligent Alert was added for use of probiotics when clindamycin was ordered. On 12/31/13, as part of the training for this new software system, an "Intelligent Alert System Refresher" was completed and three Pharmacy staff attended. The Provision Action Information also indicated an additional in-service was held on 1/8/14 (1/7/14 according to the Competency Based Training Roster) for the topic "G6PD and screening new orders." Two Pharmacy staff attended this in-service session. On 1/15/14, Pharmacy staff attended a refresher training focusing on order entry into the WORx software system. Based on the Monitoring Team's review, the Facility was in substantial compliance with this provision.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule of completed QDRRs was submitted for the prior 14 months. In this report, each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR date of completion for the past four completed calendar quarters, as well as the available information that had been completed for the current quarter (submitted data ending 2/4/14). For the time period of 12/13/12 through 2/4/14, completion of QDRR information was provided according to the residence. According to a submitted document entitled: "AUSSLC QDRR schedule and completion dates," all QDRRs were completed on one date per residence. According to the data the Facility submitted, for the 3rd and 4th Quarters of the fiscal year 2012-13, 23 of 23 residences had QDRR completion within the Pharmacy guidelines. For the 1st and 2nd Quarter of the fiscal year 2013-14, 22 residences were listed. One residence was not included on the list, but clarification indicated one residence was closed, and residents were moved to another residence. For the 1st Quarter of the current fiscal year, 22 residences had information indicating timely completion of the QDRRs. For the 2nd Quarter of the current fiscal year, as of 2/4/14, 13 of 13 residences had information	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		indicating timely completion of the QDRRs. The other residences were not due. For submitted residences for the current fiscal year, compliance was 100 percent for both quarters. A sample of 58 QDRRs was reviewed and these are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 58 QDRRs (100%). ▪ The lab results did include exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (e.g., most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ Fifty-eight of 58 labs (100%) had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. ▪ The lab testing completed, and the frequency with which laboratory testing was completed did indicate that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. Based on the Monitoring Team's review, the Facility was in substantial compliance with this provision.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted the Pharmacy and Psychiatry sections of Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 23 chemical restraints used from July 2013 to December 2013. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that 10 individuals had 23 chemical restraints from July through December 2013. For the 23 chemical restraints, the Pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 23 chemical restraint forms, 23 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in 23 out of the 23 (100%) chemical restraint forms completed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	▪ Side effects, adverse effects, and drug/drug interactions were noted in 23 of 23 (100%) of the completed chemical restraint forms. ▪ There were 17 statements that were considered recommendations, and 13 involved lack of vital sign monitoring by nursing according to policy. ▪ The range of time for completion of the forms was from less than one to eight days following the chemical restraint. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Because of Avatar's multiple screen form completion process, the Pharmacy completed their section prior to the Psychiatry section being completed. This allowed the psychiatrist to scroll through and review the Pharmacy information. Review of these documented showed: ▪ Of the 23 completed, there were 21 (91%) forms on which the psychiatry comment section was completed. However, the problem was the quality of the input from the Psychiatry Department. As is discussed in further detail with regard to Section J.3, the comments from the Psychiatrist were minimal. In general, these comments seemed to simply agree with the pharmacist's observations and did not thoroughly address the important issue of how further episodes might be prevented going forward. ▪ For 21 of 23 (91%), clinical justification was documented. ▪ Side effects were mentioned in 21 of 23 (91%) reviews. ▪ There were 14 recommendations documented. A graph of the number of chemical restraints per month was submitted for January 2012 through December 2013. The graph indicated wide swings in chemical restraint use (e.g., from zero to seven per month). After an initial decrease from February 2012 through April 2013, the pattern changed to more variation, with two spikes in May and October 2013. The Provision Action Information, updated 1/17/14, documented that a Restraint Review Board was currently being created with participation of Pharmacy, Psychology, and Psychiatry (although the Pharmacy and Psychiatry Departments were not considered as members of the board). These meetings were to begin in early February 2014. <u>Polypharmacy</u> Of the 58 QDRRs reviewed, polypharmacy was noted in 40 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 40 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 40 of 40 (100%) QDRRs by referencing the documentation reviewing benefit/risk of medication regimen. ▪ Potential interactions with other drugs or food/side effect risk was reviewed in 40 of 40 (100%) QDRRs. ▪ For 40 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of	

#	Provision	Assessment of Status	Compliance
		effectiveness and appropriateness of the drug regimen. Psychotropic polypharmacy also was reviewed through the Department of Psychiatry Polypharmacy Report. At the 2/26/14 P&T Committee, a handout included an updated report. Data was included tracking monthly psychotropic polypharmacy use. From April 2013 through January 2014, there were five individuals prescribed two or more medications from the same class of psychotropic medication. From April 2013 through January 2014, there was little variation in numbers of individuals receiving three or more psychotropic medication (regardless of class or indication). The numbers varied from 14 to 17 through the prior months, with 17 individuals listed for January 2014. There were four individuals receiving both types of psychotropic polypharmacy (i.e., two or more medications from the same class, and three or more medications regardless of class or indication). The total number of individuals on psychotropic polypharmacy varied from 15 to 18 from April 2013 through January 2014. For the most recent time period, there were 18 in January 2014. The total number of individuals receiving psychotropic medication had decreased from 126 in April 2013 to 116 in January 2014. The percentage of the population on psychotropic medication had increased from 13.5 percent in April 2013, to 15.5 percent in January 2014. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 26 of the 58 QDRRs. ▪ Of these, 26 of 26 (100%) QDRRs documented justification with appropriate diagnoses; and ▪ Twenty-six of 26 (100%) QDRRs indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 58 QDRRs, 58 (100%) were screened for medications associated with potential significant anticholinergic side effects. Forty-eight QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 48 of 48 (100%) QDRRs indicating this medication was prescribed; ▪ Forty-eight of 48 (100%) QDRRs documented clinical justification of the use of each of the medications contributing to anticholinergic load (i.e., a determination that the clinical burden of the side effects was less than the benefit); and ▪ Forty-eight of 48 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 58 QDRRs reviewed, 26 listed atypical antipsychotic medication. Of these, 26 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate).	

#	Provision	Assessment of Status	Compliance
		The Facility was found to be in noncompliance with this provision. As noted above, the QDRRs included the necessary components and provided valuable feedback. The Pharmacy Department's review of the use of stat medications was thorough, but the remaining concern was the thoroughness of the Psychiatry Department's review of the use of these medications.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of 58 QDRRs showed the following: ▪ Of the 58, 58 (100%) had a PCP signature. o Of the 58, 58 (100%) had the date the PCP reviewed the document. o There were 37 recommendations from the 58 QDRRs. o Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 37 out of 37 (100%). o The PCP responded within 14 days of the QDRR being completed by Pharmacy in 58 of 58 (100%) QDRR. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 32 of 58 QDRRs. o Agreement was documented in 18 of 32. o Disagreement with justification and plan was documented in zero out of 32. o No recommendation was made and response was not indicated in 14 of 32. o The psychiatrist responded within 14 days of the QDRR being completed by Pharmacy in 32 of 32 (100%). To determine if the recommendations agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRRs. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility indicated there were only two QDRRs in the prior six months with recommendations that were not accepted by the PCPs. These two were submitted and are listed in the documents reviewed section. In two of two (100%) cases, the response, rationale, and plan were written on the QDRR. The Pharmacy tracked the review and completion by the PCPs and psychiatrists in a document entitled "QDRR Delivery Tracking." For each residence, when the Pharmacy completed the QDRR, information was logged into the tracking document, the number of QDRRs and date sent to the PCP, the number of QDRRs and date returned, the number of QDRRs and date sent to the psychiatrist, and the number and date returned. Additionally, the numbers of reviewed and completed QDRRs were forwarded to the residence with the date. This allowed tracking of all QDRRs and a process to ensure timely completion through the system. The Pharmacy Department also had an internal monitoring system to track QDRR recommendations to completion. As the QDRRs were completed for a residence, the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		recommendations were listed in a document entitled "QDRR Recommendation Tracking," which listed each recommendation, whether accepted, and documentation of closure. A residence-specific copy of recommendations was sent to the PCP, and a copy with highlighted concerns for MOSES and DISCUS completion was forwarded to the RN Case Manager of the residence.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	As discussed with regard to Section J.12, this provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the DISCUS, and the monitoring of more general systemic effects related to psychotropic medication with the MOSES every six months (per the Healthcare Guidelines). An important component of this provision was the latency between the time the nurse completed the exam, and the prescribing physician reviewed the documentation. The review of the sample of the records of 17 individuals prescribed psychotropic medication indicated that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for 16 of the 17 (94%) individuals. The individual for whom the testing had not been completed in a timely manner was Individual #394, for whom the most recent MOSES was dated 5/6/13. The records of the 17 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all (100%) of these individuals. The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 17 individuals indicated the following three individuals were not prescribed an antipsychotic medication: Individual #90, Individual #353, and Individual #141. The review of the records of the remaining 14 individuals indicated that the DISCUS had been completed within the prior three months and at three-month intervals prior to that for all but the following six individuals (most recent DISCUS evaluations): Individual #294 (9/26/13), Individual #304 (9/13/13), Individual #204 (9/13/13), Individual #6 (7/29/13), Individual #358 (9/26/13), and Individual #292 (9/26/13), for whom there was also a gap of three months between the 4/30/13 and 9/26/13 evaluations. Thus, the DISCUS had been completed as specified for eight of the 14 (57%) individuals and had been reviewed in a timely manner by the prescriber for all of the 14 (100%) individuals. The numbers and specific information for the individuals whose records comprised this sample have been provided to enable to Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for the Monitoring Team's review. The MOSES and DISCUS also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to	Noncompliance

#	Provision	Assessment of Status	Compliance
		those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of three individuals (100 percent of those who fit the above criteria) was selected: Individual #200, Individual #169, and Individual #270. The review of records for these individuals in relation to the MOSES indicated that the examination had been performed as required for none of the three (0%) individuals. The most recent MOSES Evaluation for Individual #270 had been completed on 5/23/13. The most recent evaluation for Individual #200 had been completed on 4/30/13, and the prior one had been completed on 8/7/12. The only MOSES in the record for Individual #169 was dated 4/23/13. The prescriber had reviewed all of these records in a timely manner. The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified for only two of the three (67%) individuals: Individual #270 and Individual #200. More specifically, the DISCUS for Individual #169 had been completed on 1/3/14, but the prior one had been done on 4/22/13, so there was a gap of greater than three months. The prescriber had signed all of these in a timely manner. The discrepancy was significant between the results of the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those prescribed Reglan and no traditional psychotropic medication. The monitoring of individuals prescribed Reglan, but not also a psychotropic agent clearly needs to be improved, because this medication can cause significant side effects. These may include acute extrapyramidal motor side effects, which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. As indicated in the Monitoring Team's reports for the reviews conducted in November 2011 and November 2012, the responsibility for performing the DISCUS had transitioned from the Psychiatric Nurses to the RN Case Managers assigned to individuals' residences. Accordingly, during the Monitoring Team's current onsite review, a request was made for evidence supporting training of the nurses responsible for performance of the DISCUS. The materials submitted in response to this included the list of the nurses that had completed this training on one of the following dates: 2/27/13 and/or 5/16/13. The Facility was found to be in noncompliance with this provision. This finding is related to the deficiencies in the completion of the DISCUS side effect monitoring tool for individuals prescribed antipsychotic agents, and the completion of both the DISCUS and MOSES for those prescribed Reglan.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.</td><td>
<u>Training</u>
There were 1180 employees at AUSSLC required to complete the new employee orientation topic "Observing and Reporting Clinical Indicators of Health Status." According to the Facility's data, as of 1/20/14, compliance was 99 percent. Twelve staff had not completed this course, according to a "course due/delinquent" training roster.

New nursing staff also completed an additional training in ADRs, entitled: "Adverse Drug Reactions - Identifying and Reporting." The Pharmacy Department provided this training. Thirty-three of 33 (100%) of eligible new nursing staff completed this training. Training occurred on the following dates: 7/22/13, 10/3/13, 10/21/13, 11/21/13, and 12/30/13.

Additionally, for two other new health care professionals (i.e., one PCP and one Pharmacist), the Pharmacy Department provided initial ADR training. The training content was described as "proper procedure for reporting adverse drug reactions." The PCP was trained on 11/14/13, and the Pharmacist completed on-the-job training on 12/18/13.

Nursing staff completed an annual refresher course concerning ADRs. The Pharmacy Department provided this training. Based on the Facility's data, one hundred sixteen of 116 (100%) nurses completed this training. The annual refresher occurred on the following dates: 4/15/13, 4/16/13, 4/17/13, 4/18/13, 4/19/13, and 4/24/13.

As part of an annual refresher, the November 2013 P&T Committee meeting of 11/14/13 included an agenda item of refresher training on ADRs for P&T Committee members, which included PCPs and Pharmacists.

The following table represents data extracted from the ADR reports:

<table>
<tr><th>Date</th><th>Medication</th><th>Reaction</th><th>Date Pharmacy Notified</th><th>Naranjo ADR Problem Scale</th><th>ADR Reported to Med Watch</th><th>Added to Allergy Profile/Drug Alert</th></tr>
<tr><td>10/3/13</td><td>Bactrim</td><td>Neutropenia</td><td>10/3/13</td><td>4</td><td>N</td><td>Y</td></tr>
<tr><td>10/13/13</td><td>Cephalexin</td><td>Neutropenia</td><td>10/13/13</td><td>3</td><td>N</td><td>Y</td></tr>
<tr><td>10/7/13</td><td>Hibiclens</td><td>Rash</td><td>10/7/13</td><td>3</td><td>Y</td><td>Y</td></tr>
<tr><td>9/11/13</td><td>Olanzapine</td><td>Seizures</td><td>9/11/13</td><td>4</td><td>N</td><td>Y</td></tr>
<tr><td>9/25/13</td><td>Amlodipine</td><td>Edema</td><td>9/25/13</td><td>5</td><td>N</td><td>Y</td></tr>
<tr><td>9/26/13</td><td>Isoniazid</td><td>Transaminitis</td><td>9/26/13</td><td>8</td><td>N</td><td>Y</td></tr>
<tr><td>10/4/13</td><td>Baclofen</td><td>Apnea</td><td>10/4/13</td><td>5</td><td>Y</td><td>N</td></tr>
<tr><td>11/5/13</td><td>Clonazepam</td><td>Transaminitis</td><td>11/5/13</td><td>4</td><td>N</td><td>Y</td></tr>
<tr><td>9/26/13</td><td>Clobazam</td><td>Agitation</td><td>9/26/13</td><td>7</td><td>N</td><td>Y</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		11/2/13 | Albuterol | Tachycardia | 11/2/13 | 4 | N | Y 10/27/13 | Silodosin | Dizziness | 10/27/13 | 1 | N | N 12/10/13 | Levofloxaci | Hyponatremia | 12/10/13 | 4 | Y | Y 12/20/13 | Lisinopril | Pos/angioedema | 12/20/13 | 2 | N | N 12/19/13 | Ezogabine | Hyperthermia/ urinary retention | 12/19/13 | 2 | Y | Y 12/31/13 | Augmentin | Rash | 12/31/13 | 7 | N | Y 1/29/14 | Sulfa/TMP | Rash | 1/29/14 | 3 | N | Y 1/10/14 | Cephalexin | Thrombocytopeni | 1/10/14 | 4 | N | Y 2/17/14 | Ciprofloxaci | Rash | 2/17/14 | 3 | N | Y Training of employees indicated compliance. Training of new nurses and refresher training for health care professionals indicated compliance. The ADR process, with discussion and determination of whether to refer to MedWatch at the P&T Committee, occurred in all cases. AUSSLC was found to be in substantial compliance with this provision.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	A DUE calendar was submitted as part of the 8/29/13 P&T Committee meeting minutes. This was the 2013/2014 DUE fiscal year schedule. It included the following topics and quarter to be completed: ▪ Atypical Antipsychotics and metabolic syndrome - Quarter 1 (9/2013 - 11/2013); ▪ Benztropine - Quarter 2 (12/2013 - 2/2014); ▪ Drugs affected by low serum protein - Quarter 3 (3/2014 - 5/2014); and ▪ Lithium - Quarter 4 (6/2014 - 8/2014). During the prior eight months, three DUE studies were completed: ▪ A DUE concerning Pyridoxine and Levetiracetam was dated 8/5/13. This was presented at the 8/29/13 Pharmacy and Therapeutics Committee meeting. The DUE focused on evidence of Keppra-induced behavioral disturbances, the effect of Pyridoxine supplementation on this Keppra side effect, and the use of Pyridoxine at AUSSLC. A summary of a literature review was followed by a report of the individuals receiving Pyridoxine at AUSSLC. Of 25 individuals prescribed Pyridoxine, 20 individuals were prescribed Pyridoxine because of Keppra therapy or Pyridoxine was started near the start date of Keppra. Four of the records indicated a positive impact of Pyridoxine. It was noted that the majority of Pyridoxine orders occurred from 2001 to 2006. The DUE concluded that the 20 individuals be evaluated for the appropriateness of Pyridoxine therapy. For those that were in one of two categories (i.e., documented efficacy or at increased risk of psychiatric decompensation), continuation was considered appropriate. For those that did not fall into either of these categories, an evaluation of continued treatment was suggested. ▪ A second DUE was entitled: “Atypical or Second Generation Antipsychotics,” dated	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		10/30/13. This study was reported at the 11/14/13 P& T Committee meeting. The purpose of the DUE was to determine whether metabolic syndrome was present, was monitored, and/or was treated for those prescribed second-generation antipsychotics. A 10 percent sample of individuals prescribed second-generation antipsychotics was reviewed (n=9). Thirty-three percent had metabolic syndrome and 90 percent had at least one risk factor for metabolic syndrome. The most common risk factors were dyslipidemia, and weight increase. Seventy-five percent were treated for the adverse metabolic effects. Metabolic side effects were reviewed in eight of nine QDRRs. Justification of use of the second-generation anti-psychotic occurred in each case. A review of monitoring indicated waist circumference was not measured by nursing for any individual, although it was an area included in the Quarterly Nursing Assessment form. Only two of nine had orders for periodic fasting blood glucose levels. Others had glucose testing ordered, but it was not clear if these were fasting values. Two of nine had orders for routine blood pressure checks. Others had blood pressures recorded quarterly by nursing on the Quarterly Nursing Assessment. Based on this information, the DUE included recommendations for all individuals prescribed second-generation antipsychotics. These included ensuring waist circumference measurement quarterly, monthly weights, lipid levels at least annually, blood pressure measurements quarterly or more often if appropriate, and fasting blood glucose annually. ▪ A third DUE was entitled: "Benztropine." This was presented at the 2/26/14 Pharmacy and Therapeutics Committee meeting. The purpose was to assess whether benztropine prescribing was clinically appropriate for the individuals at AUSSLC. Of the individuals at AUSSLC, 13 were prescribed Benztropine. All were reviewed (100% sample size) for the following: indication for use, whether a contraindication or drug interaction existed, duration of treatment, and overall appropriateness of use. Information in the report included gender, age, prescribed indication (i.e., extrapyramidal syndrome, drooling, dystonia, akathisia, and tremor), presence of contraindications (i.e., absolute, relative, and cautions), drug interactions (i.e., additional anticholinergic medications prescribed, specific medications or class of medications), and length of therapy. It was recommended that the use of benztropine for each individual be reviewed for appropriateness of use and the report included several recommendations for treatment options. To determine impact of findings leading to in-service education and/or corrective actions, a follow-up study was conducted for one prior DUE and presented at the 11/14/13 Pharmacy and Therapeutics Committee meeting. This was a follow-up to a DUE performed 8/5/13 concerning Pyridoxine and Levetiracetam. A recommendation from the DUE of 8/5/13 included evaluation of each individual prescribed Pyridoxine for the appropriateness of this therapy. A second recommendation was to discontinue Pyridoxine for individuals without documented efficacy or who were not at increased risk of psychiatric decompensation. The initial DUE indicated 20 individuals were prescribed Pyridoxine for which the indication was Keppra-induced behaviors in 20 of the 25. For the follow-up of 8/5/13, there were 28 individuals prescribed Pyridoxine.	

#	Provision	Assessment of Status	Compliance
		Although one individual had been discharged, three residents had been started on Pyridoxine due to Isoniazid being prescribed. One additional individual had been started on Pyridoxine after starting Keppra, to reduce behaviors. The follow-up summary indicated that the number of individuals on Pyridoxine had increased, that 20 individuals were on Pyridoxine to potentially reduce Keppra-induced behaviors, and no individual had Pyridoxine discontinued from the original DUE. This was reported at the P&T Committee meeting of 11/14/13. From the minutes of the 2/26/14 P&T Committee meeting, a follow-up to the metabolic syndrome/second generation anti-psychotic medication use was reported. From the DUE, a sample of nine individuals had been reviewed to determine if metabolic syndrome was present, was being monitored, and/or was treated. For the follow-up study, these same nine individuals were reviewed to determine whether any monitoring changes had occurred. It was noted that since 11/1/13, nursing physical assessments had been completed on six of these individuals. Six of six had blood pressure recorded. One of six had a waist circumference recorded. Three of six had a notation that the individual refused the waist measurement. For one of six, the entry line was blank. For one of six there was the notation of "tape unavailable." Nine of nine had monthly weights. Nine of nine had lipid levels scheduled at least annually. There was no change in standing orders for fasting blood glucose levels. The original two of nine with this order were the only ones with fasting glucose orders. Further discussion to improve compliance then followed. Based on these findings, the Facility was found to be in substantial compliance with this provision.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	<u>Policies and Procedures regarding Medication Variances</u> A copy of the policy "Medication Variances," dated March 2013, was submitted. The Pharmacy Department had updated the medication variance procedure addendum to this policy in October 2013. This focused on the role of each Department in receiving information concerning a medication variance and the role of each Department in data entry of a medication variance. There were no new or revised policies or procedures concerning medication administration in the prior six months. However, a policy entitled: "Medication Administration Guidelines," revised August 2013 was submitted, with a training roster documenting 102 of 105 (97%) completed training in September 2013. <u>Pharmacy Review of Categorization of Errors</u> The Pharmacy Department did not provide information verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy Department's interpretation of the medication error categorization. It was not determined whether the Pharmacy Department provided monitoring of categorization of medication errors in order to ensure accuracy by the nursing staff. <u>Committee Monitoring of Medication Errors/Variances</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		The development, progress, and tracking of medication errors and trend analysis were reflected in the minutes of the Medication Variance Committee meetings, which the Clinical Pharmacist chaired. Since the Monitoring Team's last visit, the Committee met on 8/11/2013, 9/10/13, 10/9/13, 11/21/13, and 12/10/13. The Medication Variance Committee met during the week of the Monitoring Team's onsite visit, on 2/24/14. Details of this meeting are reviewed here as an example of the content of the Committee meetings. Data from 2012 to 2014 indicated there had been a decrease in Pharmacy medication variances over the past three years. At the 2/24/14 meeting, analysis of the trend indicated that the weekly cart fill process continued to be the source of most Pharmacy variances, and the decrease in distractions during the cart fill process had improved the medication variance rate. Additionally, weekly meetings occurred with the Pharmacy technicians to review Pharmacy-generated variances, prior to the weekly cart fill process. Weekly meetings also included the monthly totals of Pharmacy variances. Meetings with dispensing Pharmacists occurred one-on-one to review variances and identify systems issues. Action steps taken since January 2014 included separation of look-alike, sound-alike medications in the dispensing bays. Pharmacy also reminded the nursing staff at two Nurse Education meetings to promptly alert the Pharmacy when an error was discovered on the MAR. At the 2/24/14 medication variance meeting, tracking of liquid valproic acid on one residence occurred on a weekly basis, because the PCP noted variation in drug levels. Weekly review of the liquid medication identified that the remaining volume in the bottles varied through the weeks. The reason for the variation had not been determined, but was a first step in developing an action plan. For January 2014, there were five medication variances attributed to Woodhollow Unit, 22 medication variances from Sunrise, 49 medication variances at Castner Unit, and five medication variances in the Infirmary. Core information from the Medication Variance Committee minutes are provided in the following tables: The number of medication variances per Department were provided per month:	

Month	Pharmacy Department	Nursing Department	Medical Department	Dental Department	Total
August 2013	32	116	1	0	149
September 2013	10	152	0	0	162

#	Provision	Assessment of Status	Compliance

October 2013	25	44	0	0	69
November 2013	10	32	1	1	44
December 2013	26	144	2	0	172
January 2014	16	81	0	0	97
Total	**119**	**569**	**4**	**1**	**693**

The November 4, 2013 P & T Committee meeting indicated that the reduced numbers in nursing might have been due to lack of reporting.

The number of medication variances per month were categorized:

Month	Category A	Category B	Category C	Category D	Category E
August 2013	38	31	58	22	0
September 2013	51	48	60	2	1
October 2013	21	4	44	0	0
November 2013	11	0	30	3	0
December 2013	45	72	47	6	2
January 2014	26	35	36	0	0
Total	**192**	**190**	**275**	**33**	**3**

A description of major categories of medication variances per month included the following:

Month	Excess Unknown Returns (Doses)	Unknown Shortage (Doses)	MAR Not Initialed	Documented Omission
August 2013	77	42	Not available	38
September 2013	69	23	Not available	24

#	Provision	Assessment of Status	Compliance

October 2013	43	51	Not available	29
November 2013	119	29	Not available	22
December 2013	87	50	Not available	31
January 2014	91	32	Not available	52
Total	**486**	**227**	**Not available**	**196**

Additional Pharmacy Monitoring Processes

The Pharmacy Department provided a list of action steps taken to reduce medication variances since the Monitoring Team's last visit, listed in the Provision Action Information document, or that had been a continuing project by the Pharmacy Department. These included:

- From July through December 2013, new employee nurses (33) were trained on medication variance as part of their new employee orientation.
- Revision was made to the excess/short form for medications requested from or returned to the Pharmacy. This included additional options for the excess or shortage, as well as a statement ensuring other options had been considered before determining the medication was an unknown category. It also required a box to be checked when the nurse completed the medication variance form. Duplicate copies of the excess/short form via carbon copy were sent to the Nursing Department for appropriate follow-up.
- For medications being sent on furlough when an individual left AUSSLC, the nurse that verified the medications was to sign the verification statement, as well as name the transporter and the person receiving the medication.
- In September, a process began that included a Pharmacy review of MARs to ensure accuracy and clarity.
- In October, the Pharmacy implemented a revised controlled substance administration record and weekly fill for controlled substance liquids.
- The Pharmacy began matching up controlled substance administration records by serial number, reviewing any inaccuracies, and initiating medication variance forms, when appropriate.
- A task force was begun to discuss medication variances. This occurred on 10/23/13.
- On 12/11/13, the Pharmacy, along with the Medical Compliance Nurse and Nurse Educator met to review training for medication variance data entry into the AVATAR system by the nurse managers. On 12/19/13, a subsequent meeting included a discussion of proper coding of medication variance and entry into AVATAR.
- As of January 2013, the Pharmacy began to participate/present at all Nurse Education meetings with the following topics being discussed in recent months: calcitonin administration, revised floor stock list, conversion of Neosporin use to Polysporin use,

#	Provision	Assessment of Status	Compliance
		difference between a solution and suspension along with the importance of shaking well prior to administration, reminder of MAR information being generated by the Pharmacy, refill review, and that errors were to be reported as soon as discovered. ▪ An AUSSLC policy entitled: "Nursing Protocol: Furlough and off campus medication administration," effective May 2013, was followed by in-service training in September 2013. One hundred two of 105 (97%) of nurses completed the training. ▪ On 1/8/14, the Pharmacy began monitoring bulk liquid seizure medications for individuals in one of the residences due to increased seizure activity. ▪ On 2/11/14, Pharmacy staff completed an in-service on "unusual incidents - medication variance." Four Pharmacy staff signed the competency-based training roster. ▪ The Dental Department began to be included in the medication variance data. ▪ The Pharmacy utilized "weekly set fill logs" that required the nurses to count the received medication, document the count, and return this information at the beginning of the weekly fill. These were tracked by Pharmacy until received. ▪ School medication was tracked monthly to ensure accountability of medication and prevent/document medication variances. ▪ The Pharmacy completed medication room inspections and forwarded results to the Nursing Department. A schedule was submitted for medication room inspections in 24 areas. Each month, these were inspected, on a rotating basis of six each week. ▪ At the 2/26/14 P&T Committee meeting, a new nursing position was created (Medication Variance Coordinator). This position would assist in achieving quality database management for medication variances, as well as providing a needed tracking system to improve timeliness and quality of reviews. The Medication Variance Committee on 2/24/14 also had approved this position. ▪ The Pharmacy Department completed an internal QA review of the new order process. Each week, 10 orders were audited to determine the following: correct patient, correct drug, correct dose, correct start date, correct stop date, indication, correct prescriber, and correct route. Raw data was submitted verifying completion of this internal audit process. Results are documented under the Pharmacy medication variance section in the above charts. This data indicated ongoing Pharmacy review of new orders to reduce medication variances originating in the Pharmacy Department. <u>Medication Error Reports</u> Copies of the last 10 medication error forms were requested. Copies of the last nine medication error forms were submitted for review. The Monitoring Team member reviewed and classified the medication variances according to the State Office policy/guideline. There was zero Class A medication errors, five Class B medication errors, four Class C medication errors, and zero Class D medication errors. Seven different medications were involved in these nine medication variances. Follow-up of the errors was documented in nine of nine errors. It was noted that the Facility staff had not categorized the medication variances on the forms for six of nine errors.	

#	Provision	Assessment of Status	Compliance
		Medication Observation Monitoring The Facility indicated that there were no medication observation records readily retrievable for this review. The Facility remained in noncompliance with this provision. The challenge ahead was the continued search for causes of medication variances and development of a systems approach to reduce these events. This will require ongoing collaboration with the Nursing Department.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section O; o The following documents for Sample O.1 (i.e., smaller sample size) for eight individuals (i.e., Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223): PNMT Referral Form, OT/PT/SLP/Registered Dietician (RD) consultations for past year, PNMT Post-Hospitalization assessment, Tool for Confirming Pneumonia Diagnosis, Modified Barium Swallow Study (MBSS), PNMT meeting minutes (individual-specific) for past six months, if applicable, and PNMT consultations and copies of emails to IDT staff, if applicable; o The following documents for Sample O.2 (i.e., smaller sample size for this review) for four individuals (i.e., Individual #375, Individual #307, Individual #286, and Individual #423) assessed by the PNMT since the last review and two individuals (i.e., Individual #389 and Individual #213) who had been discharged from the PNMT since the last review: PNMT assessment and PNMT assessment addendum, if applicable; PNMT action plan; Head of Bed Evaluation (HOBE) assessment; annual ISP, including IRRF and IHCP; Change of Status IRRF and IHCP; ISPAs for past six months; individual-specific PNMT meeting minutes for past six months; Integrated Progress Notes for past six months; PNMT Discharge Summary; ISPA addressing PNMT discharge; PNMT meeting minutes related to discharge; and PNMT assessment; o The following documents for Sample O.3 (i.e., full monitoring for Section O.3 per Facility request) for 15 individuals (i.e., Individual #206, Individual #381, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #223, Individual #103, Individual #51, Individual #40, Individual #261, Individual #351, Individual #278, and Individual #302) and an additional seven individuals on the current PNMT caseload (i.e., Individual #389, Individual #307, Individual #93, Individual #286, Individual #182, Individual #423, and Individual #398): PNMPs and dining plans with all written and photographic instructions in color, ISPs, ISPAs for the last year, ISP Preparation Meeting list of IDT members required to attend ISP meeting, OT/PT assessment completed prior to the ISP, and evidence of PNMP implementation for PNMPs revised after the individual's annual ISP; o PNMPs and dining plans for 58 individuals in multiple residences, dining rooms, and day programs, including: Individual #149, Individual #126, Individual #264, Individual #381, Individual #433, Individual #78, Individual #319, Individual #64, Individual #338, Individual #24, Individual #297, Individual #435, Individual #370, Individual #368, Individual #159, Individual #429, Individual #160, Individual #201, Individual #37, Individual #308, Individual #246, Individual #228, Individual #173, Individual #457, Individual #253, Individual #51, Individual #72, Individual #50, Individual #102,

	Individual #422, Individual #299, Individual #16, Individual #40, Individual #358, Individual #294, Individual #119, Individual #60, Individual #105, Individual #354, Individual #195, Individual #63, Individual #340, Individual #353, Individual #181, Individual #147, Individual #416, Individual #328, Individual #178, Individual #260, Individual #62, Individual #22, Individual #398, Individual #363, Individual #117, Individual #323, Individual #171, Individual #18, and Individual #191; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged; o State and Facility Physical Nutritional Management policies and protocol; o List of continuing education sessions in which PNMT members participated; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff; o List of changes in PNMT evaluation form; o List of individuals with PNM needs; o List of individuals without PNM needs; o Dining Plan (template) with changes; o PNM and PNMT-related database reports, and spreadsheets generated by Facility; o List of individuals on modified/thickened liquids; o List of individuals who require mealtime assistance; o List of individuals who receive nutrition through non-oral methods; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency; o List of individuals with Body Mass Index (BMI) equal to or greater than 30; o List of individuals with BMI equal to or less than 20; o List of individuals who have had an unplanned weight loss of 10 percent or greater since the last review; o List of individuals who have had a choking incident since the last review; o List of individuals who have had an aspiration and/or pneumonia incident since the last review; o List of individuals who have had a fall since the last review; o List of individuals who have had a decubitus/pressure ulcer since the last review; o List of individuals who have experienced a fracture since the last review; o List of individuals who have had a fecal impaction since the last review; o List of individuals who are non-ambulatory or require assisted ambulation; o List of individuals with poor oral hygiene; o List of individuals who received a feeding tube since the last review; o List of individuals who are at risk of receiving a feeding tube; o List of individuals who have received a MBSS or other diagnostic swallowing evaluation during the past year; o Schedule of meals by residence; o Curricula on PNM used to train new staff responsible for directly assisting individuals;

	o List of approved trainers for PNM foundational training; o List of approved trainers for PNM non-foundational training; o Agenda and curriculum for competency-based, annual refresher training related to PNM; o List of completed PNMT Nursing Post Hospitalization Assessments/Evaluations; o Current employees who were required to completed PNM annual refresher training, including date of completion; o Current employees who were required to complete annual refresher training; o Current PNM monitoring forms including date of implementation of the form, instructions with any changes made since the Monitoring Team's last review highlighted, list of staff responsible for monitoring, monitoring schedule, and monitoring schedule for individuals at risk; o QA/QI meeting minutes related to PNM, PNMT and the HT Department; o Facility Individual Risk List; o Photograph protocol; o Shoe Monitoring protocol; o List of individuals requiring individual-specific training; o List of staff who have been trained for individuals who require individual-specific training; o Individual-specific competency performance check-offs; o Weight Committee meeting minutes for past six months; o PNMT presentations at medical morning meetings for the months of December 2013 and January 2014; o Gastrostomy Tube Presentation by PNMT Nurse; o PNMP tracking spreadsheet for the past three months; o Residential Services SSLC's Safe Mealtime and Positioning Practices; o Unit Director for Castner's Mealtime Packet; o Meeting minutes for MTC workgroup for January 2014; o Mealtime Notebook for "Up the Hill;" o MTC Tracker for staff who have completed Phase I, II, and III; o Episode Tracker for past three months; o Copies of PNMT Systemic Issues resolution evidence; o Emails from PNMT Nurse for PNMT referrals; and o Weekly falls review meeting minutes for the months of January and February 2013. ▪ **Interviews with:** o Dr. Michael Gayle, PT, DPT, MA, OCS, Director of Habilitation Therapy; o Diane Hierholzer, OT, PNMT Lead; o Sharon Price, PNMT RN; o Meghan Trenz, PNMT PT; o Janice Taylor, Lead SLP; o Susan Hanson, Lead PT; o Chris Strickland, Lead OT; o Briseida Pena, HT Administrative Assistant; and o Bob Wayman, Unit Director and Mealtime Coordination Workgroup Leadership Staff

	Member. ▪ **Observations of:** o Fifty-eight individuals in multiple residences, dining rooms, and day programs (i.e., 501, Infirmary, 782, 783, 784, 788, 732-D, 732-E, 732-P, 779-H, 779-R, 793, 794, and 795), including Individual #149, Individual #126, Individual #264, Individual #381, Individual #433, Individual #78, Individual #319, Individual #64, Individual #338, Individual #24, Individual #297, Individual #435, Individual #370, Individual #368, Individual #159, Individual #429, Individual #160, Individual #201, Individual #37, Individual #308, Individual #246, Individual #228, Individual #173, Individual #457, Individual #253, Individual #51, Individual #72, Individual #50, Individual #102, Individual #422, Individual #299, Individual #16, Individual #40, Individual #358, Individual #294, Individual #119, Individual #60, Individual #105, Individual #354, Individual #195, Individual #63, Individual #340, Individual #353, Individual #181, Individual #147, Individual #416, Individual #328, Individual #178, Individual #260, Individual #62, Individual #22, Individual #398, Individual #363, Individual #117, Individual #323, Individual #171, Individual #18, and Individual #191; and o QA/QI meeting, on 2/25/14; and o PNMT meeting, on 2/25/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment for Section O, as well as interviews with the Director of HT, the following was found: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-based audit tools for PNMT assessments, PNMT Attendance Tracking Sheets, PNMP audit tool, and AUSSLC PNMP Compliance Monitoring form. The Facility was not using the State Monitoring Tool for Section O. ▪ The data presented in the Self-Assessment reflected the completion of additional activities, such as review of the PNMT Caseload Activities Tracker, Daily Medical Meetings for PNMT Nurse attendance, Episode Tracker, continuing education spreadsheet, etc. ▪ The Self-Assessment identified the sample sizes, which included the information necessary to determine the percent sample in comparison with the overall population. ▪ The monitoring tool and audits did not include adequate standards, and criteria. The audit tools were missing instructions that would support consistency among monitors. ▪ The following staff/positions were responsible for completing the audit tool: The Director of HT, PNMT members, and Facility therapists. Currently, no Facility PCMs were responsible for completing the Self-Assessment. The Director of HT and therapists were working with a Facility PCM to provide training in compliance monitoring. In the future, if data is collected by a PCM, it should be identified in the Self-Assessment. ▪ Adequate inter-rater reliability had not been established between the Director of HT, PNMT

	members, and therapists. ▪ The Facility used other relevant data sources, including, for example, Competency Training and Development (CTD) participation rosters for new employees and veteran staff, QIDP database for assessment completion and attendance, review of Provision Action Information, HT spreadsheets, Facility Integrated Risk Ratings – by Home, continuing education database, and review of Master Lists (e.g., individuals who receive enteral nutrition, individuals who require mealtime assistance, individuals who received a Modified Barium Swallow, PNMP database, etc.). ▪ The Facility presented some of the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with the following subsection: Section O.3. This was not consistent with the Monitoring Team's findings. The Monitoring Team found a rating on noncompliance for Section O.3. The Facility rated itself as not being in compliance with Sections 0.1, O.2, O.4, O.5, O.6, O.7, and O.8. The Monitoring Team's findings for these sections were the same. ▪ The Facility's data identified some areas in need of improvement, but did not consistently provide specific information regarding the analysis of the information and/or the development of interventions to address findings that did not support compliance. Very limited analysis, and occasional reference to activity designed to address the issues identified were included in the Self-Assessment.
	Summary of Monitor's Assessment: At the time of the Monitoring Team's onsite review, the Facility Physical and Nutritional Management Team (PNMT) was functioning with the disciplines defined in the Settlement Agreement. However, the PNMT membership had not been consistently staffed with the required disciplines throughout the past six months. Consequently, required PNMT members were not in attendance at a significant number of meetings. The Facility's evidence showed that medical providers were not routinely participating in PNMT meetings. Some PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. The Facility did not have a comprehensive physical and nutritional management (PNM) policy. On a very positive note, the PNMT was identifying and resolving system issues. The Facility PNMT Guidelines had been updated to define the PNMT referral process. However, the Facility's IDTs had not been trained on the revised PNMT Guidelines. Some individuals who had experienced a change in status had been referred to the PNMT, but other individuals who should have been referred had not been referred. The PNMT was not completing assessments per established timelines. PNMT assessments were missing many necessary assessment elements. PNMT assessment recommendations had not been integrated into individuals' IHCPs. ISP Preparation meetings had not been conducted for individuals to determine which IDT members were required to attend the annual ISP meetings. The Monitoring Team could not determine if the appropriate disciplines were present during the annual ISP meetings, because requested signature sheets were not submitted for review for individuals in the Monitoring Team's sample. Individuals' Physical and Nutritional Management Plans (PNMPs) were missing necessary components. Teams had not met to

	approve individuals' PNMPs that had been revised after the annual ISP meeting. There had been some improvement in staff compliance with dining plan implementation since the last review, when compliance was zero percent, to this review, when compliance was 26 percent. On a positive note, during dinner mealtime observations in the dining room for Hummingbird and Roadrunner, there were no mealtime errors observed. However, during observations in multiple other dining rooms, staff were not following dining plan instructions. Facility therapists had expanded written and pictorial instructions for wheelchair and alternate positioning to provide staff with additional instructions to support the correct implementation of individuals' PNMPs. In addition, the training curriculum for new employees and veteran staff had been revised to place more emphasis on the implementation of individuals' PNMPs and dining plans. Although there had been some improvement in staff implementation of PNMPs from the last review, additional work needed to be done. The Facility therapists had revised the New Employee Orientation (NEO) and annual refresher PNM foundational competency-based training to place more emphasis on staff's understanding of the implementation of PNMPs and dining plans. The Facility therapists had identified individuals whose staff would require individual-specific training, had developed individual-specific performance check-offs, and had provided some training. The therapists were in the process of finalizing the system for the provision of individual-specific training, and the process for alerting management and direct support professionals of individuals' staff that would require this training. The Facility had implemented the Mealtime Management System campus-wide, but additional work needed to be done to ensure Mealtime Coordinators (MTCs) and Table Captains performed their duties as defined. Since the last review, the Facility had reinitiated PNMP monitoring. PNMP monitoring was being completed for meals, positioning, lifting/transfers, and communication. The Self-Assessment for Section O.6 presented a cumulative monitoring score for the months of September, October, November, and December 2013 for positioning, meals, and lifting/transfer. The Monitoring Team questioned the reliability and validity of these cumulative scores. For example, 27 positioning monitoring forms were completed in December with a cumulative score of 99%. The Monitoring Team's direct observations did not find this level of compliance with positioning in wheelchairs and/or alternate positioning.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates for policy, staffing of PNMT and continuing education) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As noted above with regard to the documents reviewed section, four samples were selected for the review of Section O. These included:	Noncompliance

#	Provision	Assessment of Status	Compliance
	Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	▪ **Sample O.1** consisted of a smaller sample of eight individuals chosen from a list the Facility provided of individuals identified as being at a medium or high risk for PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, or osteoporosis], requiring mealtime assistance and/or prescribed a dining plan, at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room, and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These eight individuals were: Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223): ▪ **Sample O.2** consisted of four individuals who were assessed by the PNMT since the last review: Individual #375, Individual #307, Individual #286, and Individual #423. In addition, a sample of two individuals who had been discharged by the PNMT was selected, including: Individual #389 and Individual #213; ▪ **Sample O.3** was comprised of 15 individuals who had experienced a change in status and/or were at risk for PNM concerns and seven individuals who were on the current PNMT caseload (i.e., Individual #206, Individual #381, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #223, Individual #103, Individual #51, Individual #40, Individual #261, Individual #351, Individual #278, Individual #302, Individual #389, Individual #307, Individual #93, Individual #286, Individual #182, Individual #423, and Individual #398). This sample was chosen to assess substantial compliance for Section O.3 as requested by the Facility. ▪ **Sample O.4** consisted of 58 individuals (i.e., Individual #149, Individual #126, Individual #264, Individual #381, Individual #433, Individual #78, Individual #319, Individual #64, Individual #338, Individual #24, Individual #297, Individual #435, Individual #370, Individual #368, Individual #159, Individual #429, Individual #160, Individual #201, Individual #37, Individual #308, Individual #246, Individual #228, Individual #173, Individual #457, Individual #253, Individual #51, Individual #72, Individual #50, Individual #102, Individual #422, Individual #299, Individual #16, Individual #40, Individual #358, Individual #294, Individual #119, Individual #60, Individual #105, Individual #354, Individual #195, Individual #63, Individual #340, Individual #353, Individual #181, Individual #147, Individual #416, Individual #328, Individual #178, Individual #260, Individual #62, Individual #22, Individual #398, Individual #363, Individual #117, Individual #323, Individual #171, Individual #18, and Individual #191) observed in residences, dining rooms, and day programs. This included random, individual-specific observations as well as observations of individuals in Samples O.1 and O.2.	

#	Provision	Assessment of Status	Compliance
		Updates The AUSSLC Provision Action Information, updated 2/5/14, reported the following actions were completed for Section O.1: ▪ 9/6/13 - An audit system was developed to determine if required documentation/instructions, that clarify a person's PNMP, was present or not with the PNMP. The audit also looked at individual-specific instructions as well as general instructions; ▪ 10/9/13 - Revisions were made to the PNMT Guideline to further refine and define the process; ▪ 10/11/13 - one SLP contractor was hired for the PNMT. One PT contractor was hired on 10/1/13 for the PNMT, but resigned within two weeks to take full-time employment elsewhere; ▪ 10/14/13 - Approval was granted to hire one additional Dietician contractor for the PNMT and to provide services for individuals who receive nutrition enterally; and ▪ 11/29/13 - Habilitation Therapy and Nursing completed C-Diff protocols for use in the homes, backpacks for joey pumps were re-fabricated in the wheelchair shop in order to better support the pumps, Habilitation Therapy and Infirmary staff worked on getting a dishwasher so that adaptive equipment could be cleaned at the Infirmary, and it was delivered and installed, Habilitation Therapy and Nursing worked together and now have nosey cups for med passes. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.1 included an action plan. The following action step was in the process of completion: ▪ Develop system to integrate PNMT monitoring results and graphs of intervention results into QA and Risk Management systems to track and trend the frequency, antecedents, and correlations with identified health risk indicators. The implementation of this action step appeared to be appropriate in working to achieve compliance within this section. Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. In addition, Section O.1 specifically requires that: "The Facility shall provide each individual who requires physical or nutritional management services with a Physical and	

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		Nutritional Management Plan (PNMP) of care consistent with current, generally accepted professional standards of care… The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team." The status of these requirements is discussed with regard to Section O.3. **PNM Policy and Role of the PNMT** The Facility submitted the following policies and/or procedures: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ State Policy 006.3: At Risk Individuals, effective 12/7/12; ▪ State Policy 003.1: Quality Assurance, effective 1/26/12; ▪ AUSSLC Physical, Nutritional Management Team Operational Guidelines, effective date of October 2013; ▪ AUSSLC PNMT RN: Back-Up Process, not dated; ▪ AUSSLC PNMT In-Service Protocol, not dated; ▪ PNMP Revision, revised 5/15/13, ▪ PNMP Finalization, revised 5/15/13; ▪ PNMP Delivery, revised 5/15/13 ▪ Falls Tracker Review, not dated; ▪ Episode Tracker Review, not dated; ▪ Compliance Monitoring Form, dated 10/4/13; ▪ AUSSLC – IDT Active Treatment Meal Time Procedures, effective date of 10/10/13; ▪ Photograph protocol, not dated; ▪ Shoe Monitoring protocol, not dated; and ▪ Habilitation Therapy Referral Form, not dated. AUSSLC had established PNM policies that included the following elements, though some of these were included in the DADS At-Risk Policy, Physical Nutritional Management Policy, and QA Policy: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan; ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP to be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a	

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		speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; and ▪ PNMT follow-up. Based on the Monitoring Team's review of the policies/protocols, the Facility did not have policies and/or protocols that addressed the following elements: ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (not stated specifically in the policy, but clearly in practice); ▪ A system of effectiveness monitoring; ▪ Description of a sustainable QA system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns (not stated specifically in the policy, but clearly in practice), including: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers meeting, QA/QI meeting); o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the	

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		resolution of systemic issues; and ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide); o Identification of monitors and their roles and responsibilities; o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring; o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician; and o Frequency of monitoring to be provided to all levels of risk. As a result, the Facility did not have a comprehensive PNM policy that included all of the preceding elements. **Core PNMT Membership** The AUSSLC PNMT had the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, and Speech Language Pathologist. Additional core PNMT members included a QIDP and a PNMP Coordinator. However, since the last review, the PNMT had not been functioning with the required members. The PNMT PT and PNMT SLP joined the PNMT on 11/1/13. **Consultation with Medical Providers and IDT Members** Update: The PNMT did not have assigned medical providers or consultants. It was reported that the only professional medical personnel that the PNMT confers with were the Facility primary care providers assigned to the individuals on the PNMT caseload. During the time period of 7/1/13 to 12/31/13, primary care providers attended one of the 208 PNMT meetings (.5%). During the Monitoring Team's next review, the following will be reviewed: ▪ For ___ of ___ individuals (%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities; and	

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		▪ For ___ of ___ individuals in Sample 0.2 (%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Five of five (100%) PNMT core members (i.e., OT, PT, SLP, RD and RN) were licensed to practice in the state of Texas. During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ (%) PNMT core members had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Specialized training is defined as graduate education or continuing education content that is relevant to enhancing the provision of supports to individuals with identified PNM concerns. **Continuing Education** One of five PNMT staff (20%) (i.e., PNMT Lead/OT) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ OT attended: Making Digital Materials Accessible for Individuals with Disabilities (9/29/13), How to Recognize and Describe Dementia (10/15/13), Aging in Place: Part 1 (10/15/13), Aging in Place: Part 2 (10/18/13), Calming the Cognitively Impaired (10/18/13), Marfan Syndrome: Inherited Disorder Has Far Reaching Effects (10/18/13), MRSA [Methicillin-resistant Staphylococcus aureus]: May Be Waiting Right Around the Corner (10/20/13), Blood Count Basics (10/21/13), Gastroesophageal Reflux Disease: Infancy through Adulthood (10/27/13), Habilitation Therapies Conference (10/31/13 to 11/1/13), NS Enteral Nutrition: Optimal Use of Feeding (11/4/13) for a reported total of 16.5 hours of continuing education; ▪ RN attended: Cardiac Case Studies (9/13/13), EKG [electrocardiogram] Strip Identification and Evaluation (9/13/13), Hypo/Hyperthermia in the Elderly (9/13/13), Hemodynbamic Monitoring: An Introduction (9/18/13), Medical Error: What You Need to Know (9/18/13), Interpretation of ABGs [arterial blood gases]: A Four Step Method (9/16/13), Skin and Wound Care (10/14/13), and Habilitation Therapies Conference (10/31/13 to 11/1/13) for a total of 9.4 hours; ▪ PT attended: Habilitation Therapies Conference (10/31/13 to 11/1/13) for a reported total of 1.25 hours of continuing education; and ▪ SLP attended: Myofascial Release and Other Manual Techniques in Dysphagia Management (12/7/13 to 12/8/13) for a reported total of 1.2 hours of	

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		continuing education. **PNMT Meetings** The Presentation Book for Section O and the Facility Self-Assessment for Section O.1 indicated from 7/1/13 to 12/31/13, there were 208 PNMT core meetings. The attendance percentages by PNMT members were as follows: ▪ PNMT OT – 202 of 208 meetings (i.e., 97%); ▪ PNMT RN – 170 of 208 meetings (i.e., 82%); ▪ PNMT SLP – 120 of 208 meetings (i.e., 58%); ▪ PNMT PT – 140 of 208 meetings (i.e., 67%); ▪ PNMT RD – 16 of 208 meetings (i.e., 8%); ▪ PNMT QIDP – 208 of 208 meetings (i.e., 100%); and ▪ PNMT PNMP Coordinator – 96 of 208 meetings (i.e., 46%). The Facility reported that the PNMT did not have a SLP, PT, or RD during part of this time period. There should be a minimum of 80% attendance rate by core members and a 90% attendance rate with the addition of back-up members, if the Facility choses to have back-up members. During the Monitoring Team's next review, the following additional indicators will be reviewed: ▪ Since the last on-site review, of the ____ weeks, the team met on ____ (%). ▪ ____ of ____ (%) PNMT meeting minutes included documentation of appropriate topics, including at a minimum: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals for individuals in the sample. **Resolution of Systemic Concerns** The Facility PNMT Guidelines statement of procedures identified that PNMT members would "identify system issues." In 2013, the AUSSLC PNMT had identified the following system issues: ▪ Preparation of database of residents on thickened issues; ▪ Management and care of the gastrostomy tube; ▪ Feeding pump backpacks; ▪ Facility formula concerns, ▪ Resident positioning for dental; ▪ Resident positioning in the Infirmary; ▪ Resident weights; ▪ CPAP [continuous positive airway pressure]/BiPap [bi-phasic positive airway pressure] care and maintenance; ▪ Wound care; ▪ Maintenance of bath trolleys;	

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		▪ Proper use of nosey cups during medication administration; ▪ Updating PNMPs for Nursing process; ▪ Nursing equipment needs; ▪ Standardized diet orders project; and ▪ Adaptive equipment in the Infirmary. The PNMT kept a notebook of these system issues that included a statement of the system issues, departments involved, brief discussion of the PNMT plan, and resolution. For example, the PNMT initiated competency-based staff training on the daily cleaning/checking of bathing trolleys. The Facility in collaboration with the PNMT members should formalize the process it used for resolution of system issues through the development and implementation of Facility policy/protocols that include the policy elements presented above. On a positive note, the Facility Director had initiated a Systems Committee that would provide a positive forum in which the PNMT could present system issues for Facility resolution. In summary, the Facility did not have a comprehensive PNM policy and/or procedure that encompassed the identified elements within this section. The Facility PNMT at the time of the review was functioning with the appropriate disciplines as defined in the Settlement Agreement. However, the PNMT had not been consistently staffed with the required disciplines throughout the past six months. The Facility presented evidence that medical providers were not routinely participating in PNMT meetings. The PNMT was meeting on a regular basis. There should be a focus on continuing education for new PNMT members as all disciplines currently on board. The PNMT was actively addressing Facility system issues. The Facility should formalize the resolution of system issues in Facility policy and/or protocol.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller samples for Samples O.1 and O.2) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.2: ▪ 9/3/13 **-** Reviewed the PNMPs for residents who receive nourishment and medication enterally and for the nine residents who have had aspiration and receive food and medication orally. The purpose of the review was to ensure that positioning instructions and pictures were accurate and clear. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.2 included an action plan with the following action steps to be completed: ▪ Develop fully integrated action plans for individuals at highest risk;	Noncompliance

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	individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	▪ Train IDTs on the PNMT process to ensure teams understand and implement it, with an emphasis on PNMT referrals; and ▪ Implement PNMT Assessment Audit Tool and Tracking Log. The implementation of these action steps appeared to be appropriate in working to achieve compliance within this section. In addition, to reach substantial compliance with this section, the PNMT should initiate referrals and the completion of assessments within established timeframes. In addition, PNMT assessment recommendations should be integrated in IHCPs. **<u>Identification of PNM Risk</u>** The AUSSLC Self-Assessment indicated that on 5/15/13, a protocol was developed and implemented that defined the system to maintain and update lists of individuals who required mealtime assistance, positioning assistance associated with swallowing activities for individuals who have difficulty swallowing, and individuals who require assistance to eat. However, the Facility did not provide a copy of this protocol as requested in the pre-review document request. As a result, the following could not be completed: ▪ The Facility **did/did not have** a sustainable system to maintain and update lists identifying each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems.") **<u>Physical and Nutritional Management Team Referral Process</u>** Since the last review, the PNMT had revised the Facility PNMT Guidelines, which included a description of the PNMT referral process. The guidelines stated: "when an individual has been identified as unstable by crossing the set of thresholds of the Episode List/Tracker, the PNMT QIDP will notify all members of the PNMT." The individual would be discussed by the PNMT at the weekly PNMT core meeting. Individuals could be referred to the PNMT by any one of the following means: ▪ When an individual had been identified as unstable by the PNMT, the IDT will be notified and an ISPA requested to discuss referral; ▪ When a written consult is received from a PCP; ▪ From an individual's IDT; and/or ▪ From a local or State Administrator. A document submitted for TX-AU-1402-XII.8 indicated the PNMT did not use a referral form. However, the Presentation Book for Section O included a copy of a PNMT Referral Review form. Based on interview with the PNMT Lead, IDT members had not received training on the revised PNMT Guidelines. None of the individuals' records reviewed for Sample O.2 provided a copy of the PNMT Referral Review form. In addition, the PNMT	

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		Guidelines did not reference and/or discuss this form. Additional work needed to be done to educate IDTs on the PNMT referral process, because individuals who should have been referred to the PNMT had not been referred. Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT, based on the Facility policy. Three of seven individuals (43%) were appropriately referred to the PNMT based on the criteria included in the Facility policy. More specifically: ▪ One of the eight individuals (i.e., Individual #223) did not meet the PNMT referral criteria. ▪ Three individuals (i.e., Individual #62, Individual #142, and Individual #302) had been referred to the PNMT. ▪ Four of the eight individuals should have been referred to the PNMT, but had not been referred: o Individual #206 had received a feeding tube during a hospital visit but the IDT did not refer this individual to the PNMT. o Two individuals had been hospitalized; ▪ Individual #147 had been hospitalized from 11/10/13 to 11/12/13 with a discharge diagnosis of "recurrent aspiration pneumonia." Individual #147 should have been referred to the PNMT. ▪ Individual #70 experienced unplanned weight loss as documented in his nutrition assessment of 11/20/13. The assessment reported his BMI at 20 and the Facility list of Weight BMI Reading ≤= 20 reported his BMI to be 18.3 on 12/9/13. In addition, he was hospitalized from 11/19/13 to 11/23/13 with a discharge diagnosis of "probable aspiration pneumonia." Individual #70 should have been referred to the PNMT. o Individual #340 was experiencing unplanned weight loss and skin breakdown. Individual #340 had a Body Mass Index of 12.7, which identified her as "underweight." She had been reported to be experiencing an unplanned weight loss. However, the Facility did not provide a list as requested by the Monitoring Team to identify individuals who had had unplanned weight loss of 10% or greater over six months, showing the history of recorded weight loss leading to the identified weight loss percentage, including the weekly and/or monthly progress of the weight loss. The Facility did not have a sustainable system to identify individuals who were experiencing unplanned weight loss. In addition, Individual #340 was experiencing ongoing episodes of skin breakdown.	

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		The Facility list of Individuals Who Receive Nutrition Through Non-Oral Methods, not dated, did not identify any individuals who had received a feeding tube since the last review. However, Individual #260 had received a feeding tube on 8/28/13, while hospitalized. As a result, the Monitoring Team did not have confidence in the accuracy of the Facility's list of individuals who received enteral nutrition. Consequently, the Monitoring Team was not able to assess the following indicator: ▪ ____ of ____ individuals (%) who received a feeding tube (not on an emergency basis) since the last review had been referred to the PNMT prior to the placement of the tube. ▪ None of one (0%) individual (i.e., Individual #206) who received an emergency feeding tube placement since the last Monitoring Team review had been referred to the PNMT after the emergency feeding tube placement. In addition, the PNMP Nurse Post Hospitalization Assessment/Evaluation, dated 8/29/13, did not recommend a referral to the PNMT. **PNMT Assessment** For the four individuals in Sample O.2, one of four PNMT assessments (25%) (i.e., Individual #375) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). None of four (0%) PNMT assessments were completed in no more 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. Individual #423 had been referred on 1/16/14, but his assessment had not been completed. Individual #286's PNMT Minutes, dated 12/6/13, indicated he "had had 2 aspiration pneumonia's in a year [,] PNMT will look into his case further." His PNMT assessment had not been completed. PNMT assessments for Individual #307 and Individual #375 were not signed and/or dated by PNMT members. Consequently, the Monitoring Team could not ascertain if the two completed PNNT assessments had been completed in no more than 30 days of the date of initiation and/or no more than 45 days in extenuating circumstances. Based on review of two individuals' records (i.e., Individual #307 and Individual #375) the comprehensiveness of the PNMT assessment components were as follows: ▪ Two of two (100%) contained date of referral by the IDT; ▪ Two of two (100%) contained the date the assessment was initiated; ▪ Two of two (100%) contained evidence of review and analysis of the individual's	

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		medical history; ▪ None of two (0%) identified the individuals' current risk rating(s), including the current rationale; ▪ None of two (0%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Two of two (100%) contained evidence of discussion of the individuals' behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ One of two (50%) (i.e., Individual #375) contained assessment of current physical status; ▪ One of two (50%) (i.e., Individual #375) contained assessment of musculoskeletal status; ▪ One of two (50%) (i.e., Individual #375) contained evaluation of motor skills; ▪ None of two (0%) contained evaluation of skin integrity; ▪ None of two (0%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ None of two (0%) contained evaluation of current adaptive equipment; ▪ None of two (0%) contained nutritional assessment, including, but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ None of two (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ ____ of ____ (%) identified residual thresholds, if enterally nourished. This was not applicable for these two individuals (i.e., Individual #307 and Individual #375) as they ate orally; ▪ Two of two (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ None of two (0%) contained respiratory status; ▪ None of two (0%) contained evidence of review/analysis of lab work; ▪ None of two (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Two of two (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ One of two (50%) (i.e., Individual #307) contained oral hygiene status; ▪ Two of two (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Two of two (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Two of two (100%) identified the potential causes of the individual's physical and nutritional management problems;	

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		▪ One of two (50%) (i.e., Individual #375) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ Two of two (100%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of two (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of two (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Two of two (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); ▪ Two of two (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ None of the two (0%) contained signatures with dates. PNMT assessments did not contain the majority of components necessary. Missing components for some individuals' PNMT assessments as presented above included: assessment of physical status; musculoskeletal status; motor skills; skin integrity; respiratory status; evaluation of potential or actual drug/drug and drug nutrient interactions; measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; and the assessment completion date by a therapist. To achieve substantial compliance with PNMT assessments, the assessments should be initiated and completed within established timeframes and include the components identified within this section. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For none of the two (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs, and IHCPs. PNMT assessment recommendations were integrated in PNMP Follow-Up documentation that addressed recommendations and plans. The Monitoring Team had difficulty tracking completion of PNMT assessment recommendations in PNMT meeting minute documentation. There was no PNMT plan presented for review. PNMT recommendations were not integrated into IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In none of the two (0%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ The following was not applicable: ____ of ____ HOBE assessments were conducted	

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		(%), the HOBE recommendations were integrated into individuals' plans. HOBE assessments for Individual #307 and Individual #375 were not applicable at the time of the PNMT assessment process. ▪ In none of the two (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of the two (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In none of the two (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the two (0%) individuals' plans reviewed, the plans defined triggers. ▪ In none of the two (0%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of two (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. ▪ In none of the two (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. **Individuals Discharged by the PNMT** Two individuals (i.e., Individual #389 and Individual #213) were reviewed who had been reported to be discharged by the PNMT. However, a review of PNMT discharge records submitted for Individual #389 indicated that he had not been discharged by the PNMT. Review of one individual's discharge summary (i.e., Individual #213) developed by the PNMT and an ISPA found: ▪ One of the one (100%) individual had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ None of the one (0%) individual's discharge summary provided objective clinical data to justify the discharge. ▪ None of the one (0%) individual's ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ None of the one (0%) individual's ISPA documentation and/or action plan	

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		included criteria for referral back to the PNMT, if they differed from the criteria included in the PNMT policy. In summary, the PNMT Guidelines had been updated to define the PNMT referral process. However, the Facility's IDTs had not been trained on the revised PNMT Guidelines. Some individuals who had experienced a change in status had been referred to the PNMT, but other individuals who should have been referred, had not been referred. The PNMT was not completing assessments per established timelines. PNMT assessments were missing many necessary assessment elements. PNMT assessment recommendations had not been integrated into individuals' IHCPs. The Facility remained out of compliance with Section O.2.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	The parties agreed the Monitoring Team would conduct full monitoring for this subsection, because the Facility found substantial compliance according to their internal self-assessment activities. However, the Monitoring Team's review did not substantiate a finding of substantial compliance for this section as discussed below. The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.3: ▪ 11/29/13 - 100% of PNMP/Dining Plans are in place in the current approved format. This was completed in 4/13 and has been monitored over the last six months. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.3 included an action plan with the following action steps and completion status: ▪ Expand suction tooth brushing program for all individuals who receive enteral nutrition unless otherwise contraindicated (completion status – in process); ▪ Ensure photographs for optimal positioning are reviewed for accuracy (completion status – in process); and ▪ Complete Head of Bed Elevation Evaluations for all individuals where appropriate (completion status – in process). The implementation of these action steps appeared to be appropriate in working to achieve compliance within this section. **<u>Identification of Individuals Requiring a PNMP</u>** Two hundred and sixty-nine (96%) of the 280 individuals living at AUSSLC had a PNMP. A statewide ISP Preparation process had been included in DADS SSLC policy, and was to occur three months prior to the annual ISP meeting. During this meeting, IDT members were to plan for the annual ISP meeting. This meeting was to include the completion of a form that identified IDT members required to attend the annual ISP meeting. None of the	Noncompliance

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		22 individuals' requested records in Sample O.3 (0%) provided evidence of the ISP Preparation meeting list of IDT members required to attend the annual ISP meeting. Furthermore, only four of the 22 individuals' ISPs (i.e., Individual #206, Individual #62, Individual #302, and Individual #398) included a completed ISP signature sheet. However, these four individuals were missing key IDT members. As a result, the Monitoring Team was not able to discern if the PNMPs had been developed based on input from IDT members. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, residential staff, medical and nursing staff, and the PNMT, as appropriate. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. The absence of team members (i.e., RD, OT, PT, SLP, Dental, psychologist, medical provider and direct support professional) impacted the teams' ability to provide adequate input in a review of the effectiveness of an individual's PNMP and the need for revision of an individual's PNMP, if appropriate. The review of an individual's PNMP should be an important factor when identifying disciplines that should be present during the annual ISP meeting. Based on the documentation the Facility provided, none of 22 individuals' PNMPs (0%) in Sample O.3 were adequately reviewed by the individuals' IDTs in the annual ISP meetings. Each individual's ISP had a section for the review and approval of the PNMP, but limited information was included in these sections. The IDT discussion should include evidence of review of effectiveness as well as accuracy, updates/revisions agreed upon by the team, and specified changes required with rationale. **PNMP Format and Content** PNMPs for 22 individuals in Sample O.3 were reviewed with the following results: ▪ PNMPs for 22 of 22 (100%) individuals were current within the last 12 months. ▪ PNMPs for nine of 22 (41%) (i.e., Individual #142, Individual #103, Individual #51, Individual #40, Individual #261, Individual #278, Individual #307, Individual #182, and Individual #398) individuals included a list of risk levels and triggers. The remaining 13 individuals' PNMPs were missing high risk levels as identified on the Facility's Individuals Risk List (TX-AU-1402-X.46); ▪ In 16 of 22 PNMPs (73%) (i.e., Individual #206, Individual #381, Individual #62, Individual #142, Individual #340, Individual #40, Individual #261, Individual #351, Individual #278, Individual #302, Individual #389, Individual #93, Individual #286, Individual #182, Individual #423, and Individual #398), there were large and clear photographs with instructions. ▪ Twenty-two of 22 (100%) PNMPs listed the adaptive equipment required by the individual with rationale.	

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		▪ Fourteen of the 22 individuals used a wheelchair as their primary mobility. In five of 14 PNMPs (36%) for individuals who used a wheelchair as their primary mobility (i.e., Individual #206, Individual #381, Individual #62, Individual #340, and Individual #182), positioning instructions for the wheelchair, including written and pictorial instructions were provided that included safe elevation ranges and frequency of re-positioning. ▪ In 22 of 22 PNMPs (100%), positioning was adequately described per the individuals' assessments. A review of OT/PT assessments showed they did provide a description of alternate positioning, including safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 22 of 22 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. ▪ In 14 of 22 (64%) PNMPs (i.e., Individual #206, Individual #142, Individual #70, Individual #223, Individual #103, Individual #40, Individual #261, Individual #351, Individual #278, Individual #302, Individual #389, Individual #307, Individual #286, and Individual #423) bathing instructions were provided. For the remaining individuals, staff instructions did not consistently include strategies, independence, and level of staff assistance required. ▪ In 22 of 22 (100%) PNMPs toileting-related instructions were provided, including check and change. ▪ In 22 of 22 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 22 of 22 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Twenty-two of 22 (100%) dining plans were current within the last 12 months. ▪ Eight individuals had feeding tubes with no oral intake (i.e., Individual #381, Individual #62, Individual #51, Individual #389, Individual #93, Individual #286, Individual #182, and Individual #398). None of eight (0%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 13 of 22 (59%) (i.e., Individual #381, Individual #62, Individual #70, Individual #340, Individual #223, Individual #51, Individual #40, Individual #389, Individual #93, Individual #286, Individual #182, Individual #423, and Individual #398) PNMPs/dining plans, position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Fourteen individuals ate orally within this sample (i.e., Individual #206, Individual #142, Individual #70, Individual #340, Individual #147, Individual #223, Individual #103, Individual #40, Individual #261, Individual #351, Individual #278, Individual #302, Individual #307, and Individual #423).	

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		o In 13 of 14 (93%) PNMPs/dining plans, for individuals who ate orally, diet orders for food texture were included. In Individual #70's PNMP, dated 1/15/14, the diet texture was not consistent with his annual ISP dated 12/16/13, and/or his OT/PT Assessment of Current Status. There were no ISPAs provided to explain the PNMP diet texture change. o In 13 of 14 (93%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. In Individual #70's PNMP, dated 1/15/14, the fluid consistency was not in alignment with his annual ISP, dated 12/16/13, and/or his OT/PT Assessment of Current Status. There was no ISPA provided to explain the PNMP/dining plan liquid consistency change. o In 13 of 14 (93%) PNMPs/dining plans for individuals who ate orally, dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. Individual #351's dining plans listed adaptive equipment, but for one piece of equipment (i.e., nosey cup) no rationale was provided. ▪ In 13 of 22 PNMPs (59%) (i.e., Individual #206, Individual #381, Individual #62, Individual #142, Individual #103, Individual #51, Individual #40, Individual #261, Individual #351, Individual #302, Individual #286, Individual #182, and Individual #423), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In 12 of 22 PNMPs (55%) (i.e., Individual #206, Individual #62, Individual #142, Individual #70, Individual #40, Individual #261, Individual #302, Individual #389, Individual #93, Individual #286, Individual #182, and Individual #423), oral hygiene instructions were included, including general positioning and brushing instructions. The remaining individuals' PNMPs did not include general positioning and/or brushing instructions. ▪ Twenty-two of 22 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** The Facility protocols for PNMP Revision, PNMP Finalization, and PNMT Delivery, revision dates of 5/15/13, provided explicit internal instructions for therapy staff in these processes, but did not provide instructions for how IDT members would be informed of these revisions, how IDT approval would be obtained, and/or how staff would be provided training on PNMP revisions. Revised PNMPs were to be delivered by email to identified disciplines, and the PNMP Coordinator would deliver a laminated copy of the revised PNMP and/or dining plan. In addition, there was no discussion of how the	

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		HT Department and/or QA/QI would monitor to ensure revised PNMPs and/or dining plans were present in individuals' notebooks, medication administration records (i.e., MAR), and/or dining rooms. Sixteen of the 22 individuals in Sample O.3 had their PNMPs revised after their annual ISP meeting. These individuals' records were reviewed and the following was found: ▪ For the 16 individuals in Sample O.3 for whom the IDT identified changes were needed to the PNMP after the annual ISP meeting, none of the 16 individuals' revised PNMPs (0%) (i.e., Individual #206, Individual #381, Individual #62, Individual #70, Individual #147, Individual #223, Individual #103, Individual #40, Individual #351, Individual #278, Individual #389, Individual #307, Individual #93, Individual #182, Individual #423, and Individual #398) had been reviewed and approved by the IDT in an ISPA meeting. ▪ For individuals for whom the PNMP was revised, there was supporting documentation that none of the 16 (0%) individuals' revised PNMPs had been implemented. AUSSLC – Notification/Information Training Rosters were submitted for some individuals that corresponded with the PNMP revision date, but the Monitoring Team could not ascertain if all required staff had been provided competency-based training on PNMP revisions. In addition, for some individuals, the date of the training rosters was not in alignment with the PNMP revision date. The Facility found substantial compliance with this section, but based on this review, the Monitoring Team did not agree with the finding of substantial compliance. In summary, ISP Preparation meetings had not been conducted for individuals to determine which IDT members were required to attend the annual ISP meetings. The Monitoring Team could not determine if the appropriate disciplines were present during the annual ISP meeting as requested signature sheets were not submitted for review for individuals in Sample O.3. Individuals' PNMPs were missing necessary components as identified within this section. Individuals' PNMPs that had been revised after the annual ISP meeting had not been discussed in an ISPA meeting, and so team approval had not been obtained for these revisions. The Facility remained out of compliance with this subsection.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and	The parties agreed the Monitoring Team would conduct full monitoring for this subsection. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.4 included an action plan with the following action step and completion status: ▪ Monitor for effectiveness and compliance (compliance status – in process). The implementation of this action steps appeared to be appropriate in working to achieve compliance within this section.	Noncompliance

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	after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs and Dining Plans** Observations were completed in the Infirmary, day programs (i.e., 501 and Milestone), and residences including dining rooms (i.e., 782, 783, 784, 788, 732-D, 732-E, 732-P, 779-H, 779-R, 793, 794, and 795) with the Director of HT, PNMT OT, PNMT PT, and/or the Unit Director for Castner. There had been some improvement in staff compliance with dining plan implementation from the last review (0% compliance) to this review (26% compliance). On a positive note, during a dinner mealtime observation in the dining room for Hummingbird and Roadrunner, there were no mealtime errors observed. However, observations in multiple other dining rooms, staff were not following dining plan instructions. Based on the Monitoring Team's mealtime/snack observations, nine of 35 individuals' dining plans (26%) (i.e., Individual #433, Individual #297, Individual #435, Individual #370, Individual #368, Individual #323, Individual #171, Individual #18, and Individual #191) were being implemented as written. The remaining 26 individuals' dining plans (i.e., Individual #264, Individual #78, Individual #319, Individual #64, Individual #338, Individual #24, Individual #159, Individual #429, Individual #160, Individual #201, Individual #37, Individual #308, Individual #228, Individual #173, Individual #457, Individual #40, Individual #358, Individual # 294, Individual #119, Individual #60, Individual #105, Individual #354, Individual #195, Individual #416, Individual #126, and Individual #149) were not being implemented correctly and/or dining plans were not present. The following concerns were noted which had the potential to place individuals at risk during mealtimes and/or snacks: ▪ A pulled staff in the Infirmary was assisting an individual to eat without a dining plan; ▪ Snacks were being presented in a day program without dining plans present for staff reference; ▪ Table captains were presenting food and/or fluid at too fast a pace; ▪ Mealtime Coordinators and Table Captains did not appear to understand their roles and responsibilities. For example, MTCs did not intervene to correct staff not following dining plan presentation techniques; ▪ Individuals were poorly positioned in their wheelchairs and/or dining chairs without intervention by the MTC and/or Table Captain; and ▪ Staff were not referring to dining plans before and/or during the meal; Although there was some improvement in dining rooms, additional work needed to be done to ensure MTCs and Table Captains perform their duties as defined by the Facility Mealtime Management system. The Mealtime Management workgroup should operate with a sense of urgency to develop strategies to resolve staff noncompliance with the implementation of individuals' dining plans.	

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		Based on observations the Monitoring Team conducted with the Director of HT, PNMT OT, and PNMT PT: ▪ Three of 11 individuals (27%) (i.e., Individual #102, Individual #62, and Individual #22) were positioned correctly in their seating systems. The remaining eight individuals (i.e., Individual #422, Individual #299, Individual #181, Individual #178, Individual #260, Individual #398, Individual #363, and Individual #117) were not positioned in their seating systems. ▪ One of nine individuals' (11%) (i.e., Individual #50) alternate positioning plans were implemented as written. The remaining eight individuals' (i.e., Individual #246, Individual #51, Individual #72, Individual #63, Individual #340, Individual #353, Individual #147, and Individual # 328) alternate positioning plans were not being followed as written. ▪ One of one individual (100%) (i.e., Individual #457) staff performed a pivot transfer correctly. ▪ None of one individual's PNMP (0%)(i.e., Individual #364) was being followed during a medication administration pass. The following concerns were noted during these observations: ▪ Individuals were poorly positioned in their seating systems; ▪ Individuals in alternate positions were not in alignment with written and photographic instructions; and ▪ Individuals in bed were not at the prescribed degree of elevation, because chains were not placed in the correct position. On a positive note, the therapists had expanded written and pictorial instructions for wheelchair and alternate positioning to provide staff with additional instructions to support the correct implementation of an individual's PNMP. In addition, the training curriculum for new employees and veteran staff had been revised to place more emphasis on the implementation of individuals' PNMPs and dining plans. Although there had been some improvement in staff implementation of PNMPs (i.e., the last review the compliance percentage was zero), additional work needed to be done. As has been stated in previous exit interviews and subsequent reports, the correct implementation of PNMPs by staff should be a major focus of the Facility. To achieve substantial compliance within this section, the Facility should, with a sense of urgency, place a high priority on staff compliance with individuals' PNMPs and dining plans. The Facility remained out of compliance with this provision.	
O5	Commencing within six months of the Effective Date hereof and with	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The	Noncompliance

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	full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	noncompliance finding stands. Facility Updates for Section O.5 through Section O.8 were conveyed through information provided in the Facility Self-Assessment, Provision Action Information, Action Plans, documents provided in response to the Monitoring Team's pre-review document request, and interviews conducted with the Director of HT, PNMT members, and Facility therapists. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.5: ▪ 9/18/13 - Reviewed and revised New Employee Orientation instruction material/process. The new process added annual refresher training in Lifting and Transferring, Meal Time Monitoring/Management, and Positioning for staff required to be certified in these areas. Additional Competency-Based Training was also added to this new process. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.5 included an action plan with the following action step that was in the process of completion: ▪ Implement competency-based training with all staff regarding strategies and instructions within the PNMP (completion status – in process). This action step was appropriate in working towards achieving substantial compliance with Section O.5. In addition, the Facility should implement a training database to document the completion of individual-specific PNM training for required veteran staff. **New Employee Orientation (NEO)** The Facility therapists had revised the PNM foundational competency-based training curriculum effective 10/1/13. The revised curriculum included the following content: ▪ PNMP; ▪ Positioning; ▪ Mealtime assistance including adaptive equipment; ▪ Feeding and mealtime management including dysphagia; ▪ Lifting and transfers; ▪ Communication. All new employees were required to successfully complete PNM foundational competency performance check-offs. The Facility CTD Participation reports with the date range of 7/1/13 to 12/31/13, indicated that 161/161 (100%) new employees had completed and successfully passed PNM training prior to working with individuals.	

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		New employees were required to complete the following performance check-offs: ▪ Bed positioning; ▪ Mechanical lift; ▪ Roho cushion inflation; ▪ Wheelchair positioning; ▪ Stand pivot transfer; ▪ Hosiery/compression sock; ▪ Hearing aids/dry ear precautions; ▪ Mealtime safety; ▪ Simply Thick; ▪ Communication; and ▪ Sign language. There were 19 approved trainers for NEO PNM training: four PTs, two Physical Therapy Assistants (PTAs), four SLPs, five OTs, two Certified Occupational Therapy Assistants (COTAs), one Audiologist, and one PNMP Coordinator. The revision of the NEO PNM competency-based training curriculum to place additional emphasis on implementation of individuals' PNMPs and dining plans was a positive development. During the Monitoring Team's next review, the following will be reviewed: _____ of _____ new employees (%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. **PNM Core Competencies for Current Staff** The Facility Self-Assessment and Presentation Book for Section O indicated that PNM Annual Refresher training had been expanded beyond lifting/transfer to include the following content: ▪ Mealtime safety; ▪ Using Simply Thick; ▪ Hearing aids/dry ear precautions; ▪ Communication to include Augmentative Communication Devices and sign language; ▪ Mechanical lift; ▪ Stand pivot; and ▪ Wheelchair positioning. On 10/2/13, training for veteran staff on the revised annual refresher training curriculum was initiated. Facility CTD participation reports indicated that during the time period from 10/1/13 to 12/31/13, 60 out of 60 veteran staff who were required to	

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		complete annual refresher core PNM competency-based training had successfully passed the training and PNM performance check-offs. Based on interview, the Facility therapists had been conducting multiple classes on a monthly basis with the goal of having all veteran staff complete the annual refresher training. For example, two classes per month were conducted for October, November, and December 2013. These classes were expanded to three a month for January and February 2014. The Facility will need to identify the total number of veteran staff who are required to complete the core PNM foundational training and the total number of staff who have completed the core PNM training. The provision of this information will provide evidence that all direct support professionals responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing. There were 19 approved trainers for Annual Refresher PNM training: four PTs, two PTAs, four SLPs, five OTs, two COTAs, one Audiologist, and one PNMP Coordinator. During the Monitoring Team's next review, the following will be reviewed: ▪ ____of ___current staff that require training (%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. ▪ ____of ____ staff (%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. **Annual Refresher Training** As noted above, the Facility had expanded the Annual Refresher PNM training and was in the process of providing this training to required veteran staff. The revised Annual Refresher training will be required for all staff on an annual basis. During the Monitoring Team's next review, the following will be reviewed: ▪ _____ of _____ current staff that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months. **Individual-Specific Training** Based on interviews with therapy staff, sixteen individuals had been identified whose staff will require individual-specific training and the type of training (i.e., mealtime, mobility, transfer, positioning, etc.). The therapists were in the process of providing individual-specific staff training. In addition, individual-specific staff performance check-offs had been developed. The Facility was in the beginning stages of this process.	

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		During the Monitoring Team's next review, the following will be reviewed: ▪ For ___ of ____ staff assigned to individuals with PNMPs in Sample O.1 and O.2 (%), there is evidence of exchange of the information included in the PNMP prior to the provision of services. ▪ For individuals in Samples O.1 and O.2, ____ of ____ (%) staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. ▪ ____ of ____ (%) staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. ▪ The Facility **did/did not** have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. **<u>Facility Mealtime Coordination Committee Initiatives</u>** The Monitoring Team conducted an interview with the Unit Director for Caster to learn more about the implementation of the Mealtime Management System. Since the last review, the Mealtime Management System had been expanded campus-wide with the following initiatives: ▪ All dining rooms had a Mealtime Notebook that includes Dining Room Procedures (i.e., staffing, mealtime options, food service, transporter duties, MTC responsibilities, and Table Captain duties), monthly assignment of MTCs for each meal, mealtime management guidelines, and seating assignment for tables and meal schedule; ▪ Development and implementation of AUSSLC – IDT Active Treatment Meal Time Procedures, effective date of 10/10/13 which included determination of dining style, creation and implementation of Home Procedures, role of the MTC, role of the direct support professional in the dining room, training required for MTCs, and mealtime oversight and monitoring; and ▪ There were three phases of competency-based training for MTCs. To be certified as a MTC, all three phases of the training and competency check-offs had to be completed. The AUSSLC Meal Manager Training roster, not dated, indicated that 14 MTCs had successfully completed all three phases of the training. Eighty-eight staff had completed Phase I of the MTC training. Sixty-two of the 88 staff (70%) had completed Phase II of the MTC training. The implementation of the Mealtime Management System campus-wide was a significant positive initiative in working to provide a foundation for a safe environment for individuals during mealtimes and snacks. However, as discussed with regard to Section O.4, additional work needed to be done to ensure MTCs and Table Captain understand and implement the Facility Mealtime Management System.	

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		In summary, the Facility had revised the NEO and annual refresher PNM foundational competency-based training to place more emphasis on staff's understanding of the implementation of PNMPs and dining plans. The Facility therapists had identified individuals whose staff would require individual-specific training, had provided some training, and had developed individual-specific performance check-offs. The therapists were in the process of finalizing the system for the provision of individual-specific training, and the process for alerting management and direct support professional of individuals' staff who would require this training. The Facility had implemented the Mealtime Management System campus-wide, but additional work needed to be done to ensure MTCs and Table Captains performed their duties as defined.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding stands. The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.6: ▪ 9/17/13 - Re-implemented PNMP monitoring based on risk level. The monitoring checked for proper positioning, adaptive equipment, and food texture; ▪ 10/3/13 – PNMP Coordinators were trained by a COTA on improved PNMP monitoring and changes to the monitoring process. The OT/PT/SLP Therapists would be monitoring for reliability to determine if the PNMP Coordinators are competent to monitor PNMPs; ▪ 10/4/13 - Therapists, PTAs, and COTAs began reliability monitoring of their plans and assessing them with the monitoring conducted by the PNMP Coordinators. This process will determine if the PNMP Coordinators are competent in monitoring the PNMPs and if more training is needed; and ▪ 11/7/13 - Therapists began conducting their own monitoring of individuals and their PNMPs. The PNMP Coordinators also continued to monitor PNMPs. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.6 included action steps that had been completed and did not include any action steps to be completed in the future. The Facility should develop and implement a PNM monitoring policy/procedures that includes the elements related to monitoring described with regard to Section O.1. In addition, the Facility should analyze current monitoring results that do not appear to accurately reflect staff PNMP compliance, and determine what changes need to be made to ensure valid monitoring results. **Facility's System for Monitoring of Staff Competency with PNMPs**	Noncompliance

#	Provision	Assessment of Status	Compliance
		On 10/4/13, the Facility re-initiated PNM monitoring (i.e., TX/AU-1402-XII.22). The Facility used the following compliance monitoring tool: AUSSLC PNMP Compliance Monitoring, revised 4/10/13, for positioning, meals, snacks, medication administration, oral care, bathing, lifting/transfer, and communication. At the time of the review, PNM monitoring was being conducted for meals, lifting/transfers, positioning, and communication. There was 30 therapy staff responsible for PNM monitoring: five PTs, two PTAs, five SLPs, six OTs, two COTAs, one Audiologist, and nine PNMP Coordinators. The PNM monitoring schedule for individuals was determined by their risk ratings for choking, aspiration, gastrointestinal problems, falls, skin integrity, and challenging behaviors. If an individual was ranked high in any of these areas, monitoring was to be conducted on a monthly basis. A medium ranking in these categories would require quarterly monitoring. The Self-Assessment for Section O.6 presented a cumulative monitoring score for the months of September, October, November, and December 2013 for positioning, meals, and lifting/transfer. The Monitoring Team questioned the reliability and validity of these monitoring cumulative scores. For example, 27 positioning monitoring forms were completed in December with a cumulative score of 99%. The Monitoring Team's direct observations did not find this level of compliance with positioning in wheelchairs and/or alternate positioning. The Self-Assessment self-rating for Section O.6 stated: "the department and facility need to improve its positioning, meal and lifting/transfer performance training of staff, tracking, and auditing for improving services delivery, and associated key metrics. Aggressive improvement and initiatives are being implemented in the first and second quarter of 2014 for these processes." The Monitoring Team agreed with this statement. During the Monitoring Team's next review, the following will be reviewed: ▪ Monitoring tools **did/did not** include adequate indicators to determine whether or not "staff demonstrated competency in safely and appropriately implementing" mealtime and positioning plans. ▪ Monitoring tools **did/did not** include adequate instructions. ▪ The staff conducting monitoring **were/were not** competent in the areas they were monitoring. The PNMP monitoring process did/did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, based on the following: ▪ ____ of the ____ monitoring forms (%) focused on oral intake (meals and snacks); ▪ ____ of the ____ monitoring forms (%) focused on bathing;	

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		▪ ____ of the ____ monitoring forms (%) focused on medication administration; ▪ ____ of the ____ monitoring forms (%) focused on oral care; and ▪ ____ of the ____ monitoring forms (%) focused on positioning. ▪ ____ of the ____ occurred during first shift; ▪ ____ of the ____ occurred during second shift; and ▪ ____ of the ____ occurred during third shift. **Monitoring for Individuals in Samples** During the Monitoring Team's next review, the following s will be reviewed: ▪ For individuals in Sample O.1, PNM compliance monitoring over the past three months for ____ of ____ individuals (%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. ▪ For individuals in Sample O.2, PNM compliance monitoring over the past three months for ____ of ____ individuals (%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. ▪ For the past three months, problems were noted on ____ of ____ monitoring forms. Of these, documentation of adequate follow-up was provided on the form for ____ (%). Since the last review, the Facility had reinitiated PNMP monitoring. PNMP monitoring was being completed for meals, positioning, lifting/transfers, and communication. The Facility should develop and implement a PNM monitoring policy/procedures that includes the elements related to monitoring discussed with regard to Section O.1. In addition, the Facility should analyze current monitoring results that do not appear to accurately reflect staff PNMP compliance, and determine what steps need to be taken to obtain valid monitoring results. The Facility remained out of compliance with this subsection.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.7: ▪ 10/14/13 - Re-designed and re-implemented use of the Universal Monitoring Tool by adding criteria that defines each item on the tool thereby making the question of correct implementation of the PNMP more evident to the PNMP Coordinators.	Noncompliance

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		The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.7 included an action plan with the following action steps and completion status: ▪ Conduct person–specific monitoring directed by the integrated Action Plan with Measurable Outcomes (completion status – in process). The development and implementation of a Facility policy/procedure for effectiveness monitoring would assist the Facility in achieving compliance in this section. **<u>IDT and PNMT Monitoring to Assess Individuals' Progress and/or Effectiveness of Plans</u>** The Facility Self-Assessment for Section O.7 indicated data was reviewed to ensure the IDTs addressed a Change of Status within five days. The results indicated that 78 of 113 ISPAs (69%) addressed changes of status within five days. The intent of this section significantly expands beyond IDT members addressing a change of status within five days. This section requires the Facility to develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties (i.e., effectiveness monitoring), and revise interventions as appropriate. The outcome of effectiveness monitoring should be to ascertain if prescribed interventions have been effective in minimizing and/or eliminating identified PNM concerns, and in instances in which progress has not been made, interventions should be reviewed and modified, as appropriate. Simply put, is the individual better or worse? This question should be answered through a review and analysis of data that staff are collecting and measuring against goals in the ISP/IHCP. These goals should be based on objective clinical data (e.g., identification of an oxygen saturation threshold that an individual will maintain for an identified period of time). The objective clinical data that should be collected to assess the individual's health/wellness should be identified in individual's IHCP goals and tracked by identified staff (e.g., nursing). Therapists should complete effectiveness monitoring by reviewing data in individuals' records and direct observation, which might include a hands-on assessment. During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ (%) individuals' records in Sample O.1, and ____ of ____ (%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. ▪ ____ of ____ (%) individuals' records in Sample O.1, and ____ of ____ (%) individuals in Sample O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. ▪ For ____ of ____ (%) individuals receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan.	

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		▪ _____ of the _____ individuals' records showed a change of status based on the established clinical indicators. Of these, ___ (__%) contained evidence that, as appropriate, the team met and interventions were reviewed and changed, as appropriate, in a timely manner. Based on review of trigger sheets and supporting documentation for individuals in Sample O.1: ▪ ____ of ____ (%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. ▪ ____ of ____ (%) individuals' Trigger sheets included individualized triggers as indicated. ▪ ____ of ____ (%) individuals' Trigger sheets were completed correctly. ▪ ____ of ____ (%) individuals' Trigger sheets were reviewed by the RN on a daily basis. The Facility remained out of compliance with this section.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **<u>Updates</u>** The AUSSLC Provision Action Information, updated 2/5/14, reported the following for Section O.8: ▪ 10/14/13 - In the process of hiring a Dietician contractor to work with individuals who receive nutrition and medication enterally; and ▪ 12/10/13 - The PNMT Nurse conducted a literature research on G-Tube dislodgement frequency and causes and how often it is recommended they be changed. She reported her findings and the Medical, Nursing, and Pharmacy Departments are working collaboratively on creating policy based on the research. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section O.8 included an action plan with the following action steps and completion status: ▪ Monitor for inclusion of Aspiration Pneumonia/Enteral Nutrition (APEN) information in each annual assessment for individuals who are enterally fed (compliance status – in process). The implementation of this action step appeared to be appropriate in working to achieve compliance within this section.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Assessment of Individuals Who Receive Enteral Nourishment As discussed with regard to Section O.2, the Facility list of individuals who were enterally fed was not accurate. Self-assessment results for Section O.8 indicated: "based on findings of this self-assessment, this provision is not in substantial compliance due to not having an integrated assessment and/or discuss [sic] as well as documented plans for any modifications of intake. Individuals on enteral feeding require an enhanced monitoring system, improved head of bed evaluation system, integrated discussion amongst the medical and IDT teams. Improvements and initiatives are being implemented in the first and second quarter of 2014." The Facility should develop and implement a protocol for defining the pathways to return an individual to oral intake and/or receive a less restrictive approach to receiving enteral nutrition, as appropriate. During the Monitoring Team's next review, the following will be reviewed: ▪ The Facility **did/did not** have a sustainable system to maintain and update a list of individuals who were enterally fed. ▪ ___of___ individuals who receive enteral nutrition were evaluated at a minimum annually. ▪ ___ of ___ (%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. In order to determine medical necessity of enteral nutrition, documentation should include the following areas: o Nutritional assessment of current type of formula and schedule; o Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and o Assessment of Oral Motor status by SLP and/or OT to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. ▪ ___ of the ___ (%) individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** During the Monitoring Team's next review, the following will be reviewed: ▪ ___ of ___ (%) individuals in Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. All individuals receiving enteral nutrition should be assessed annually by the IDT to determine if improvements can be made to progress towards a less restrictive diet. This means the individual should be:	

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		o Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual is a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as part of assessment findings. o Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings and determine if there is a possibility for modification to the least restrictive schedule. Justification for/or against medication of formula/schedule should be included as part of assessment findings. ▪ ____ of the ____(%) individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. The plan should include all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation and monitoring); o Time and schedule of interventions; o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (i.e., method for tracking progress); and o Frequency of subsequent assessments and staff responsible. ▪ ____of the ____ (%) individuals' plans to return to oral eating were based on the results of the IDTs' discussion and integrated in the IHCP, ISP, and/or an ISPA. The IRRF should provide clinical assessment data to identify an individual's potential to return to oral eating and provide justification for the medical necessity of the feeding tube. Any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. ▪ ____ of the ____ (%) individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCPs should include timeframes consistent with the clinical needs of the individual. The IHCPs should be implemented according to the timeframes included, unless a reasonable explanation is provided. ▪ ____ (%) of the staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. Training conducted by the licensed clinician should include a return demonstration. ▪ ____ of the ____ (%) individuals' plans were monitored as outlined in the plan. Individuals' plans should be monitored to meet the frequency and requirements in the plan, and should be conducted by monitors with demonstrated competency in the plan.	

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		▪ ____ of the ____ (%) individuals' plans were modified by the IDT. For ___ (___%) of these individuals' plans, the IDT met, reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the plan is being implemented as written, staff are adequately trained, etc. In addition, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours or sooner if it is a critical concern, when a change is indicated, such as for a change in status or based on effectiveness monitoring findings. The Facility remained out of compliance with this subsection.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o For the following documents for eight individuals in Sample P.1 [i.e., individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or were at high risk for PNM concerns]: Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223: PNMT Referral form, Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, 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, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, MBSS, if applicable, PNMT Post Hospitalization assessment, PNMT individual-specific meeting minutes for past six months if applicable, and PNMT consultations and copy of emails to IDTs if applicable; o For the following five individuals in Sample P.2 (i.e., Individual #385, Individual #389, Individual #40, Individual #138, and Individual #453) who were reported to receive direct OT and/or PT services, the following documents: OT/PT assessment, direct OT or PT intervention plan, evidence of therapy discharge or termination, monthly progress notes of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, OT/PT consults for past six months, and ISP Preparation Meeting list of IDT members required to attend annual ISP meeting; o State and Facility policies and procedures related to the provision of OT/PT supports and services; o Organizational chart for Habilitation Therapy Department; o List of current OT, COTA, PT, PTA, and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Facility OT/PT assessment, assessment update, and other additional assessment templates used by OTs and PTs; o Tracking Log of completed individual OT/PT assessments; o Wheelchair seating and PNM clinic assessment (templates); o Compliance Monitoring form template; o Competency-based performance check-off sheet templates for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; o Summary reports and monitoring results related to OT/PT; and o List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: o Dr. Michael Gayle, PT, DPT, MA, OCS, Director of Habilitation Therapy;

	○ Susan Hanson, Lead PT; ○ Chris Strickland, Lead OT; and ○ Briseida Pena, HT Administrative Assistant; ▪ **Observations of**: ○ Individuals in residences, dining rooms, and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment and interviews with the Director of HT, the following was found: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tools (i.e., OT/PT assessment and PNMP audit tool). The Facility was not using the State Office Settlement Agreement Monitoring Tool for Section P. ▪ The monitoring tool and audits did not include standards and criteria. The audit tools were missing instructions to support consistency among monitors. ▪ The Self-Assessment identified the sample sizes used to complete audits, including the information necessary to determine the percent sample in comparison with the overall population. ▪ The following staff/positions were responsible for completing audits for the Settlement Agreement for Section P: the Director of HT and therapists. Currently, no Facility PCMs were responsible for completing the Self-Assessment. In the future, if data is collected by a PCM, it should be identified in the Self-Assessment. ▪ Adequate inter-rater reliability had not been established between the Director of HT and therapy staff. ▪ The data presented in the Self-Assessment reflected the completion of additional review activities, such as review of OT and PT attendance at ISP meetings, and review of CTD training rosters, etc. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings consistently based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with the Section P.2. The Monitoring Team's review did not support this finding. The Facility rated itself as being in noncompliance with Sections P.1, P.3 and P.4, which was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement, but did not provide specific information regarding the analysis of the information and/or the development of interventions to address finding that did not support compliance.
	Summary of Monitor's Assessment: The Facility therapists collaborated with the State Office and Facility Administration to add four additional Orientation and Mobility Specialists. This expanded capacity to provide services such as assessments, training, and active treatment for individuals who were visually impaired and/or hearing impaired. A training curriculum was developed and implemented to provide training to clinical staff and direct support professionals in Sighted Guide and Hand-Under-Hand techniques. Staff from numerous departments worked together to develop a work/day program center to

	meet the unique needs of individuals with visual and hearing impairments. Individuals' OT/PT assessments included 18 of 22 assessment elements. However, essential elements were missing. Individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements. None of the five individuals reviewed who were receiving direct OT and/or PT interventions had therapy plans. Monthly progress notes had not been completed that included the necessary elements. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs. The Facility did not have OT/PT policies/protocols that included the necessary elements.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection. The noncompliance finding from the previous review stands. **Definition of Samples** ▪ **Sample P.1** consisted of the following eight individuals: Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223; and ▪ **Sample P.2** consisted of five individuals who received direct OT and/or PT services, including: Individual #385, Individual #389, Individual #40, Individual #138, and Individual #453. In the pre-document request, the Facility indicated that only one individual (i.e., Individual #385) received direct OT and/or PT intervention. The Monitoring Team asked during interviews with the Director of HT, Lead PT, and Lead OT whether there were additional individuals who were receiving direct OT and/or PT interventions. Four additional individuals were identified and were added to Sample P.2. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section P.1: ▪ 10/9/13 - Vacant OT position was filled by a contract OT. OT Section was now fully staffed with five OTs, and one of them on the PNMT; ▪ 11/2/13 - Contracted PT was hired as a full time equivalent and transferred to the PNMT. Another contract PT was hired to fill this vacancy in the PT section, which was now fully staffed with five PTs, and one of them on the PNMT.	Noncompliance

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		In addition, the Facility therapists collaborated with the State Office and Facility Administration to add four additional Orientation and Mobility Specialists to expand services for assessments, training, and active treatment for individuals who were visually impaired and/or hearing impaired. A training curriculum was developed and implemented to provide training to clinical staff and direct support professional staff in Sighted Guide and Hand-Under-Hand techniques. Staff from numerous departments worked together to develop a work/day program center to meet the unique needs of individuals with visual and hearing impairments. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section P.1 included an action plan. The following lists the action steps that were in the process of completion: ▪ Review data to determine if assigned monthly OT/PT Assessment of Current Status are being completed 11 or more working days prior to the ISP Meeting; ▪ Review data to determine if PT/OT Consultation Reports have been completed; ▪ Review data to determine if OT/PT Assessment of Current Status meet established standards of competency; ▪ Review data to determine if training for therapists occurred when audits of Assessment of Current Status reveals a score of less than 80%; ▪ Ensure assessments are performed in accordance with assessment timelines for individuals receiving OT/PT services or who have had a significant change in status; ▪ For individuals that have been placed in the community, OT/PT assessment will be updated within 45 days of an individual's move; ▪ Integrate Therapy Plan outcomes measures and/or related skill acquisition programs for individuals who receive direct therapy, whenever appropriate; ▪ Implement auditing process to validate inclusion of specific requirements of the OT/PT Comprehensive Assessment and the OT/PT Current Assessment of Status; and ▪ Develop Assessment Tracking Log. These action steps were relevant to Section P.1, and should assist the Facility in working towards achieving compliance with Section P.1. **<u>Timeliness of Assessments</u>** No individuals had been admitted to AUSSLC since the last review. Based on review of eight assessments for individuals in Sample P.1 : ▪ Six of eight individuals' OT/PT comprehensive assessments or assessments of current status (75%) (i.e., Individual #206, Individual #62, Individual #70, Individual #340, Individual #147, and Individual #223) were dated as having been completed at least 10 days prior to the annual ISP.	

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		▪ Eight of eight (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **<u>OT/PT Assessment</u>** Based on review of eight assessments for individuals in Sample P.1 (i.e., Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223) the comprehensiveness of the OT/PT assessments was as follows: ▪ None of eight (0%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Eight of eight (100%) assessments included medical diagnoses. ▪ Eight of eight (100%) assessments included medical history. ▪ Six of eight assessments (75%) (i.e., Individual #206, Individual #62, Individual #340, Individual #147, Individual #302, and Individual #223) documented analysis of the impact of diagnoses and relevance of medical history to functional status. ▪ Eight of eight (100%) assessments addressed health status over the last year. ▪ Eight of eight assessments (100%) included a comparative analysis that clearly analyzed the individuals' level of health status with previous years or assessments. ▪ Eight of eight assessments (100%) included a section that reported health risk levels that were associated with PNM supports. ▪ Seven of eight assessments (87%) (i.e., Individual #206, Individual #62, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223) listed medications and potential side effects relevant to functional status. ▪ Eight of eight (100%) individuals' OT/PT assessments included individual preferences, strengths, and needs. ▪ Eight of eight (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Eight of eight (100%) individuals' OT/PT assessments included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ Four individuals required a wheelchair as a primary mobility device (i.e., Individual #206, Individual #62, Individual #340, and Individual #147). Four of four assessments (100%) provided a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. Four individuals (i.e., Individual #142, Individual #70, Individual #302 and Individual #223) did not	

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		use wheelchairs for their primary mobility. ▪ None of eight assessments (0%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. More specifically, the assessments did not address the results of PNMP compliance monitoring. ▪ Eight of eight assessments (100%) included recommendations for services and supports. ▪ None of eight (0%) assessments included a comparative analysis of current functional motor and activities of daily living skills with previous assessments. Assessments would provide a description of the individual's current functioning related to motor skills and daily living skills. However, the assessments did not provide previous assessment data and/or results within these areas with analysis to address whether the individual's functional skills had remained the same, improved, and/or there had been regression. ▪ Eight of eight assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP/dining plan that addressed the individuals' PNM risk levels; ▪ Eight of eight (100%) assessments included discussion of the individual's potential to develop new functional skills. ▪ Eight of eight (100%) assessments identified the need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. ▪ Eight of eight (100%) assessments included a monitoring schedule. The assessments indicated that direct support professionals were to monitor individuals' assistive equipment on a daily basis. Although PNMP compliance monitoring was not discussed in the assessment, the PNM monitoring schedule for individuals was determined by their risk ratings for choking, aspiration, gastrointestinal problems, falls, skin integrity, and challenging behaviors. If an individual was ranked high in any of these areas, monitoring was to be conducted on a monthly basis. A medium ranking in these categories would require quarterly monitoring. ▪ However, there was no discussion of PNMP compliance monitoring. . ▪ Eight of eight (100%) assessments included a reassessment schedule. ▪ Eight of eight (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. As required by State Office, therapists had included their opinion about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needed were missing in the community.	

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		▪ Eight of eight (100%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The eight OT/PT assessments reviewed all had 18 of 22 assessment elements present. The following elements were not present in all and/or some of the assessments: ▪ Analysis of the impact of diagnoses and relevance of medical history to functional status; ▪ Medications and potential side effects relevant to functional status. ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; and ▪ Comparative analysis of current functional motor and/or activities of daily living skills with previous assessments. The following eight individuals in the samples had experienced a change in status since the last review: Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223: ▪ For none of eight (0%) individuals, did updates provide the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. In summary, individuals' OT/PT assessments included 18 of 22 assessment elements. Individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements. The Facility remained out of compliance with this subsection.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility,	The parties agreed the Monitoring Team would conduct full monitoring for this subsection, because the Facility found substantial compliance according to their internal self-assessment activities. However, the Monitoring Team's review did not substantiate a finding of substantial compliance as discussed within this section. **<u>Updates</u>** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section P.2: ▪ 11/29/13 - A monthly Assessment of Current Need Clinic was initiated to routinely look at the individuals' needs and to determine if their status was changing. The individuals looked at were those with PNMPs, and also those with wheelchairs; and ▪ 12/12/13: The Lead OT and PT Therapists met with all OT and PT Therapists to review the results of the audit tool implementation. A plan was created based on the findings and discussion that will bring all therapists in line with the	Noncompliance

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	range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Department's audit tool process. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section P.2 included an action plan. The following lists the action steps that were in the process of completion and/or not started: ▪ Direct therapy or services deemed necessary by the comprehensive OT/PT assessment will commence within 30 days of identification of need. ▪ QIDP, with the IDT, will integrate OT/PT recommendations with skill acquisition programs, the individuals' daily programming, and schedules. ▪ QIDP will ensure that individual-specific identified needs for direct/indirect supports are included in the individuals' plan/daily schedule. These action steps were relevant to Section P.2, and should assist the Facility in working towards achieving compliance with Section P.2. **Direct OT/PT Interventions** The Facility reported in the pre-document request that one individual (i.e., Individual #385) received direct OT and/or PT services. During an interview with the Director of HT, Lead OT, and Lead PT, the Monitoring Team inquired if there were additional individuals receiving direct therapy interventions. Four additional individuals were identified (i.e., Individual #389, Individual #40, Individual #138, and Individual #453). A review of these five individuals' records found: ▪ For revisions in direct intervention plans made since the last visit, none of five (0%) individuals' direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The Monitoring Team was not able to discern if direct intervention plans had been implemented for any of the five individuals, because plans were not submitted. ▪ For one of five (20%) (i.e., Individual #389) individuals' records reviewed, the current OT/PT assessment and/or consultation identified the need for direct intervention with rationale. ▪ For none of five (0%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ The Monitoring Team requested evidence of direct therapy discharge or termination. No documentation was submitted to ascertain if therapy had been terminated. Consequently, the Monitoring Team was not able to complete the following: For ____ of ____ individuals' records whose therapies had been terminated (%), termination of the intervention was well justified and clearly documented in a timely manner. When an individual is discharged from therapy, there should be progress notes to document their discharge from therapy. The therapist should provide clinical justification for the termination of a direct intervention plan. The team should discuss the recommendation to	

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		terminate the program within 10 working days, and the team's decision should be documented through an ISPA meeting. **Indirect OT/PT Programs** The implementation of these plans is discussed with regard to Section O.4 for PNMPs, and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** A review of the eight assessments and ISPs/ISPAs for individuals in Sample P.1 (Individual #206, Individual #62, Individual #142, Individual #70, Individual #340, Individual #147, Individual #302, and Individual #223) and five individuals in Sample P.2 found the following: ▪ For six of 13 individuals' ISPs (46%) (i.e., Individual #206, Individual #62, Individual #302, Individual #138, Individual #453, and Individual #40), an OT or PT attended the ISP or ISPA meeting, if the individual was receiving any direct or indirect OT/PT service, or adequate justification was provided. ▪ For individuals receiving OT/PT supports and services (PNMPs and/or direct intervention), four of 13 plans (31%) (i.e., Individual #142, Individual #70, Individual #340, and Individual #302) were developed within 30 days of the date of the ISP, or an ISPA meeting following the assessment/update, or sooner as indicated by need. ▪ For none of 13 individuals (0%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment. ▪ In none of 13 (0%) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. ▪ For none of 13 individuals (0%), the ISP/ISPAs contained measurable objectives related to interventions. Generally accepted practice standards for comprehensive progress notes related to PT/OT interventions include that they: ▪ Contain information regarding whether the individual showed progress with the stated goal, including summary of clinical data and other documentation to substantiate progress and/or lack of progress with the therapy goal(s); ▪ Describe the benefit of the goal to the individual; ▪ Report the consistency of implementation; ▪ Identify recommendations/revisions to the OT/PT intervention plan, as indicated, related to the individual's progress or lack of progress; and ▪ Are completed on at least a monthly basis.	

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		Based on the Monitoring Team's review: ▪ None of five (0%) individuals (i.e., Individual #385, Individual #389, Individual #40, Individual #138, and Individual #453) receiving direct OT/PT services was provided with comprehensive progress notes at least monthly that contained each of the indicators listed above. There were no monthly progress notes provided, including a summary and analysis of the data for the month. ▪ For individuals who received indirect OT and/or PT programs (e.g., PNMPs or SAPs), monthly documentation from the OT and PT and/or QIDP was present for none of the five individuals (0%), including the following: o Information regarding whether the individual showed progress with the stated goal(s), including a summary of clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. In summary, none of five individuals receiving direct OT and/or PT interventions had direct therapy intervention plans. Monthly progress notes had not been completed. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs. The Facility remained out of compliance with this subsection.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection. Substantial compliance with Section O.5 is the standard for compliance with this section. The noncompliance finding from previous review stands. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section P.3: ▪ 11/29/13 - Added monthly core competency training curriculum to the formal CTD training schedule. The Habilitation Therapy Department staff conduct this training annually and as needed. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section P.3 included an action plan. The following lists the action steps that were in the process of completion and/or not started: ▪ Implement competency-based training with all staff regarding strategies and instructions within the PNMP.	Noncompliance

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		These action steps were relevant to Section P.3 and should assist the Facility in working towards achieving compliance with Section P.3. Competency-based training for the implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with Section P.3. The Facility was not in substantial compliance with Section O.5 and, therefore, Section P.3 remained out of compliance.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection. The noncompliance finding from previous review stands. **<u>Updates</u>** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section P.4: ▪ 10/4/13 - Therapists, PTAs, and COTAs began reliability monitoring of their plans and assessing them with the monitoring conducted by the PNMP Coordinators. This process will determine if the PNMP Coordinators are competent in monitoring the PNMPs and if more training is needed; and ▪ 11/7/13 - Therapists began conducting their own monitoring of individuals and their PNMPs. The PNMP Coordinators also continued to monitor PNMPs. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section P.2 included an action plan. The following lists the action steps that were in the process of completion and/or not started: ▪ Develop and implement system to develop corrective actions where appropriate, based on analysis and trends. This action step was relevant to Section P.4, and should assist the Facility in working towards achieving compliance with Section P.4. In addition, the Facility should develop and implement policies and/or procedures to define the provision of OT and PT services and supports at AUSSLC. **<u>Monitoring System</u>** Monitoring of PNMPs is discussed in detail with regard to Section O.6. Substantial compliance with Section O.6 is the standard for compliance with this provision. The Facility was not in substantial compliance with Section O.6. Since the last review, the Assessment of Current Status (ACS) Clinic had been initiated. All individuals on campus that had a PNMP were to be scheduled for the clinic based on the date of their annual ISP meeting. The clinic appointment was to be scheduled at least one month before their annual ISP meeting. The clinic was to be staffed by	Noncompliance

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		physical therapists, occupational therapists, speech pathologists, and a team leader (i.e., senior therapist). During the clinic, the team leader and therapist reviewed each individual's PNMP and discussed the current supports and interventions listed on the PNMP. Each member of the team signed the PNMP Review Declaration form, acknowledging the PNMP was reviewed and discussed. The PNMP Audit Tool form was also completed in the clinic to ensure each section of the PNMP was present, necessary information was documented, the wording was clearly understood, and the document was in the correct format. The team also reviewed PNMP supporting documentation (i.e., photographs and instructions). Any individual-specific instruction pages that were missing and/or needed to be updated were documented on the PNMP Supporting Documents Checklist. The initiation of the ACS Clinic was a positive development and should assist the Facility in working to achieve substantial compliance with Section O.3 and Section P.4. In addition to the ACS Clinic, individuals who used wheelchairs as their primary mode of mobility were scheduled to attend a wheelchair clinic. The Facility did not have comprehensive OT/PT policies and/or procedures. When finalized, the Facility OT/PT policies should include the following elements and reference the DADS Occupational/Physical Therapy Services Policy 014, as applicable: ▪ Description of the role and responsibilities of OT/PT; ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identification of monitors and their roles and responsibilities; ▪ Definition of a formal schedule for monitoring to occur; ▪ Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identification of the frequency of assessments; ▪ Definition of how individuals' OT/PT needs will be identified and reviewed; and ▪ Requirements for documentation for individuals receiving direct services. The Facility should evaluate the current process completed by PNMP Coordinators to	

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		review individuals' prescribed PNMP equipment. These monthly reviews should ensure **all** of an individual's prescribed assistive equipment is reviewed for presence, cleanliness, and in working condition on at least a monthly basis. In addition, a tracking system should be developed and implemented to ensure that if any piece of equipment is in need of repair and/or needed to be replaced, this is accomplished within 30 days, unless justification is provided. During the next review, the following will be reviewed: ▪ For ____ of ____ (%) individuals, positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. ▪ ___ of ___ individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (%), equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, then action was taken within 48 hours. The Facility did not have a comprehensive OT/PT policy. The Facility should develop and implement OT and PT policies/protocols that include the necessary elements presented in this subsection. The Facility remained out of compliance with Section P.4.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o List of staff in the Dental Department, including names, title/role, and degrees; o List of staff in the Dental Department and their CPR certification status; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months; ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; ▪ Have refused dental services; ▪ Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documentation confirming pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam. o Most recent comprehensive exams and other dental visits in prior six months for one individual from each residence. A copy from dental office record of visit and copy from active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record) for: Individual #355, Individual #389, Individual #213, Individual #22, Individual #399, Individual #169, Individual #444, Individual #432, Individual #282, Individual #93, Individual #6, Individual #147, Individual #385, Individual #422, Individual #348, Individual #354, Individual #238, Individual #406, Individual #445, Individual #160, Individual #159, and Individual #344; o Five most recent off-site oral surgery consults and progress notes past six months; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental

	services, and/or quality assurance/enhancement reports, including subsequent corrective action plans; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for appointment (i.e., prophylaxis, annual, etc.), name, dates of refusals and date of completion; o List of those who have not seen dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill requirement/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last on-site visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment – prophylaxis, annual, etc.); o List of no shows/missed appointment per building per month for the last six months; o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, residential manager, team, etc.); o QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows last six months, including any ISPA that documented discussion/action plans concerning dental refusals and other dental missed appointments; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment including time and date of first symptom/concern, and time/date first seen in the dental office for: Individual #53, Individual #10. Individual #414, Individual #275, and Individual #220; o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; o For five individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation (i.e., medical, anesthesia clearance, etc.,), and post-operative checklist or monitoring forms, IPNs on date of procedure, etc., for: Individual #208, Individual #5, Individual #429, Individual #105, and Individual #200; o For the past six months, copies of any correspondence concerning restraint and sedation use at time of office visit (e.g., to QDDP, team, psychologist, etc.); o In response to request for individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring (including pre-treatment sedation sheets). Information was provided for the following individuals: Individual #142, Individual #335, Individual #296, Individual #288, and

	individual #246; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the Dental Department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach (lower dosage, less mechanical restraint duration, etc.)); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #266, Individual #208, Individual #409, Individual #100, and Individual #287; o List of those who receive suction tooth brushing treatment; o List of those who have been identified as benefiting from suction tooth brushing treatment but who are not receiving suction tooth brushing at time of the Monitoring Team's visit (i.e., waiting for equipment, training, care plan revision, etc.); o Copy of 10 annual dental assessments completed in last 30 days and for the prior year of these same individuals: Individual #324, Individual #308, Individual #359, Individual #297, Individual #390, Individual #5, Individual #200, Individual #105, Individual #208, Individual #340, and Individual #429; o Dates of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams (including odontogram); o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #359, Individual #324, Individual #308, Individual #297, Individual #5, Individual #390, Individual #105, Individual #200, Individual #429, and Individual #208; o The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, poor ratings, with date of data. Also, a list of individuals for whom an oral hygiene rating was not obtained during this time; o For those individuals for whom care plans/ISP indicate they brush their own teeth, the oral hygiene scores, with dates of the scores, over the prior one year; o List of those individuals that floss their own teeth; o List of individuals provided instructions on flossing with dates of training; o For those individuals that brush their own teeth but do not floss, the reason for not flossing their own teeth. Requested information included whether a skill acquisition plan had been created or implemented for flossing;

	○ For those that are edentulous, list of those with dentures; ○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.; ○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, date pneumonia documented, date of the most recent dental visit prior to the pneumonia, type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; ○ For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; ○ For the self-assessment process, a list of the databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and for data collected periodically rather than continuously, the frequency of data collection; and ○ Presentation Book for Section Q. ▪ **Interviews with**: ○ Rhonda Stokley, DDS, Dental Director; and ○ James Boston, DDS, Staff Dentist.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: "Dental Monitoring Tool" audits of dental records for treatment plans and verification of NPO orders. ○ These monitoring/audit tools included many clinical indicators, but there needed to be an expansion of indicators to allow the Facility to determine compliance with the various requirements of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. Monitoring of individuals with poor oral hygiene to determine the types and quality of preventive intervention appeared to be a need (i.e., in residence teaching to individual or staff, in residence monitoring of staff providing oral hygiene assistance, etc.). QA of quality and completeness of data for dental desensitization, and monitoring timely analysis of data were areas needing further oversight. ○ The monitoring tools included adequate methodologies, such as record reviews. ○ The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in

	the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o It could not be determined if the monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Dental Department staff. o It was not determined whether the dental staff assigned responsibility for conducting the audits/monitoring had been determined to be competent in the use of the tools and competent to review the relevant area(s). o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate. An example included the Dental Tracking Log. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with Section Q.2. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to improve oral hygiene ratings in the individuals residing at AUSSLC.
	Summary of Monitor's Assessment: The Dental Department provided a broad spectrum of clinical dental services. The annual dental assessments were timely. The refusal rate for dental appointments was low, and each individual was tracked. The annual dental assessments and summaries provided considerable detail of information. Emergencies were tracked to completion. Additional training was provided to nurses concerning nothing by mouth (NPO) status for individuals scheduled for general anesthesia to minimize intra- and post-op complications. Areas of concern included the lack of transition information and the lack of ISP risk rating in the dental summary, which was forwarded to the IDT. Oral hygiene scores across campus remained a challenge. Desensitization or other strategies to reduce the need for sedation did not appear to include those undergoing general anesthesia. There appeared to be little focus on proactive approaches to reducing the rate of tooth loss.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the	Staffing A Dental Director, a Staff Dentist, two Registered Dental Hygienists, and two Registered Dental	Noncompliance

#	Provision	Assessment of Status	Compliance
	Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Assistants staffed the Dental Department. There was also an Administrative Assistant. CPR certification was submitted for the Dental Department staff. For six clinical dental staff, six (100%) were current in CPR. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from July 2013 through January 2014 in a document entitled: "Dental Clinic: Annual Exams July 2013 – January 2014 (7 months)." This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from the list. The list included names of 194 individuals. This was based on incomplete information, one of 17 pages from this database was missing, and, therefore, not all of the individuals residing at AUSSLC were covered. In addition, three of these had database errors/typographical errors and was removed. There were no new admissions in the past seven months. Of the remaining 191 individuals, 191 were listed with prior annual examination dates. Of these 191, 174 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 92 percent. There were 17 overdue annual examinations. This was consistent with the Dental Department findings. From a graph entitled: "Timeliness of Annual Dental Exams July 1, 2013 thru January 31, 2014," the timeliness per month varied from 87 to 100 percent. For the most recent months, the following information was provided for timeliness of the annual dental assessments: November 2013 – 94 percent, December 2013 – 100 percent, and January 2014 – 97 percent. The Facility had achieved substantial compliance with this clinical area of timely completion of annual dental assessments. The Dental Department submitted a document entitled: "Dental Clinic: July 2013 - December 2013: Those who have not seen Dentist in one year and reason (past due for annual exam)." This document indicated 13 individuals residing at AUSSLC had not seen a dentist in the prior 365-day time period for the annual exam. Reasons were provided, and none were due to refusals. Separately, copies of 11 annual dental assessments that were completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments were submitted. For 11 of 11 (100%) of these individuals, an annual dental assessment had been completed within 365 days. The contents of this submitted document (annual dental assessment) included the following components: ▪ Three of the four (75%) applicable submitted assessments had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. Seven assessments were conducted under general anesthesia. ▪ Eleven of the 11 (100%) submitted assessments had entries for oral hygiene rating. ▪ Ten of the 10 (100%) submitted assessments for individuals with teeth had entries for periodontal condition/probing with measurements. ▪ One of 11 was edentulous.	

#	Provision	Assessment of Status	Compliance
		▪ Ten of the 11 (91%) submitted assessments had entries for oral cancer screening (intra-oral exam and extra oral exam screening)/soft tissue exam. ▪ Eleven of the 11 (100%) submitted assessments documented a summary of findings/treatment during the annual visit. ▪ Ten of the 11 (91%) submitted assessments included a dental treatment plan. ▪ Zero of the 11 submitted assessments documented oral hygiene recommendations. These recommendations were included in the annual dental summaries that the IDTs utilized. ▪ Ten of the 11 (91%) submitted assessments documented oral hygiene instruction. ▪ Ten of the 11 (91%) submitted assessments documented risk rating. ▪ Zero of the 11 (0%) submitted assessments documented community transition preparedness. Copies of 10 annual dental summaries (i.e., the report submitted to the IDT for the ISP process) was submitted for review that had been completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed summaries. The content of this submitted document (annual dental summary) included the following components: ▪ Ten of 10 (100%) submitted summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of 10 (100%) submitted summaries had entries for oral hygiene rating. ▪ Ten of 10 (100%) submitted summaries for individuals with teeth had periodontal condition. ▪ Zero was edentulous. ▪ Ten of 10 (100%) submitted summaries had entries for oral cancer screening (i.e., tissue exam). ▪ Of those with teeth, periodontal probe measurements were recorded in zero of 10, including pocket depth. However, this was recorded in the annual dental assessment. It was noted that all 10 underwent general anesthesia/TIVA. ▪ Ten of 10 (100%) submitted summaries documented a summary of findings/treatment during the annual visit. ▪ Ten of the 10 (100%) submitted summaries included a dental treatment plan. ▪ Ten of the 10 (100%) submitted summaries documented oral hygiene recommendations. ▪ Zero of the 10 (0%) submitted summaries documented ISP dental risk rating. ▪ Zero of the 10 (0%) submitted summaries documented community transition preparedness. Differences included the following information that was recorded in the annual dental assessment, but not recorded in the annual dental summary provided to the IDT: periodontal probe measurements and ISP dental risk rating. The reason for not including this information in the dental summary for IDT review was not determined. <u>New admissions</u> During the time period from July 1, 2013 through December 31, 2013, there were no new admissions.	

#	Provision	Assessment of Status	Compliance
		Oral Hygiene (OH) An oral hygiene index was completed on each individual at the time of the annual exam. The most recent OH scores were submitted for the entire campus, in a document entitled: "January 2014 Client OH Ratings Campus Wide report as of 1/31/2014." According to this document, for a census of 280 individuals, 107 (38%) had a good oral hygiene score, 94 (34%) had a fair oral hygiene score, and 79 (28%) had a poor oral hygiene score. It was noted that one individual was not examined during the prior year due to lack of cooperation and by default was given a poor OH rating. From this data, those that were edentulous were removed, as 41 of 43 had an OH rating of good and two had a rating of fair. One individual was partially dentate and remained on the list. For those individuals with teeth, 66 of 237 (28%) had a good oral hygiene rating, 92 of 237 (39%) had a fair oral hygiene rating, and 79 of 237 (33%) had a poor oral hygiene rating. The Facility provided a breakdown of oral hygiene scores per month. It was not indicated whether these scores were recorded at the time of the annual exam, during periodic prophylactic care visits, or at other visits. Duplication of individuals could not be determined. The Facility was able to determine the percentage of dentate individuals in each of the oral hygiene rating categories. Information per month included the following, recorded as numbers of individuals, then as percentage of total dentate population:	

Month	Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
August 2013	61/25%	94/39%	88/36%
September 2013	61/25%	97/40%	84/35%
October 2013	61/25.4%	101/42.1%	78/32.5%
November 2013	65/27.2%	9/38.5%	82/34.3%
December 2013	69/29%	89/37.4%	80/33.6%
January 2013	66/27.8%	92/38.8%	79/33.4%

Further emphasis on oral hygiene (i.e., training in the residence, monitoring in the residence, skill acquisition plans for tooth brushing, and skill acquisition plans for dental office cooperation) might assist in increasing the numbers of individuals that improve oral hygiene.

Oral Hygiene Training
Information was provided on the various oral hygiene training settings (i.e., new employee orientation, chair-side in dental office, in residence, as well as specific suction tooth brushing training). For staff training during New Employee Orientation, the following staff were trained per month for the topic "tooth brushing/oral hygiene:"

#	Provision	Assessment of Status	Compliance

Staff Department	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
Direct Support Professionals	35	23	8	13	20	18
Nursing	0	2	3	10	5	0
Other	3	4	3	6	11	6
Total	**38**	**29**	**14**	**29**	**36**	**24**

A denominator of the total number of new employees eligible for training to allow a percentage of eligible staff trained was not provided.

The Dental Department provided information concerning the number of individuals and staff receiving oral hygiene instruction at the dental office (chair-side). The tracking system did not differentiate between training of staff and training of individuals.

Dental Appointments with Oral Hygiene Instruction	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
# of appointments	37	44	64	33	30	42

Oral hygiene instruction also occurred in the home, from submitted data:

Population	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
Individuals	0	0	0	8	6	0
Staff	0	0	0	4	4	136

The staff training in January 2014 focused on suction tooth brushing. Four direct support professionals were trained and 132 nursing staff were trained in this procedure.

Training rosters for suction tooth brushing were submitted. The following dates of training and number of staff trained were derived from this information. The dates may have included more than one session during that day:

Date	# of staff	Date	# of staff
1/13/14 to 1/17/14, 1/22/14	18	1/13/14	12
1/14/14	19	1/15/14	19
1/16/14	11	1/17/14	19

#	Provision	Assessment of Status	Compliance

1/29/14	7	1/30/14	4
Total	**55**	**Total**	**54**

The grand total was 109. The Facility indicated training of 136 staff. The reason for the difference in numbers was not identified.

The Facility was asked to submit actions taken to improve oral hygiene in individuals with poor oral hygiene ratings. The following information was provided during the Monitoring Team's onsite review, and reflects actions taken from August 2013 through January 2014:

- During this time period, data was submitted indicating there were 72 appointments in which individuals with poor oral hygiene ratings received oral hygiene instruction. A review of this information identified that data from November 2013 had been duplicated. The total number of appointments was corrected to 59 appointments.
- The IDTs also met to discuss the oral hygiene of individuals with poor oral hygiene ratings. From submitted data, from August 2013 through January 2014, there were 35 ISPs that addressed poor oral hygiene ratings, there were five ISPAs, and there were 32 tooth brushing SAPs created.
- Of the 32 tooth brushing SAPs developed, the date developed was submitted for 12. For the remainder, the date of development was "not known." The date of implementation was submitted in 32 of 32 SAPs. In August 2013, three SAPs were implemented. In September 2013, one SAP was implemented. In October 2013, three SAPs were implemented. In November 2013, four SAPs were implemented. In December 2013, five SAPs were implemented. In January 2014, 16 SAPs were implemented. For the 32 individuals, data analysis was "not available." For those identified with poor oral hygiene, it is recommended that the Dental Department take additional steps. Members of the Dental Department might need to monitor the implementation of the SAPs specific to individuals with poor oral hygiene, as well as monitor to ensure the direct support professionals assist appropriately, and each has completed competency-based training in assisting with oral hygiene/tooth-brushing. Each home should be visited during the tooth-brushing time at frequent intervals (up to several times weekly) as several staff will need to be trained and monitored. The Dental Department should keep a log of observations as proof of onsite training and monitoring. Additionally, frequent visits to the Dental Clinic for tooth-brushing, tooth-brushing instruction, and flossing might be appropriate.

Suction Tooth Brushing

As part of preventive oral care, suction tooth brushing was provided to those with one or more of the following indications for this procedure: risk of aspiration, history of aspiration, risk of silent aspiration, unable to manage thin liquids safely, unable to spit, and unable to brush independently. A list submitted indicated 31 individuals received suction tooth brushing, which was 31 of 281 (11%) of the total population residing at AUSSLC.

#	Provision	Assessment of Status	Compliance
		Twenty-nine additional individuals were identified as qualifying for suction tooth brushing, but had not received this service. Several steps were taken in preparation for increasing the number of individuals that would have suction tooth brushing. On 9/19/13, training of the two dental hygienists by a nurse experienced with suction tooth brushing occurred. Training logs were submitted for this. As of 9/23/13, a system was implemented to ensure filters and canisters were replaced according to schedule. An inventory of suction machine components was initiated to ensure needed parts were readily available. An assessment was completed on all existing suction machine apparatus as of 10/24/13. The goal of the assessment was to determine whether the machines were set up correctly and whether replacement parts were needed. A copy of the initial findings was submitted as evidence of this task. A laminated instruction card was created as of 10/24/13 that was attached to the suction machine apparatus. This was to provide guidance to the staff in determining when the apparatus was correctly set up. A monitoring system to ensure the equipment was set up correctly and parts were being replaced was also created as of 10/24/13. In-service training as a refresher course to nurses, as well as training of new nurses on suction tooth brushing, occurred by 1/22/14. A document was submitted entitled "Suction tooth brushing: Protocol for dental clinic 2014." This included many of the monitoring and assessment steps noted above. A template of the monitoring log was attached. It was not indicated when the monitoring would be implemented. A competency-based training checklist was created for training of staff in the residences. A list (undated) was submitted identifying direct support professionals that would be trained on suction tooth brushing. Physicians were asked to determine whether direct support professionals could perform this function for individuals for whom nurses were providing suction tooth brushing, because this would require a modification of physician orders. Physicians also were asked to determine whether individuals that were pending suction tooth brushing could be brushed by nurses only or by direct support professionals, in order to ensure the initial physician order was complete. *Individuals with Self-Brushing Plans* Sixty-one individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of these 61 individuals were submitted for the prior two ratings completed at the time of the annual exam. It was noted that there were several ratings that were three to six months apart, which would make any change or trend in oral hygiene scores less apparent. However, based on the submitted information, 27 remained in the same category of oral hygiene rating. There were 11 that maintained a good oral hygiene rating. For 11, the individuals maintained a fair oral hygiene rating. For five, the individuals continued to have poor oral hygiene ratings. For 17 individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. For two individuals, the ratings improved from poor to fair. For 14 individuals the ratings improved	

#	Provision	Assessment of Status	Compliance
		from fair to good. For one individual, the ratings improved from poor to good. For sixteen individuals, the oral hygiene ratings worsened. For two individuals, the rating changed from good to poor. For nine individuals, the ratings changed from good to fair. For five individuals, the ratings changed from fair to poor. This is an additional population needing an aggressive approach to oral hygiene. Frequent monitoring, and repeated training, as well as frequent dental appointments might provide the structure needed to ensure quality oral hygiene skills are developed and maintained. *Flossing* The Dental Department listed one individual that flossed. A list of those individuals with independent tooth brushing skills was provided, along with the reasons for those individuals not being able to floss independently or with assistance. Reasons included historical information that one-on-one training with the hygienist several times did not lead to progress, but safety concerns due to continued poor technique led to the conclusion that these individuals should not floss by themselves. As a result, in the prior six months, there was no training of individuals in flossing their own teeth. Skill acquisition plans for flossing had not been created <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from July through December 2013, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. A list of 25 individuals that had pneumonia 30 times was submitted. For one individual. the pneumonia was listed as aspiration pneumonia and occurred the same day as the dental appointment, which utilized general anesthesia. During the visit, there was an exam, prophylaxis care, fluoride treatment, two fillings, and x-rays completed. As mentioned elsewhere, the Dental Department noted some individuals had emesis during or after the anesthesia, and discovered that nurses were administering medications without minimizing the volume of pudding or other food vehicle used when getting the individual to accept and swallow the medication. An in-service was held with nurses with instruction by the Dental Department. The pneumonia task force forms created should be completed in any individual developing pneumonia after a dental procedure. Vital signs should be recorded by nurses in the homes prior to the appointment and reviewed by the Dental Department prior to the use of general anesthesia as evidence there were no signs of developing illness prior to the procedure. From other documentation provided, 25 individuals that developed 30 episodes of pneumonia had been designated as being at high risk for aspiration, and were at risk for developing pneumonia whether or not dental care was completed. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department provided the breadth of services required for routine dental care for the individuals at AUSSLC. According to a document entitled "Dental Clinic: Preventive July 2013 – January	

#	Provision	Assessment of Status	Compliance

2014 (7 months)," the following was the breakdown per month of the number of prophylactic care treatments completed:

Month	Number of Prophylactic Care Treatments
July 2013	64
August 2013	27
September 2013	59
October 2013	77
November 2013	40
December 2013	35
January 2014	48
Total	**350**

A document entitled "Dental Clinic: Restorative July 2013 – January 2014 (7 months)," provided the following information:

Number of Restorations Per Visit	Number of Visits	Number of Restorations Per Visit	Number of Visits
1	35	7	1
2	13	8	1
3	5	9	1
4	4	11	1
5	4		
		Total visits	**65**

The following were the number of visits per month for restorations, and the total number of restorations completed per month:

Month	Number of Visits	Number of Restorations Per Visit	Total # of Restorations for Month
July 2013	11	1-8	25
August 2013	10	1-7	24
September 2013	11	1-11	29
October 2013	15	1-4	26
November 2013	9	1-5	18
December 2013	3	1-9	12
January 2014	6	1-5	13
Total	**65**		**147**

#	Provision	Assessment of Status	Compliance

Discussion with the Dental Department indicated the majority of fillings (i.e., glass ionomer) were to restore anatomic contours to the teeth to prevent food from collecting on the teeth. The contours are considered due to acid from GERD and/or bruxism, as well as fractures, some of which were due to bruxism.

From a document entitled: "Dental Clinic: List of those seen for Dental Emergencies July 2013 - January 2014 (7 months)," the following was recorded:

Month	Number of Emergencies	Seen Same Day	Seen Next Work Day	Month	Number of Emergencies	Seen Same Day	Seen Next Work Day
July 2013	8	5	1	November 2013	6	5	1
August 2013	6	4	2	December 2013	5	5	0
September 2013	7	6	0	January 2014	6	5	1
October 2013	5	4	1	**Total**	**43**	**34**	**6**

For two emergencies, one individual did not show for the emergency visit, but was seen two days later, and one was seen after return from furlough.

From a document entitled: "Dental Clinic Extractions July 2013 – January 2014 (7 months)," 25 individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to four per visit. Fifteen individuals had one tooth extracted. Six individuals had two teeth extracted. Two individuals had three teeth extracted. Two individuals had four teeth extracted. The following information provided the breakdown by visit and numbers of teeth extracted per visit:

Month	# of Visits With Extractions	One Tooth Extracted	Two Teeth Extracted	Three Teeth Extracted	Four Teeth Extracted
July 2013	5	2	2	1	0
August 2013	2	2	0	0	0
September 2013	5	3	2	0	0
October	3	2	1	0	0

#	Provision	Assessment of Status	Compliance

2013						
November 2013	6	4	0	1	1
December 2013	1	1	0	0	0
January 2014	3	1	1	0	1
Total	**25**	**15**	**6**	**2**	**2**

The Dental Department indicated that 70 percent of extractions were considered due to loss of bone stability.

From a submitted document entitled "Dental Clinic: Annual Exams July 2013 – January 2014 (7 months)," the following information was provided:

Month	**# of Completed Annual Exams within 365 days of Prior Exam**	**# of Completed Annual Exams Past 365 days of Prior Exam**
July 2013	8	2
August 2013	20	2
September 2013	30	4
October 2013	47	4
November 2013	17	3
December 2013	18	1 (data incomplete)
January	34	0, 1 pending overdue
Total	**174**	**16 completed and 1 pending**

Timely completion according to the Dental Department was 180 of 194 (93%). Timely completion as calculated by the Monitoring Team member was 174 of 191 (92%). For three individual, no date of prior exam was listed and was removed from the calculation. Additionally, the data from December 2013 was incomplete.

<u>X-rays</u>
The Dental Department referred to the document entitled: "American Dental Association, US Department of Health and Human Services. The Selection of Patients for Dental Radiograph Examinations (revised 2004)" in the "Annual Dental Assessment Policy" in guiding the determination for ordering x-rays. The Dental Director provided a summary review of x-ray completion. Individuals undergoing general anesthesia would be expected to have up-to-date x-rays. For others, the level of cooperation dictated which x-rays were completed. Bitewings are associated with less discomfort and less gagging, and are more successfully completed than periapical x-rays. The level of cooperation and

#	Provision	Assessment of Status	Compliance
		the level of need determined which x-rays were completed. When there was known or suspected pathology, the risk to benefit analysis indicated the need to obtain x-rays, which was done under general anesthesia when there was lack of cooperation from the individual and the individual was able to medically tolerate the anesthesia. For those in whom there was no suspected dental pathology, or there was extensive health or airway concerns, then the risk outweighed the benefit in obtaining dental x-rays. The above guidance was used in determining x-ray completion for individuals at AUSSLC. A list of those with x-rays completed, type of x-ray completed, and date of x-ray was submitted in a document entitled "…campus x-ray data." This list included 281 individuals. Forty-three of these were edentulous. Two hundred thirty eight were reviewed to determine status of current x-ray completion:	

Type of X-ray	2014	2013	2012	Prior to 2012	Not completed
Any type	16	175	24	19	4
Full mouth x-ray series	8	113	58	23	31

From the above information, during the past two years (2014 only included one month), 215 dental x-rays of any type were completed. This was 215 of 238 (90%). During the past two years (2014 only included one month), 179 completed a full mouth x-ray series. This was 179 of 238 (75%).

<u>Edentulous individuals/dentures</u>
Information submitted in a document entitled: "Edentulous/Dentures" indicated 44 individuals residing at AUSSLC were edentulous, for a rate of 44 of 281 (16%). No individual became edentulous since July 2013.

Three of 44 individuals that were edentulous had dentures. Two of these three had upper and lower dentures. One individual had an upper denture only, as the individual was partially dentate. Forty-one individuals that were edentulous did not have dentures. Reasons given for all 41 were the same: inadequate cooperation for denture fabrication to be completed.

For the submitted annual dental summaries, the document did not record whether the individual was a candidate for dentures and whether the level of cooperation was inadequate.

<u>Oral Sedation</u>
Monitoring and evaluation of use of oral sedation was reviewed. Five active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review:

- Five of five confirmed NPO status or nothing per G-tube at the time of the dental visit. Zero individuals were documented to not need NPO status.
- Five of five (100%) listed the medication administered, the dose, and the route.

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Zero of five (0%) listed pre-procedure vital signs in the home.
Five of five (100%) had an examination note/operative IPN/Dental Progress Note (DPN) on the date of the visit.
Five of five (100%) documented pre-procedure vital signs at the dental office. For one individual, the pre-procedure vital signs occurred as part of the general anesthesia procedure.
Five of five (100%) documented intra-procedure vital signs or attempts at vital signs. For four of five, vital signs were obtained while under general anesthesia.
Five of five (100%) documented post-procedure vital signs.
Adequate documentation regarding effectiveness of sedation was found in five of five (100%) of the active records.
Five of five (100%) documented a post-dental procedure IPN note.
Five of five (100%) included documentation of current sedation consent from guardian/LAR.
Zero of five (0%) included documentation of HRC review and approval.
Zero of five (0%) included a restraint checklist.

<u>General Anesthesia/TIVA</u>
The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period July 2013 through January 2014. The number of appointments utilizing general anesthesia/TIVA completed per month follow:
<table>
<tr><th>Month</th><th>Number of Completed Visits with General Anesthesia/TIVA</th><th>Number of Scheduled Visits with General Anesthesia/ TIVA Not Completed at Initial Appointment</th><th>Had Follow-Up Complete General Anesthesia/TIVA Appointment</th></tr>
<tr><td>July 2013</td><td>12</td><td>1</td><td>0</td></tr>
<tr><td>August 2013</td><td>28</td><td>3</td><td>1</td></tr>
<tr><td>September 2013</td><td>33</td><td>3</td><td>4</td></tr>
<tr><td>October 2013</td><td>34</td><td>6</td><td>3</td></tr>
<tr><td>November 2013</td><td>23</td><td>3</td><td>5</td></tr>
<tr><td>December 2013</td><td>13</td><td>1</td><td>1</td></tr>
<tr><td>January 2014</td><td>20</td><td>1</td><td>2</td></tr>
<tr><td>Total</td><td>163</td><td>18*</td><td>16</td></tr>
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* Two individuals missed an initial appointment and a follow-up to the initial appointment. There
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#	Provision	Assessment of Status	Compliance
		were 18 appointments missed (i.e., initial and follow ups). There were 16 initial appointments missed. The active record was submitted for five individuals who had undergone general anesthesia/TIVA in January 2014. The procedures under general anesthesia/TIVA included one or more aspects of dental care. The list varied in each case, and included one or more of the following: annual exam, prophylaxis care, x-rays, extractions, and restorative care. Review of these records revealed the following: ▪ Consent by the guardian/LAR for the anesthesia was current (defined as completed and dated within 365 days of the procedure) in five of five (100%). Consent for the dental procedure was obtained in one case for extractions. ▪ A copy of the HRC review and approval was submitted in zero of five (0%). ▪ A pre-operative medical clearance was completed and submitted in zero of five (0%) cases. ▪ A pre-operative anesthesia record/clearance by anesthesia was completed and submitted in five of five (100%). ▪ Pre-operative vital signs were recorded in five of five (100%) cases. ▪ An operative note by the dentist was recorded in five of five (100%) cases. ▪ The operative anesthesia record was submitted for five of five (100%). ▪ A periodontal probe measurement was submitted for five of five (100%). ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score, Aldrete Score, or other equivalent assessment of post-anesthesia recovery was submitted in five of five (100%) of the active records. ▪ A Dental Department post-operative follow-up note was submitted for one of one (100%). Only one of the five submitted cases had extractions. The other individuals had exam, prophylactic care, and/or restorative care and follow-up was not indicated. ▪ A post-operative vital sign flow sheet was submitted in five of five (100%). ▪ Pain medication was prescribed in five of five (100%) cases. ▪ An annual dental assessment was completed while under general anesthesia/TIVA in five of five (100%) cases. The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. For the time period July 2013 through December 2013, there were 129 completed appointments for individuals listed as having been scheduled for general anesthesia/TIVA. There were 13 incidents of injuries in the following 24-hour time period involving 13 individuals. These were described as one of the following: non-serious scratch (four), blood clots in mouth (one), redness of upper arm (one), slip/trip/fall (two), found on floor (one), cut due to SIB (one), redness to cheek bone (one), slapped by peer (one), and bruise on hand (one). The Dental Clinic provided an in-service to the nurses concerning NPO status, with specific information as to whether medications could be given prior to general anesthesia, and what fluid could be given with the medication (e.g., water, etc.). Timing of NPO status was also explained, to accommodate an individual scheduled later in the day for general anesthesia versus an individual scheduled early in the morning. This was to reduce adverse events, such as vomiting during and after the dental procedure.	

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		Some individuals required pudding and other foods for a successful swallow or cooperation in taking medications and the amount of food allowed was discussed. To improve safety and efficiency in the dental office, on 1/8/14, PT provided training to five dental staff concerning dental chair positioning. Training logs were submitted for review. <u>Extractions</u> For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, guardian/LAR consent was current in five of five (100%). ▪ A dental IPN/DPN indicating the need for extractions was documented in five of five (100%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA. ▪ For four of the five cases, IV sedation/general anesthesia was used. For one of the cases, local anesthetic was used. ▪ From one to four teeth were extracted at a visit. This is informational only, ▪ Pain medication was provided in five of five (100%) cases. ▪ A follow-up dental note the following morning in the Infirmary or a phone call to the residence (when not admitted overnight to the infirmary) was documented in five of five (100%) cases. ▪ A follow-up visit was documented in five of five (100%) cases to determine healing or complications. For the above clinical indicators reviewing the dental procedure of tooth extraction, the Facility had achieved substantial compliance. There were no individuals that underwent oral surgery consultation off campus. <u>Emergency Treatment</u> The Dental Department provided a "Dental Emergency Log" for the months of July 2013 through January 2014. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: broken denture, odor from mouth, blood in mouth, ulcer, and dry mouth. The following findings are made based on this review: ▪ Five (100%) records documented the presence or not of pain. ▪ Pain was treated in one of one (100%) case. ▪ Follow-up occurred for one of one (100%) applicable case. ▪ There was documentation of closure of the dental emergency (i.e., either no further visit required or scheduled for procedure) in five of five (100%) cases. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit varied from 10 minutes to five hours and 15 minutes. This time period could not be determined in one case. For the above clinical indicators reviewing the dental procedure of emergency care, the Facility had	

#	Provision	Assessment of Status	Compliance
		achieved substantial compliance. Overall, the Facility remained out of compliance with regard to Section Q.1. However, as specifically noted with regard to specific areas discussed above, the Facility had achieved substantial compliance with a number of clinical requirements. The Facility should focus on the remaining areas to move towards substantial compliance with the entire subsection.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDT, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> Policies reviewed and updated since the last Monitoring Team's visit included the following: ▪ "AUSSLC – Dental Clinic: Annual Dental Assessment Policy," updated 1/18/14; ▪ "AUSSLC – Dental Clinic: Comprehensive Dental Care Policy," updated 1/18/14; ▪ "AUSSLC – Dental Clinic: Dental Desensitization Policy," updated 1/18/14; ▪ "AUSSLC - Dental Clinic: Criteria for Determining Usage of Enteral Sedation or General Anesthesia (GA)," revised 1/18/14; and ▪ "AUSSLC - Dental Clinic: Missed/Refused Appointments Policy" updated 1/18/14. Policies in draft form or awaiting approval included the following: "Policy and Procedure: Tooth brushing" <u>Provision of Dental Records to IDTs</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence along with the copy from the dental office records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. The number of documents located in the dental office record that were also found in the active medical record (with the exception of x-ray films) determined compliance. This would assure the IDT had all dental information available for review at the ISP and other times when needed. However, the submitted information did not appear to respond to the request, and the submitted information indicated the dental office record was a photocopy of the dental section active record. As documents at times are misfiled, not filed, or filed and later removed by various staff, the Monitoring Team member had requested a sample of documents found in both the dental office record and the active record for comparison. This request, however, was misinterpreted and not submitted. This would have provided evidence of identical documentation, but as documentation was lacking in completing this request, this area remained noncompliant. The Dental Department is encouraged to monitor both the active record and dental record to determine if records are identical in both locations.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>
<u>Refusals/Missed Appointments</u>
A review of information from a document entitled: "Dental Clinic: Refusals July 2013 –January 2014 (7 months)" for dental appointments indicated that four initial appointments were refused. Additionally, one follow-up appointment scheduled to complete the initial appointment was refused. Four individuals refused these five initial and follow-up appointments.

Of the four initial appointments, three follow-up appointments were subsequently completed.
Of the four initial appointments, one follow-up appointment was still pending/remained incomplete, and was pending an IDT plan.

One individual refused more than one appointment. Reasons for the initial, scheduled appointments that were refused included: prophylaxis (three appointments) and exam, not further defined (one appointment). The refused appointments occurred from four residences.
<table>
<tr><th>Month</th><th>Number of Refused Appointments</th></tr>
<tr><td>July 2013</td><td>3</td></tr>
<tr><td>August 2013</td><td>1</td></tr>
<tr><td>September 2013</td><td>0</td></tr>
<tr><td>October 2013</td><td>0</td></tr>
<tr><td>November 2013</td><td>0</td></tr>
<tr><td>December2013</td><td>1</td></tr>
<tr><td>January 2014</td><td>0</td></tr>
<tr><td>Total</td><td>5</td></tr>
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For the four initial appointments that were refused, a follow-up appointment was completed in three cases.

For one individual, the completed appointment occurred from one to 15 days after the refused appointment.
For one individual, the completed appointment occurred from 16 to 30 days after the refused appointment.
For one individual, the completed appointment occurred from 31 to 60 days after the refused appointment.
One individual had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document.

Submitted were copies of ISPs and ISPA in response to dental appointment refusals or missed appointments by two individuals. For one individual, there were two ISPA meetings. For one individual, there was one ISPA meeting in which the IDT reviewed implementing a desensitization plan. The final recommendation did not address creation of a desensitization plan, but did focus on an action step to improve cooperation when arriving at the dental clinic.
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#	Provision	Assessment of Status	Compliance
		Non-refusals/Missed appointments From a document entitled: "Dental Clinic Missed Appointments other than Refusals July 2013 – January 2014 (7months)," there were 49 missed/no show appointments, which were not categorized as refusals. Forty-three individuals missed these appointments. Reasons for the scheduled appointments that were missed included prophylaxis (23 appointments), exam, not further defined (16 appointments), exam and prophylaxis (four appointments), prophylaxis and x-rays (two appointments), restorations (one appointment), and other (three appointments). The missed/no show appointments occurred in 19 residences. The major reasons identified for missed appointments from July 2013 to December 2013 included: medical illness/health issues (13), referral to another anesthesiologist (four), not NPO (seven), furlough (four), scheduling conflict with anesthesiology (three), pending PT consult (one), no-show (two), behaviors in residence or office (three), weather (one), group residential visit (one), and other (two).	

Month	Number of Missed Appointments (Non-refusals)
July 2013	6
August 2013	4
September 2013	6
October 2013	12
November 2013	8
December 2013	5
January 2014	8
Total	**49**

For the 43 initial appointments that were missed, a follow-up appointment was documented in 36 cases. Six individuals missed a follow-up appointment for completion.

- For 19 individuals, the completed appointments occurred from one to 15 days after the missed appointment.
- For six individuals, the completed appointments occurred from 16 to 30 days after the missed appointment.
- For six individuals, the completed appointment occurred from 31 to 60 days after the missed appointment.
- For four individuals, the completed appointment occurred more than 60 days after the missed appointment.
- For one individual, the completed appointment date was not listed correctly (typographical error).
- Seven cases remained pending.

#	Provision	Assessment of Status	Compliance
		The Dental Department tracked refused appointments, missed/refused appointments, and preventable missed/refused appointments. Data was provided for two quarters of 2013. For the third quarter of 2013 (July to September), the refusal rate was four of 241 (2%) appointments. The missed/refusal rate was 20 of 241 (8%) appointments. The missed/refused appointment rate, determined to be preventable (e.g., not kept NPO), was 10 of 241 (4%). For the fourth quarter (October through December), the refused appointment rate was one of 227 (0.4%) appointments. The missed/refused appointment rate was 26 of 227 (11%) appointments. The number of preventable missed or refused appointments was eight of 227 (4%) appointments. The Dental Department appeared to make considerable progress in preventing refused appointments. Missed appointments for other reasons remained a challenge. Several missed appointments had potentially correctable causes (for example, not NPO). <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> The Facility had three different documents that included information concerning sedation tracking. These did not all contain the same information, and the Dental Department utilized two of these documents to obtain a complete history of sedation information. The Dental Department Tracking Log included the name, residence, dental procedure, schedule date, whether oral sedation and/or general anesthesia used, and whether a restraint was utilized (not further defined). The dental notes contained the date of the visit, type of sedation or restraint, the dosage given, the effectiveness of the sedation/restraint, and description of any less restrictive approaches that were attempted. The Pharmacy Department also had a Pre-Treatment Sedation Tracker database, which recorded the name, the type of dental procedure, date of procedure, the type and dose of drug given, the date the medication was ordered, and the effectiveness. It was not clear whether the two databases, one in the Dental Department and one in the Pharmacy Department, were able to collate information by individual, providing all pre-treatment sedation given over the past several years with this same information, to determine whether the optimal minimal dosage was being administered. Information was submitted concerning use of restraints for dental procedures. For the prior seven months (July 2013 through January 2014), there were 484 completed appointments. The dental office did not use mechanical restraints. Fourteen of 484 (3%) of completed appointments utilized oral sedation and 147of 484 (30%) completed appointments utilized general anesthesia/TIVA. The following table lists this information by month:	

#	Provision	Assessment of Status	Compliance

Month	Completed Appointments	Number of Appointments with TIVA/GA	Percentage Appointments with TIVA/GA	Number of Appointments with Oral Sedation	Percentage Appointments with Oral Sedation
July 2013	91	12	13%	0	0%
August 2013	55	27	49%	2	4%
September 2013	74	29	39%	2	3%
October 2013	96	31	32%	3	3%
November 2013	62	18	29%	3	5%
December 2013	43	12	28%	2	5%
January 2014	63	18	28%	2	3%
Total	**484**	**147**	**30%**	**14**	**3%**

The Dental Department noted that there had been a backlog of general anesthesia cases from the first half of 2013, when general anesthesiology contracts were being completed.

Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation, which was undated, but had a scan date of 2/5/14. A total of 44 individuals were listed that required sedation prior to dental treatment. The information did not separate approval for pre-treatment oral sedation from general anesthesia/TIVA. Of these, 44 (100%) had current consents.

Desensitization

A document submitted to the Monitoring Team prior to the onsite review entitled: "Summary information on desensitization plans since the Monitoring Team's last visit" provided current information (scan date 2/5/14) concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits and to reduce the need for restraint. Copies of these programs were submitted. No information was provided in this document concerning total eligible population or numbers of individuals not considered appropriate for dental desensitization or other behavioral programs to improve cooperation with dental services. According to the document:

- Sixteen individuals had plans developed for dental desensitization.
- Sixteen of 16 (100%) submitted plans were implemented.
- Data showed that for eight of 16 of these plans (50%) that were implemented, documentation of data appeared to be complete without gaps and were implemented consistently.

#	Provision	Assessment of Status	Compliance
		▪ Submitted information indicated that data was analyzed to determine progress or lack of progress in three of 16 implemented plans (19%). ▪ Data analysis of current desensitization plans indicated that six had made progress, four had made no progress, and six appeared to make variable progress. There was no summary analysis at the end of the month or for prior months. ▪ Based on analysis, plans for one individual were revised. Updated information concerning dental desensitization plans and other behavioral plans for dental cooperation was provided on site in a document dated 2/24/14. The following information was derived from this update: ▪ Number of individuals for which a desensitization/other behavioral plan was deemed appropriate: 21; ▪ Number of individuals for which a desensitization/other behavioral plan was deemed inappropriate: data unavailable; ▪ Number of individuals for which a desensitization/other behavioral plan was in draft stage: two; ▪ Number of individuals for which a desensitization/other behavioral plan was completed: 19; ▪ Number of individuals for which a desensitization/other behavioral plan was implemented: 19; ▪ Number of plans implemented one to three months: five; ▪ Number of plans implemented four to six months: six; ▪ Number of plans implemented in less than six months: 11; ▪ Number of individuals for which data from the desensitization/other behavioral plan was analyzed with results available: data unavailable; ▪ Number of individuals for which a desensitization/other behavioral plan was revised based on analysis of data collection: data unavailable; ▪ Number of individuals for which a desensitization/other behavioral plan indicated progress: 10; ▪ Number of individuals for which a desensitization/other behavioral plan indicated no progress: six; ▪ Number of individuals for which a desensitization/other behavioral plan indicated variable progress: three; and ▪ Number of individuals that had an implemented desensitization/other behavioral plan implemented but subsequently moved to the community: zero. This information appeared to be different from information submitted through the Presentation Book for Section Q. This document indicated that 32 desensitization plans had been implemented. A listing dated 1/27/14 of the "Dental Desensitization Report" included 18 individuals, which was similar to the above information. In a document entitled "Desensitization Plans 11-2013," 32 names were listed for dental desensitization. The reason for the difference in numbers was not provided.	

#	Provision	Assessment of Status	Compliance
		Since the last Monitoring Team's visit, a Pre-treatment Sedation Committee had met on a regular basis. The focus was on treatments or strategies to minimize or eliminate the need for pre-treatment sedation. A "Pre-Treatment Sedation Dashboard" tracked use of pre-treatment sedation for such parameters as the following: dental pre-treatment sedation addressed in the annual dental assessment, percentage of ISPs with dental pre-treatment sedation discussed, dental pre-treatment sedation effectiveness documented, nurse monitoring completed, and number of dental desensitization plans implemented. There did not appear to be committee review of dental desensitization plans/behavior plans for those undergoing general anesthesia for dental procedures, such as prophylaxis. The large number of individuals requiring general anesthesia, along with the need for extractions and restorations indicate the need for review of individuals that might be appropriate for dental desensitization/other behavioral plans, or other strategies to reduce the need for the use of sedation. It is recommended that each of those individuals undergoing procedures under general anesthesia for cleaning, need for fillings due to caries, and extractions, be reviewed for appropriateness of desensitization, other behavioral plan, or other strategies. It is recommended that the need for general anesthesia be demonstrated through a lack of progress in desensitization or other plans implemented to enhance cooperation without the use of this procedure, which is not without risks. Dental treatment plans should include dental desensitization or other plans for each individual for which a dental visit under general anesthesia is planned in the future. Although the individual might not demonstrate sufficient success at one or two years out and will require additional cleaning and restorations under general anesthesia, the Dental Department should ensure active desensitization or other plans are in place and are completed/documented on a frequent (i.e., daily to several times a week) basis. Currently, individuals are repeatedly administered TIVA/general anesthesia for prophylactic care and continue to require extractions without the benefit of a dental desensitization plan or other strategies to reduce the need for such restrictive practices to the extent possible. At some point, a successful dental desensitization plan has the potential to result in improved oral hygiene, a reduction in severity of periodontitis, and a reduction in tooth loss. The number of individuals requiring deep scaling and root planing would be potentially reduced and the need for general anesthesia would be diminished. Continued tooth loss, severe periodontitis, etc., indicates additional dental and behavioral supports are needed. In summary, it was noted that the Facility had only a few plans in place for desensitization. Some appeared to be having a positive impact. However, the Facility needed to demonstrate that plans were in place and being implemented with assessment of progress for each of the 163 individuals receiving TIVA/general anesthesia, as well as those that would benefit from such a plan, but do not require TIVA/general anesthesia. It is recommended that dental desensitization/other behavioral plans or strategies be made a focus and that monitoring be in place to ensure individuals not undergo procedures requiring TIVA/general anesthesia without the creation and implementation of a plan to	

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reduce the need for sedation to the extent possible. Daily (or most days of the week) evidence of the implementation of the desensitization plan should be in place. If TIVA/general anesthesia is required during the implementation of plan, then the IDT should review the plan to determine progress and adequacy of the plan, revising the plan to meet the needs of the individual.

Quality Assurance/Improvement Initiatives

The Facility submitted data concerning inter-rater reliability of audits completed for the QA monitoring tool for Section Q – Dental Services. Ten clinical indicators were reviewed. These included responses to whether the annual dental exam was completed within 365 days of the prior exam; when the individual had an emergency within the past 365 days of the audit, whether the individual was evaluated within one business day of the dental clinic being notified; whether there was documentation verifying NPO status; whether the IPN or nursing section contained the post-anesthesia vital sign sheet with measurements recorded for three days; whether the entry for the date of the appointment on the dental record and tracking log were the same; whether sedation/anesthesia/restraint was used; whether extraction occurred; whether fillings occurred; whether the oral hygiene rating was recorded; whether the individual had dental x-rays completed in the prior three years of the audit; and whether the most recent cleaning occurred within four months of the prior cleaning when "perio recal" was checked on the annual dental assessment. For the Monitoring Tool indicator "date of appointment," it is recommended that staff clarify what is being measured (e.g., documentation of entry of date in the dental record, agreement between dental records and tracking log, etc.). Inter-rater reliability data was submitted for the time period from July 2013 to December 2013. The following chart reflects the submitted information per month:

Month	Number of Indicators Listed	Number of Indicators with Compliance	Sample Size	Inter-rater Reliability %	Inter-rater Reliability Sample Size
July 2013	10	8	6 (2% of population)	97%	3
August 2013	9	4	6 (2% of population)	100%	3
September 2013	11	7	6 (2% of population)	100%	3
October 2013	11	8	6 (2% of population)	94%	3
November 2013	10	4	6 (2% of population)	79%	3
December 2013	10	5	6 (2% of population)	97%	3

#	Provision	Assessment of Status	Compliance
		Also listed, for the time period of September 1, 2013 through November 30, 2013, were the number of indicators that were most frequently out of compliance. These indicators included the following, when the number of times the noncompliance was found exceeded one time: ▪ Was the individual annual dental exam completed within 365 days of the previous exam? (seven); ▪ If the individual had an emergency within the past 365 days (i.e., one year prior to the date of audit) was the individual evaluated within one business day of the dental clinic being notified? (two); ▪ Does the IPN or the nursing section contain the post anesthesia vital sign monitoring sheet with vital sign entries for three days? (eight); ▪ Is there documentation that NPO status was verified? (three); and ▪ Has individual had dental x-rays taken within the past three years of the audit? (two), There needed to be an expansion of indicators to allow the Facility to determine compliance with the various requirements of Section Q of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. As some examples, monitoring of individuals with poor oral hygiene to determine the types and quality of preventive intervention appeared to be a need (i.e., in residence teaching to individual or staff, in residence monitoring of staff providing oral hygiene assistance, etc.). QA of quality and completeness of data for dental desensitization or other strategies to reduce the need for all types of sedation, and monitoring timely analysis of data also were areas needing further oversight.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section R; o For 10 individuals (i.e., Individual #375, Individual #328, Individual #238, Individual #389, Individual #275, Individual #2, Individual #90, Individual #406, Individual #184, and Individual #426), the following documents: Communication Comprehensive assessment; Update and Assessment of Current Status; ISP and ISPAs for past year; Positive Behavior Support Plan; skill acquisition programs related to communication and supporting documentation for implementation (indirect supports); direct SLP therapy intervention plans and supporting documentation such as IPNs, or monthly reviews by SLP; alternative and augmentative communication (AAC) programs, and supporting documentation for implementation of indirect supports; individual-specific communication monitoring for past six months; and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o List of current SLP and audiology staff along with corresponding caseloads; o List of individuals with AAC devices; o Communication Master Plan List; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SLP assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o List of individuals receiving direct speech services and focus of intervention; o List of individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication; o List of all general common area communication devices; o External SLP consultant report; and o Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review. ▪ **Interviews with:** o Dr. Michael Gayle, PT, DPT, MA, OCS, Director of Habilitation Therapy; and o Janice Taylor, Lead SLP. ▪ **Observations of:** o Individuals in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	Based on a review of the Facility Self-Assessment, as well as multiple interviews with the Director of HT, the following was found: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tools for SLP assessments, Communication Compliance Monitoring form, and HT databases. The Facility was not using the State Office Settlement Agreement Monitoring Tool for Section R. ▪ The monitoring tool and audits did not include adequate standards and criteria. The audit tools were missing instructions to support consistency among monitors. ▪ The Self-Assessment identified the sample sizes, and included the information necessary to determine the percent sample in comparison with the overall population. ▪ The following staff/positions were responsible for completion of the audits for Section R: the Director of HT and SLPs. Currently, no Facility PCMs were responsible for completing the Self-Assessment. In the future, if data is collected by a PCM, this should be identified in the Self-Assessment. ▪ Adequate inter-rater reliability had not been established between the Director of HT and SLPs. ▪ The data presented in the Self-Assessment reflected the completion of additional activities, such as tracking the completion of SLP assessments using the AUSSLC Communication Assessment Master Plan, review of SLP positions/tracking log, review of current licensure and ASHA certification for SLPs, review of continuing education spreadsheet and AAC device spreadsheet, and review of Behavior Therapy Committee meeting attendance and therapy log. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings consistently based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with Sections R.1. The Monitoring Team's review did not support with this finding. The Facility rated itself as being in noncompliance with Sections R.2, R.3, and R.4, which was consistent with the Monitoring Team's findings. ▪ The Facility data identified some areas in need of improvement, but did not provide specific information regarding the analysis of the information and/or the development of interventions to address findings that did not support compliance.
	Summary of Monitor's Assessment: The Facility had established a protocol describing the process for determining Speech Language Pathologist (SLP) caseloads. However, additional work was needed to determine what an appropriate caseload would be for SLPs at AUSSLC. The five allocated SLP positions at the Facility were filled. The SLPs were licensed to practice in the state of Texas and provided evidence of current American Speech-Language-Hearing Association (ASHA) certification. Four of the five SLPs had attended the Habilitation Therapies Conference. The Facility had not developed policies and/or procedures to define the provision of communication services and supports, including the necessary elements. The small sample of the most recently completed Speech Language (SL) assessments showed notable improvements. In addition to continuing to address the areas of the assessments still needing work, the Facility is encouraged to continue the use of the improved practices as additional individuals' SL

	assessments are completed. Although the Facility remained in noncompliance with this provision, significant progress had been made. ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' alternative or augmentative communication (AAC) systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs and/or ISPAs to structure skill acquisition, and provide a mechanism to measure progress. The Facility did not have policies/procedures to define the monitoring process for communication supports provided to individuals.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The parties agreed the Monitoring Team would conduct full monitoring for this subsection, because the Facility found substantial compliance according to their internal self-assessment activities. However, the Monitoring Team's review did not substantiate a finding of substantial compliance as discussed within this section. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section R.1: ▪ 10/14/13 - Continuing to hire for one vacant SLP position in the Speech Section The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section R.1 included an action plan with the following action steps that were in process and/or not started: ▪ Develop speech language evaluation audit tool to ensure recommended objectives are measureable and recommendations are made regarding skill acquisition programs; and ▪ Implement speech-language evaluation audit process. These action steps were relevant to Section R.1, and should assist the Facility in working towards achieving compliance with Section R.1. In addition, the Facility should develop and implement policies and/or protocols to define the provision of communication services and supports at AUSSLC. **Samples for Section R:** ▪ **Sample R.1:** Individuals identified by the Facility with expressive or receptive language disorders with assessments completed in the last 12 months, including	Noncompliance

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		the following five individuals: Individual #328, Individual #389, Individual #275, Individual #375, and Individual #238; ▪ **Sample R.2:** Two individuals receiving direct speech interventions including: Individual #406 and Individual #426; ▪ **Sample R.3:** Four individuals with a PBSP and communication deficits, including: Individual #2, Individual #90, Individual #406, and Individual #184; and ▪ **Sample R.4**: Five individuals with AAC devices including: Individual #2, Individual #90, Individual #406, Individual #184 and Individual #426. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report addresses compliance with current staffing, staff qualifications, adequate number of speech language pathologists, continuing education, and Facility policies. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **Staffing** Since the last review, the Protocol for Adequate Number of Speech Language Pathologists, dated 2/14/14, had been developed. The protocol identified the responsibilities of SLPs, described the five allocated SLP (i.e., full time equivalents), and discussed how caseloads were to be assigned. SLP responsibilities were defined, including but not limited to: "conducting assessments, developing and implementing programs, providing individual specific augmentative/alternative communication devices, providing assessment/treatment for dysphagia, providing staff training, monitoring and assisting the SAP [skill acquisition program] writers with information for programs related to communication." SLPs at AUSSLC were to be assigned caseloads "according to census and per therapists' input/special interest that would be of the greatest benefit for individuals." The caseload totals were to be based on the individual list by home, adjusted for moves, discharges, and deaths and based on the census of 280 individuals on February 14, 2014. The five SLP caseloads were reported as follows: ▪ SLP #1 had a caseload of 69 individuals. Twenty-one individuals (30%) were identified with communication services requiring an annual assessment of status. The remaining 48 individuals (70%) required an annual review of their Communication Strategies. Forty-nine individuals required an annual review of their Communication Dictionaries. ▪ SLP #2 had a caseload of 72 individuals. Eight individuals (11%) with identified communication services required an annual assessment of status. The	

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		remaining 61 individuals (89%) required an annual review of their Communication Strategies, and 69 individuals required an annual review of their Communication Dictionaries. ▪ SLP #3's caseload was 64 individuals. Fourteen individuals (22%) with identified communication services required an annual assessment of status. The remaining 50 individuals required an annual review of their Communication Strategies, and 40 individuals required an annual review of their Communication Dictionaries. ▪ SLP #4's caseload had 75 individuals. Twenty-one individuals (28%) with identified communication services required an annual assessment of status. The remaining 54 individuals required an annual review of their Communication Strategies, and 59 individuals required an annual review of their Communication Dictionaries. ▪ SLP #5 was dedicated to the PNMT and assisted other SLPs with their caseloads. The following concerns were noted with this protocol: ▪ The protocol did not address the acuity of individuals' communication/language deficit in relation to their communication services and support needs. For example, an individual's identified level of communication/language deficit was not identified to justify the SLP caseloads (i.e., moderate, severe). Similarly, the Facility's risk ratings were not used to determine acuity (e.g., individuals with high or medium risk for choking, aspiration, and challenging behavior); ▪ There were no Facility protocols to define the criteria for individuals who required an annual assessment of status; ▪ Individuals were not identified who would require a communication assessment every five years; and ▪ The protocol did not establish a SLP-to-individual ratio (e.g., 1:60) or ratios depending on need/acuity. Additional work needed to be done with the protocol to address the concerns listed above. **Qualifications:** ▪ Five of five SLPs were licensed to practice in the state of Texas. ▪ Five of five SLPs had evidence of ASHA certification. **Continuing Education** Four of the five SLPs had completed continuing education. Certificates of completion were submitted. The continuing education the clinicians attended included the following topics: ▪ Habilitation Therapies Conference (10/31/13 to 11/1/13) attended by four SLPs; and	

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		▪ The Modern Science of Hearing Aid Fitting and Counseling (9/17/13) attended by one SLP. **<u>Facility Policy</u>** The Facility did not submit any Facility-based policies and/procedures to define the implementation of communication services and supports. The Facility-based SLP/communication policies and protocols should include the following: ▪ Roles and responsibilities of the SLPs (meeting attendance, staff training etc.); ▪ Outline of the assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission); ▪ Timelines for completion of comprehensive assessments (within 30 days of identification of need via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT); ▪ A process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to intervention plans; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as problem resolution. The essential components of a monitoring policy are addressed with regard to Section R.4. The Facility found substantial compliance according to their internal self-assessment activities for Section R.1. The Monitoring Team did not agree with this finding. The Facility had established a protocol for determining SLP caseloads. However, the protocol required additional work to determine what an appropriate caseload would be for SLPs at AUSSLC. The five allocated SLP positions at the Facility were all filled. The SLPs were licensed to practice in the state of Texas and provided evidence of current ASHA certification. Four of the five SLPs had attended the Habilitation Therapies Conference. The Facility had not developed policies and/or procedures to define the provision of communication services and supports and/or include the necessary elements. The Facility remained out of compliance within this section.	
R2	Commencing within six months of	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a	Noncompliance

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	the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, did not provide any information about specific actions taken to address Section R.2. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section R.2 included an action plan with the following action step that was in process: ▪ Identify all individuals in need of augmentative communication through assessment. Although this action step was relevant to Section R.2, it was unclear how it would assist the Facility in working towards achieving compliance with Section R.2. It set forth an outcome, but not the actions necessary to achieve the stated goal. **Communication Assessments Provided for Individuals Newly Admitted to LBSSLC** No individuals had been admitted to AUSSLC since the last review. During the Monitoring Team's next review, the following will be reviewed: ▪ ___ of ___ (%) newly admitted individuals received a communication assessment within 30 days of admission or readmission. **Communication Assessment** Based on interview with the Director of HT and the Lead SLP, all individuals had received a comprehensive SLP assessment. The AUSSLC Communication Assessment Master Plan, dated 2/26/14, confirmed these findings. The SLPs will begin the process of completing comprehensive communication assessments every five years. Individuals who experienced a change of status related to communication were to be assessed as needed. Individuals who received SLP services and supports were to receive an annual assessment update. The five SLP assessments reviewed for the individuals in Sample R.1 were current within the last 12 months. Based on review of the individuals in Sample R.1, the following provides the details of the comprehensiveness of the communication assessments: ▪ One of five individuals' speech and language assessments (20%) (i.e., Individual #238) were signed and dated by the clinician upon completion of the written report; ▪ Two of five individuals' SL assessments (40%) (i.e., Individual #389 and Individual #238) were dated as completed at least 10 working days prior to the	

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		annual ISP; ▪ Five of five individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; ▪ Five of five individuals' SL assessments (100%) included individual preferences, strengths, and needs. Preferences listed were derived from the Preferences and Strengths Inventory (or other relevant document) developed by the individual's team, as well as information obtained from staff interviews; ▪ Five of five individuals' SL assessments (100%) included medical history and relevance to communication. The medical history refers to medical conditions that would impact the provision of SLP communication supports and services; ▪ Five of five individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Five of five individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. ▪ Five of five individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Five of five individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ One of five individuals' SL assessments (20%) (i.e., Individual #375) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. The remaining four individual's assessments noted their Communication Dictionaries had been updated, but did not identify the updates; ▪ Five of five individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. The SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Five of five individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. The SLP assessment provided an analysis of the individual's current communication deficits with suggestions for SAP writers and IDT members for direct interventions and/or skill acquisition programs; ▪ Two of five individuals' SL assessments (40%) (i.e., Individual #389, and Individual #238) included the effectiveness of current supports, including monitoring findings; ▪ Five of the five individuals' SL assessments (100%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC; ▪ Five of five individuals' SL assessments (100%) offered a comparative analysis	

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		of health and functional status from the previous year. For these individuals, the SLP assessment provided an overview of an individual's health status over the past year. The therapist discussed the type of supports and services that had been implemented to minimize the impact on the individual's functional status; ▪ Five of five individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments. For these individuals, the SLP assessment provided an overview of the past assessment results with the current assessment data for communication function. The assessment analysis discussed if the individual's communication performance had remained the same, had improved, and/or had regressed; ▪ Five of five individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Five of five individuals' SL assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Five of five individuals' SL assessments (100%) had a reassessment schedule; ▪ Two of five individuals' SL assessments (40%) (i.e., Individual #389 and Individual #238) supplied a monitoring schedule; ▪ Five of five individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ Five of five individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and ▪ Five of the five individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessments provided suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. The five SLP/communication assessments indicated the Facility SLPs were making progress in completing assessments that addressed multiple assessment elements. Eighteen of the 23 SLP assessment elements were present in each of the five assessment reviewed. The Facility should focus on the remaining elements, and ensure that the progress reflected in these most recently developed plans were reflected in the SL assessments for all individuals. **<u>SLP and Psychology/Behavioral Health Services Specialists Collaboration</u>** Based on a review of four individuals in Sample R.3 with Positive Behavior Support Plans	

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		the following was noted: ▪ Four of four individuals' communication assessments and PBSPs (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Four of four individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 8/26/13 to 1/13/14, participation by a SLP was noted in 15 of the 19 meetings (78%). As noted above, an abbreviated review was conducted of this section. However, the small sample of the most recently completed SL assessments showed notable improvements. In addition to continuing to address the areas of the assessments still needing work, the Facility is encouraged to utilize these improved practices as additional individuals' SL assessments are completed. Although the Facility remained in noncompliance with this provision, significant progress had been made.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample and updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, did not provide any information about specific actions taken to address Section R.3. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section R.3 included an action plan with the following action steps that were in process and/or not started: ▪ Integrate communication supports and skill expansion activities where appropriate within active treatment and/or activities of daily living; ▪ Monitor ISP samples to ensure integration of supports; and ▪ Monitor Behavioral Support Plans to ensure integration of communication supports/replacement behavior. These action steps were relevant to Section R.3, and should assist the Facility in working towards achieving compliance with Section R.3. The Presentation Book for Section R.3 indicated that recommendations for improvement of functional communication and/or use of augmentative communication devices were being included in SLP assessments. According to this information the Facility submitted, SLPs submitted their assessments with recommendations, rationales, and a description	Noncompliance

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		of interventions prior to the annual ISP meeting. These recommendations were discussed at the ISP meeting. The SLP would review the annual ISP meeting draft report for inclusion of assessment recommendations as approved during the ISP meeting. The SLP would provide feedback and/or corrections to the draft report to the meeting facilitator prior to finalization. A tracking system had not been developed to review ISP drafts to ensure the information submitted/discussed was included in the final report. **Integration of Communication in the ISP** Based on a review of the ISPs for five individuals in Sample R.4, the following was noted: ▪ Four of five individuals' SLP (80%) (i.e., Individual #90, Individual #406, Individual #184, and Individual #426) attended the annual ISP meeting. The Monitoring Team could not determine if the SLP attended the ISP for Individual #2, because the ISP attendance signature sheet was blank. ▪ None of five individuals ISPs (0%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. The missing component for the five individuals was a description of how staff were to support functional communication with the individual's AAC system. Also, the ISP did not refer to the formal staff instructions for individuals' prescribed AAC devices that had been developed. ▪ Communication Dictionaries for none of five individuals (0%) were reviewed at least annually by the IDT as evidenced in the ISP and/or ISPA. The ISPs acknowledged if the individual had a Communication Dictionary, but there was no evidence that the IDT members had reviewed the Communication Dictionary for relevance and/or discussed any changes and/or updates that might have been necessary. ▪ Three of five ISPs reviewed (60%) (i.e., Individual #90, Individual #406 and Individual #426) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of five ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate.	

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		Development and Implementation of Functional Individual-Specific Assistive Communication Systems The Monitoring Team did not complete observations of individuals' AAC devices during this review. During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____observations (%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for ____ of ____individuals (%) were noted to be in use in each observed setting. ▪ AAC systems for ____ of ____individuals (%) were portable. ▪ AAC systems for ____ of ____ individuals (%) were functional. ▪ For ____ of ____individuals (%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices** No progress was reported in regard to general use AAC devices. Observations of general use AAC devices will continue during the next review. **Direct Communication Interventions** At the time of the review, two individuals (i.e., Individual #406 and Individual #426) were receiving direct speech therapy. Sample R.2 included these two individuals. A review of these individuals' records found the following: ▪ None of two individuals' direct intervention plans (0%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For one of two individuals' records reviewed (50%) (i.e., Individual #406), the current SLP assessment identified the need for direct intervention with rationale. ▪ For none of two individuals' records reviewed (0%), there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of two individuals (0%), information was present regarding whether the individual showed progress with the stated goal on a monthly basis. There were no monthly notes for these individuals. A monthly progress note should provide a summary of data to show objectively whether or not the individuals made progress on the specific objectives included in their programs, and, if not, what the causes might have been. ▪ For none of two individuals (0%), a description was found of the benefit of the device and/or goal to the individual. ▪ For none of two individuals (0%), a report was found regarding the consistency of implementation. ▪ Due to the lack of monthly notes, the following could not be determined: For ___	

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		of two individuals (___%) recommendations/revisions were made to the communication intervention plan, as indicated, related to the individual's progress or lack of progress. Based on the therapist's monthly data, if a lack of progress is noted, team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. ▪ Individual #406 and Individual $426 had not been discharged from therapy, and therefore, the following was not applicable: For ____ of ____ individuals' records (%) reviewed termination of intervention was well justified and clearly documented in a timely manner. **Competency-Based Training and Performance Check-offs** Competency-based training and performance check-offs for communication are addressed with regard to Section O.5 for new employees and veteran staff. **Individual-Specific Competency-Based Training** The Presentation Book for Section R presented some examples of individual-specific competency performance check-offs (i.e., Dynavox Eye Max, Objects Symbols, Deaf/Blind Hello and Good-Bye Procedure, Tactile Symbols, Tactile Name Sign, Social Stories, Sign Language Board, and Cell Phone for Video Interpreter Calls). Four SLPs and 10 PNMP Coordinators were approved trainers for communication non-foundational training. There were no Facility policies and/or procedures that defined the system for the development and implementation of the provision of individual-specific training. A review of the records for individuals in Sample R.4 found: ▪ None of five individuals' staff (0%) had received individual-specific training. The Monitoring Team requested evidence of the number of staff required to complete individual-specific training the number of staff who had successfully completed individual-specific training, and performance check-offs. However, the Facility provided blank copies of individual-specific competency performance check-offs. As noted above, an abbreviated review was conducted of this section. ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' AAC systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals	

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		learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs and/or ISPAs to structure skill acquisition, and provide a mechanism to measure progress. Progress notes should include a summary of data to document progress and/or lack of progress. The Facility should develop policies and/or procedures that define the development and implementation of individual-specific training and performance check-offs for staff. The Facility remained out of compliance with this provision.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The AUSSLC Provision Action Information, updated 2/5/14, reported the following completed actions for Section R.4: ▪ 10/14/13 - The audit process is continuing; ▪ 10/15/13 - Therapists began conducting reliability monitoring of a sample of the PNMP Coordinators' monitoring; and ▪ 11/7/13 - Therapists began conducting their own monitoring of residents and their PNMPs. The PNMP Coordinators also continue to monitor PNMPs. The AUSSLC 7th Compliance Round Action Plans, updated 2/7/14, for Section R.4 did not include any action plan steps that were in process and/or had not started. **Monitoring System** As noted above, the Facility did not have a policy and/or procedure to define the communication monitoring process for compliance and/or effectiveness monitoring. This policy and/or procedure, when developed and implemented should include the following elements: ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels; ▪ The process for identification, training, and validation for monitors; ▪ The process of establishing inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).	Noncompliance

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		<u>Monitoring of Implementation of Communication Supports</u> The AUSSLC PNMP Compliance Monitoring form was used to monitor the implementation of communication supports for individuals. Five SLPs and nine PNMP Coordinators were approved monitors. During the Monitoring Team's next review, the following will be reviewed: ▪ For ____ of ____ individuals (%), monitoring of communication supports was defined in the assessment. ▪ For ____ of ____ individuals (%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. The Facility did not have monitoring policies/procedures that incorporated the elements necessary for monitoring communication supports. The Facility remained out of compliance with this subsection.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation at entrance meeting, o Section S Presentation Book; o Self-Assessment for Section S, dated 2/4/14; o Individual Support Plan for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; o Skill Acquisition Plans for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; o Skill Acquisition Plan Data Sheets for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; o Preferences and Skills Inventory for: Individual #78, Individual #421, and Individual #159; o Functional Skills Assessment for: Individual #263, Individual #406, Individual #78, Individual #246, Individual #153, Individual #421, Individual #448, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; o Vocational Assessment for: Individual #263, Individual #406, Individual #246, Individual #153, Individual #421, Individual #302, Individual #409, Individual #159, Individual #13, and Individual #425; o Day Program Assessment for: Individual #78 and Individual #448; o Active Treatment Daily Plans for: Home 729, group 1 (full day); Home 788, group 4 (6-2 and 2-10); Home 791, group 3 (6-2 and 2-10); Home 793, groups 2 and 3 (6-2); Home 795, groups 1, 2, and 3 (6-2 and 2-10); Individual #406; Individual #78; Individual #13; and Individual #425; o List of off campus community outings for July through December 2013; and o Out of Home Activities schedules for February 2014. ▪ **Interviews with**: o Tristan James, QIDP Director; Jamaun Willis, Director of Education and Training; and Jim Sibley, DADS Consultant, on 2/24/14; o Direct Support Professionals, on 2/26/14; and o Jamaun Willis, Director of Education and Training, Jim Sibley, DADS Consultant, Heather Blackwell, and Debra Woodruff, Program Compliance Coordinator, on 2/27/14. ▪ **Observations of**: o Residence 729, Residence 732 Dove, Residence 732 Phoenix, Residence 779 Falcon, Residence 779 Hummingbird, Residence 779 Roadrunner, Residence 782, Residence 783,

	Residence 784, Residence 785, Residence 786, Residence 787, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; o Computer Center; o Day Program 501, Day Program 731, and Day Program 732; o Day Program/Vocational Center 533, Day Program/Vocational Center 730, Day Program/Vocational Center 775, and Day Program/Vocational Center 779; o Work Center 527, Work Center 532, and Work Center 544; o IMRT meeting, on 2/24/14; o Pre-treatment Sedation Committee meeting, on 2/25/14; and o ISP Meeting for Individual #40, on 2/27/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: a) activities engaged in to conduct the self-assessment; b) the results of the self-assessment; and c) a self-rating. For Section S, in conducting its self-assessment, the Facility: ▪ Noted that it had provided training on writing Skill Acquisition Plans to Active Treatment Program Coordinators, QIDP staff, and education and training supervisors; ▪ Noted that 98% of the individuals residing at the Facility had Skill Acquisition Plans written for day programming and vocational services; ▪ Reviewed a sample of Functional Skill Assessments in October and December, and 57% and 47% of the assessments reviewed, respectively, were rated as containing required elements; ▪ Noted that the Preferences and Strengths Inventory was reviewed in August for inclusion in annual meetings beginning in November; and ▪ Restructured day programming in an attempt to better meet the needs of the individuals residing at the Facility. The Facility did not identify an assessment tool, nor did they provide data regarding each element of the Settlement Agreement. The Facility rated itself as out of compliance with each sub-section of Section S.
	Summary of Monitor's Assessment: The Facility clearly had initiated changes to ensure that the majority of individuals were leaving their homes to attend day habilitation or vocational programs. This was the Monitoring Team's first visit during which observations on the Castner Unit revealed very few individuals gathered in large groups in their shared living area. Changes had been introduced not only in the programs offered, but also in the scheduled transportation times. Transitions to program sites were occurring earlier and throughout the day to best meet the needs of the individuals served. Hybrid programs had been created to allow individuals to switch between day habilitation and work programs as appropriate. Further, a specialized program for individuals with visual impairment had been developed. With the addition of professional staff trained in orientation and mobility, direct support professionals had received specialized training to work with this population. Although only a small number of individuals were affected, the opportunities for community-based employment also had been expanded.

	Key staff had been trained in writing Skill Acquisition Plans, and there was a renewed focus on scheduling activities throughout the day and on weekends. Active Treatment Daily Plans were being introduced to replace individual daily schedules. These offered more in-depth information regarding both formal training and incidental teaching opportunities. Tracking of off-campus activities also was being introduced to ensure that individuals were accessing scheduled events, and if not, that problems and accompanying solutions were identified early. In spite of these changes, many of the problems identified in the past remained present. Activities were very limited, refusals to participate in daily activities persisted, and individualized habilitation planning remained compromised. The Facility remained out of compliance with all subsections of Section S.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The most recent Individual Support Plan was reviewed for 12 individuals. ISP meetings for these individuals were held between 9/12/13 and 1/8/14. A summary of findings is provided below. ▪ All of the ISPs (100%) included a review of the individual's preferences and strengths. It was unclear how this information was gathered, because the Preferences and Strengths Inventory had been completed for only three of the 12 individuals. ▪ For 10 of the 12 individuals (83%), team members agreed that the individual could be served in a less restrictive environment. o The team indicated that they did not believe Individual #246 would benefit from moving to a less restrictive environment, but then listed a range of conditions that could be met in the community. This presented contradictory information. ▪ The Integrated Risk Rating Form was included in the ISP for 10 of the 12 individuals reviewed (83%). The two exceptions were the ISPs for Individual #78 and Individual #159. Individual-specific concerns are outlined below. o For Individual #406, his behavioral health was rated as a medium risk. However, when considering a less restrictive environment, the team indicated that he could not move to the community due to "…current behavioral issues that pose a safety threat to himself and/or others. " It is suggested that if problem behaviors prohibit his living in a community setting, his behavioral health risk rating should be high. o The rationale for identified levels of risk was not provided for all factors reviewed in the IRRF for Individual #302. Similarly, there was no rationale provided for the behavioral health risk rating identified for	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #263, Individual #246, or Individual #409. ▪ In all of the 12 ISPs reviewed (100%), the individual was identified as requiring pre-treatment sedation for medical and/or dental exams. In 11 of the 12 ISPs there was a record that the team had held further discussion regarding such intervention as a rights restriction. The exception was the ISP for Individual #153. o Of the 10 individuals identified in need of pretreatment sedation for dental exams, nine (90%) had received a dental risk rating of high. Individual #448 had received a medium risk rating as pre-treatment sedation was utilized "occasionally." o Of the 10 individuals identified in need of pre-treatment sedation for dental exams, only three (30%) had action plans included in their identified goals that addressed tooth brushing. An additional four individuals had an action plan in their Integrated Health Care Plan (IHCP) that addressed oral hygiene or tooth brushing. o Individual #425 had a service objective that indicated he would visit the dental clinic and Infirmary once per month to help familiarize him with these settings. The IHCP for Individual #246 indicated that she would start a desensitization plan. The IHCP for Individual #421 noted that she would be assessed for a desensitization plan. Other than these three individuals, there was no indication that increasing one's tolerance for dental and/or medical procedures would be formally addressed. o The ISP for Individual #406 contained several contradictory pieces of information. It was noted that he did well with campus-based medical exams and procedures, yet he had an approved rights restriction for medical sedation that was not restricted to community-based services. Although his dental risk rating was identified as low in the IRRF with a rationale in part of no need for sedation, his IHCP noted that his risk rating was medium as he "…will receive general anesthesia for dental appointments if needed." ▪ A total of 49 training objectives were identified in the 12 ISPs, with a range of two to six objectives per individual. o The identified training schedule was as follows: 21 objectives (43%) to be trained twice a week; 13 objectives (27%) to be trained three times per week; six objectives (12%) to be trained once each week; five objectives (10%) to be trained daily; three objectives (6%) to be trained five times per week; and one objective (2%) for which the schedule had not yet been determined. As has been noted in the past, dense schedules of training are recommended to ensure skill acquisition. o The community was identified as a possible training environment for only four of the 49 objectives (8%). One of these four addressed	

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		Individual #78 learning to use a spin brush to brush her teeth, a skill that is most appropriately addressed in one's home. Although the community had been identified for both objectives for Individual #246, one of these objectives had not been identified at the time of the ISP meeting. In no case (0%) did the ISP identify training objectives that had been designed specifically for the community. o As noted above, only two training objectives had been identified for Individual #246. Regrettably one was "to be determined at an ISPA within the next 30 days. " Skill acquisition programs should be developed at the annual ISP meeting. o The conditions under which the training was to occur were identified in 19 of the 49 objectives (39%). Broad acquisition criteria were identified in 23 of the 49 objectives (47%). It is important to note the observable behavior the individual is to display. One objective for Individual #425 described staff behavior (e.g., take him to his day program and encourage him to go inside), as opposed to the skill the individual was to learn. It would also be helpful to identify the level of independent performance expected of the individual. o Of the 49 objectives included in the 12 ISPs, 13 (27%) matched recommended skill acquisition plans identified in the individual's Functional Skills Assessment. Assessments are only useful if they are considered when designing habilitation plans. Members of the Monitoring Team attended the ISP meeting held for Individual #40. While the IRRF discussion reflected some thoughtful analysis of identified ratings of risk, the remainder of the meeting revealed several problems. For example, data was not referenced when reviewing the individual's progress on the previous year's objectives and there was no clear reference to assessments that had been completed to help identify skill needs or training objectives. A total of 52 Skill Acquisition Plans were reviewed. Several of the plans addressed skills that had not been identified in the individuals' ISPs. This represented between three and seven plans for the 12 individuals in the sample. A summary of the review findings is provided below. ▪ In 39 of the 52 SAPs (75%) the objective identified the conditions under which an observable and measurable behavior was to occur. Of the remaining 13 objectives, 11 did not identify conditions and two did not identify the individual's behavior. Individual #409 was to have an hour break in the computer lab after completing work, and Individual #13 was to receive a handshake from the dentist. ▪ Fifty of the objectives (96%) included mastery criteria identified as a number of	

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		specified assessment trials over a specified number of months or by a specific date. What was unclear was whether the individual was to demonstrate this level of mastery during each of the months identified. ▪ None of the objectives (0%) indicated whether the skill was to be performed independently or with a certain level of prompting. ▪ Twenty-nine of the 52 SAPs (56%) addressed skills that had been identified in the action plan section of the individual's ISP. While some of the other SAPs might have been appropriate skills to teach, it is important that plans are written to address all of the skills identified at the individual's annual meeting. ▪ A task analysis was adequately identified in 23 of 27 SAPs (85%). ▪ Fifty-one of the 52 SAPs (98%) indicated one of three types of chaining techniques to be used when training the skill. Thirty-one of these 51 SAPs (61%) identified total task, 17 (33%) identified forward chaining, and three (6%) identified backward chaining. However, a behavioral chain was clearly identified in only 25 of these 51 SAPs (49%). The remaining 26 SAPs (51%) identified discrete behaviors, such as powering on a computer, exiting a vehicle, answering a question, establishing eye contact, signing into work, pointing to an object, sitting in a designated chair, or entering a building. Staff should ensure that teaching techniques are clearly and appropriately identified. ▪ Necessary materials were adequately identified in 45 of 48 SAPs (94%). (Four SAPs addressed skills, e.g., pointing to self, shaking hands, answering a question, or sitting with a group, which did not require materials.) Completing jobs at the workshop were the focus of a SAP for two individuals. Under materials, it was noted that these would depend on which job the individual chose to do. It would be helpful to list the various jobs with the materials needed to complete the job to ensure a consistent presentation of the task. ▪ The schedule for training varied widely across SAPs. Training was scheduled to occur daily in 14 SAPs (27%), three times per week in 14 SAPs (27%), twice per week in six SAPs (12%), five times per week in five SAPs (10%), and once per week in four SAPs (8%). The remaining nine SAPs did not clearly identify the number of days per week when training was to occur. Only six of the 52 SAPs (12%) identified more than one daily trial on scheduled training days. As noted in the past, it is important to provide sufficient opportunities for individuals to learn new skills. ▪ None of the SAPs (0%) clearly identified the community as a training site. ▪ In 32 of the 52 SAPs (62%), praise alone was the identified reinforcer for correct responding. As has been noted in the past, praise does not always function as a reinforcer. It may be dependent upon the relationship the individual has with the person delivering the praise, or it may not be sufficiently motivating for the individual to learn a new and possibly difficult skill. Nine of the 52 SAPs (17%) identified praise paired with a pat, hug, or high five. Nine of the 52 SAPs (17%)	

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		identified praise paired with something tangible (e.g., food, sticker) or an activity (e.g., walk, break). Two of the SAPs (4%) noted that the individual should be praised for correct responding and reminded of the money she could make if she engaged in work activities. Individual concerns are noted below. o Individual #78 was to learn to open the front door of her home. For correct responding, she was to receive praise, a hug, and be taken to eat her meal. Access to meals should never be applied contingently, and this made little sense as a reinforcer for opening the door. o An identified natural reinforcer for Individual #153 was sitting outside. It was unclear whether this was to occur immediately after her participation in an exercise video. o The FSA summary for Individual #302 noted that praise did not function as a reinforcer for him. However, all four of his SAPs identified praise as the consequence to be delivered following correct responding. ▪ While all of the SAPs (100%) provided guidelines to follow when the individual did not respond correctly, these varied in quality and practicality. o Appropriate consequences for incorrect responding included increasing the level of assistance or prompting provided to the individual. o Inappropriate consequences for incorrect responding included the following: ▪ Individual #263 was learning to choose between two soaps prior to bathing. However, the consequence for incorrect responding included asking her if she wanted something such as taking a walk. It does not seem feasible to leave one's home for a walk when preparing to bathe. ▪ If Individual #421 chose not to participate in a recycling objective, staff were to respond by suggesting that she might want to do this the next day. It was unclear how this would teach her the correct way to complete this task. ▪ Individual #13 was learning to use a washcloth if she refused to take a shower. Staff were to "…continue to tell her what to do..." if she did not respond. Such repeated verbal instruction is similar to nagging and is unlikely to result in correct responding. It is also suggested that it would be more appropriate to design a program to address her refusals. ▪ Similarly, while all of the plans (100%) included a section that reviewed teaching techniques, some were clearer than others. o The SAPs for Individual #246 offered clear instructions for staff to follow when teaching her self-care skills. The exception was the SAP that addressed her exiting the vehicle upon arrival to her day program. Although total task was identified, there were no instructions as to how	

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		to actually teach her this skill. o In the SAP that addressed Individual #448 learning to look at the nurse, staff were instructed to point to the nurse while stating: "Take your medication." It was not clear why the nurse would not simply call the individual by name to teach her to establish eye contact. o Teaching Individual #409 to choose clothing appropriate to weather conditions was a very good objective. However, other than staff prompting, the instructions did not indicate how he was to learn to identify weather conditions and corresponding clothing. ▪ Fifty-one of the 52 SAPs (98%) included plans for maintenance and generalization. Again, the quality of the plans varied across SAPs. o Appropriate generalization plans included the following: ▪ Individual #406 was to generalize a domestic and self-care skill to his family's home. ▪ Individual #78 was to learn to operate a radio using an adaptive switch. Generalization plans indicated that she would extend this skill to operating other devices. o Less clear plans included the following: ▪ On the SAP for Individual #153 that addressed using an adaptive switch, it was suggested that she would generalize this skill "…through daily practice required to address the next level of task analysis within a variety of settings…" The meaning of this statement was not clear and offered no specific guidelines to staff. ▪ Similarly, the SAP that addressed Individual #425 learning to enter his day habilitation site, suggested that generalization would be achieved "…through reducing verbal praise and daily practice to address the next level of task analysis." As noted above, the meaning of this statement was not clear and offered no specific guidelines to staff. ▪ Fifty of the 52 SAPs (96%) included the implementation date. Missing from all of the SAPs was the ISP meeting date. This would be helpful to ensure that training on SAPs begins shortly after the ISP meeting. <u>Engagement</u> During this visit, the Monitoring Team conducted PLACHECKS or measures of engagement in the homes, vocational settings, day programs, and newly created hybrid day program/vocational settings. ▪ A total of 20 PLACHECKS were collected in the homes. Measures ranged from 0% to 100%, with a mean of 32.9% engagement. It should be noted that visits to homes often revealed individuals gathered and waiting for transport to their day programs.	

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		These transition times can often result in down time, because staff are involved in escorting individuals to the vans. Although engagement scores were low, it was encouraging to observe the commitment to getting individuals out of their homes to participate in day habilitation or vocational activities. ▪ A total of 11 PLACHECKS were conducted in the workshop settings. Measures ranged from 0% to 100%, with a mean of 55% engagement. Activities were similar to those observed in the past, including preparing mailings, counting out toothbrushes or binders, and bundling pamphlets. ▪ In the day programs, four PLACHECKS were collected. Engagement ranged from 0% to 80%, with a mean of 39%. Activities were similar across settings and typically involved puzzles or pegboards. ▪ In the newly created hybrid programs, eight PLACHECKS were collected. Measures ranged from 25% to 100%, with a mean of 56.4% engagement. It should be noted that it was only in the 501 Day Program for individuals with visual impairment that consistent teaching strategies were observed. Staff consistently presented snack items in a particular order and then guided the individual to complete the pre-snack routine by moving from left to right. ▪ Visits to the computer center consistently revealed active engagement of those present. One suggestion would be to purchase touch screens so that a greater number of individuals could access this environment. At the request of Facility staff, a proposed definition of engagement could include attention to or participation in activities as indicated by communicating with others, orienting towards or looking at others or materials, or manipulating materials to complete the activity. Although the Facility had initiated changes to enhance habilitation services, for the reasons noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Prior to the ISP meeting, the team was expected to complete the Preferences and Strengths Inventory for the individual. The first part of this form required the team to record responses to a range of questions related to living options, employment activities, relationships, leisure skills, and independence. The team was also expected to record the method used to identify the individual's preferences. The second section required the team to summarize the individual's preferences and strengths. The final analysis section posed questions to help develop goals to meet the individual's preferences for future living options, employment, relationships, leisure skills, and independence. The PSIs for the 12 individuals in the sample were requested. The Facility reported that the PSI had	Noncompliance

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		been completed for three of the 12 individuals in the sample (25%). Of the three PSIs that were provided, the inventory for Individual #78 had been completed in preparation for her 2012 ISP meeting. This left only the PSIs for Individual #421 and Individual #159 to review. A summary of this review is provided below. ▪ Both PSIs were completed by the QIDP prior to the individual's ISP meeting. Staff informants were also identified in the PSI for Individual #159. Neither PSI was signed. ▪ Questions regarding future living options, employment, relationships, leisure skills, and independence were addressed in both PSIs. Staff interview was utilized in both inventories, with much information gleaned from the 2012 ISP for Individual #159. A brief summary of preferences and strengths was provided for both individuals. ▪ The final section, which guided teams to consider future planning for the individual, was left blank in the PSI for Individual #159. The information provided in this analysis for Individual #421 was very brief and incomplete. There was no evidence of consideration for ways in which the individual's life could be expanded or enhanced beyond her current experiences. As noted in previous reports, the team should engage in a thoughtful discussion of all areas outlined in the PSI, with input from the individual and those who know him/her well, to ensure that the outcome is a comprehensive profile of the individual's preferences and strengths. This should then be used to guide future planning, with barriers to goals and accompanying action plans clearly outlined. The Functional Skills Assessment was reviewed for the 12 individuals in the sample. The date of completion was identified in all of the reports (100%). In every case (100%), the assessment had been completed prior to the individual's ISP meeting. A summary of the FSA was provided for only 10 of the 12 individuals in the sample (83%). A review of these 10 summaries is provided below: ▪ Seven of the 10 summaries (70%) reflected a date of completion that was identical to the FSA. For Individual #263, Individual #448, and Individual #425, dates on the FSA and the FSA summary suggested that the summary had been written before the assessment was completed. This would suggest that the summary did not reflect the most current information regarding the individual's skills and needs. ▪ Five of the summary reports (50%) included a more comprehensive review of the individual's strengths across the 13 areas assessed. Staff should provide a thorough profile of the individual to ensure that members of the team can make thoughtful decisions regarding habilitation planning. o Staff should carefully review all summary information. In the report for Individual #448, her strengths in the area of hygiene were her observed cooperation with staff. However, under area of need, it was reported	

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		that she refuses to participate in hygiene routines. o Individual #302 had several skills identified in the academic section of the FSA. None of these were reported in the summary. o Strengths in the areas of domestic, academic, and telephone skills were identified as not applicable for Individual #13. These areas should have been addressed. ▪ Areas of need were also identified. While the summary for Individual #421 was fairly comprehensive, most were quite limited in scope and failed to guide future habilitation planning. Individual examples are provided below: o In five of the 13 skill areas, Individual #263 was to "maintain skills." Other areas noted refusal to participate or limited understanding. These did not result in a thoughtful review for future habilitation planning. o For Individual #78, her needs in nine of 13 skill areas were identified as not applicable. This showed very little effort to enhance her skills or daily experiences. o Individual 448 was to maintain her dressing and dining skills. Under communication there were no needs indicated as she "…is non-verbal." Again, this reflected very shortsighted planning with regard to her development of greater skills and independence. o Individual #302 was reported to be independent in most skill areas assessed. His areas of need were quite limited, which suggested he had learned all there was for him to know. o In the areas of communication, social skills, and dining skills, it was noted that: "all supports currently in place are working for [Individual #13]." This provided no information about plans that could be developed to expand her skills. ▪ Between two and ten skill acquisition programs were recommended in the summary reports. This computed to an average of 3.9 programs per individual. With 13 skill areas assessed, consideration should be given to the development or expansion of skills in all domains identified in the FSA. The most recent Vocational Assessment was provided for 10 of the 12 individuals in the sample. A summary of the review of these documents is provided below: ▪ Seven of the 10 assessments (70%) were completed within the 12-month period before their annual ISP meeting. The other three assessments were completed one year before the annual meeting. ▪ The person completing the assessment was identified in all of the reports (100%). None of the reports (0%) were signed. ▪ A vocational vision was identified in only three of the reports (30%). Individual #13 was reported to have an interest in working in a mailroom in a post office.	

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		The visions for Individual #421 and Individual #302 were to earn money or earn minimum wage, respectively. ▪ The recommendation for three individuals (30%) was to remain in a day program versus a vocational setting. ▪ Completed situational assessments and the individual's response to the same were reported in four reports (40%). All of these assessments involved activities that were available within the Facility's workshop settings. Only two of these four reports included the date that the situational assessment was completed. ▪ Future job exploration was recommended for three individuals (30%). The recommendations for Individual #13 were vague (i.e., situational assessments, informational interviews, and trial work from one workshop site to another), although she was the only person for whom a specific job interest had been identified. It was suggested that Individual #409 could try the recycling or car wash jobs offered on campus once he graduated from high school. Although his ISP meeting was held seven months after his identified graduation date, there was no evidence that this exploration had occurred. Lastly, it was suggested that Individual #425 participate in home chores and campus recycling. An expected date of completion was not identified for any of these individuals. At the time of the visit, six individuals were working in the community. His school staff was supporting one of these individuals, but the plan was for Facility staff to serve as his job coach once he graduated. As noted in the past, it will be important for the Vocational Services staff to focus on identifying a greater variety of jobs, with particular emphasis on matching individuals to jobs that meet their interests. This includes both situational assessments and actual job placement. Expansion should include environments beyond the workshop setting. Based upon the information reviewed above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		

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	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Data sheets for a total of 39 SAPs were reviewed. Every individual in the sample was represented with progress reviewed on between one and six SAPs. Only one month of data was reviewed for 24 of these SAPs. For the remaining 15 SAPs, between two and three months of data were reviewed. A summary of findings is provided below: ▪ Of the 39 programs reviewed, the date of program initiation was identified in 36 of the SAPs (92%). Five of these 36 SAPs (14%) had been initiated in 2012. Staff should review SAPs frequently to ensure that progress continues. ▪ For none of the 39 SAPs (0%) was there data present to clearly show that multiple daily trials had consistently been conducted. In data sheets for 28 of the 39 SAPs (72%), evidence suggested that only one trial had been conducted. This was concerning as learning of new skills may be hindered by infrequent training opportunities. In the remaining 11 data sheets, it was unclear whether multiple steps had been monitored or whether multiple trials had been conducted. ▪ Concerns remained regarding refusals or other impediments to learning. Individual examples are noted below: o Data was reviewed for four SAPs for Individual #263. Over a three-month period, no training was provided according to the documentation provided. Data was either not recorded, or in the two to three trials conducted during the month, she refused to participate. o Similar concerns were raised for Individual #406. His use of his picture communication board at work and his participation in a minimum wage job were both compromised by his frequent refusal to engage in the activity. o Individual #153 was learning to participate in an exercise video. Although she chose a video, she refused to participate in all of the opportunities presented in one month. o Individual #302 also demonstrated frequent refusals. Over 21 data points representing two different SAPs, he refused to participate in 12 of these trials (57%). o In two of the four SAPs for Individual #159, there was evidence that she refused to participate between 60% and 100% of the time. As has been noted in the past, it is critical that the individual's team meet to discuss impediments to habilitation training, with strategies designed to improve participation. The Monitoring Team requested three consecutive Monthly Reviews for the 12	Noncompliance

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		individuals in the sample. The Facility indicated that these had not been completed. The goal for the future was to complete monthly reviews that would include, amongst other analysis, information regarding active refusal to participate in training. At the time of the Monitoring Team's visit, graphic display of progress on SAPs was still not evident. Graphs provide a very clear display of an individual's progress or lack thereof in acquiring a new skill. When there is consistent evidence of a lack of progress, regression, or refusal to participate, members of the team should investigate the reason, and as appropriate, provide additional training to staff and/or revise the program to ensure that learning occurs. Since the last Monitoring Team visit, the Facility had introduced Active Treatment Daily Plans. They were designed to provide direct support professionals with guidelines for habilitation training and support for identified individuals or groups. The best examples were provided for three different groups of individuals living in Home 795. Hours of the day were identified with corresponding suggestions for SAPs, service objectives, and opportunities for incidental teaching. Specific weekend activities also were recommended. If the individual had a PBSP, replacement behaviors were identified. It will be important for staff to ensure that these schedules are carefully proofed, because in several examples, targeted problem behaviors were listed rather than functionally equivalent replacement behaviors. Communication strategies were listed for each individual along with his/her preferences. Lastly support personnel were listed along with contact numbers. These schedules were more comprehensive than the daily schedules that had been found in Individual Notebooks (I-Books) on previous visits. It remained that assessments were not utilized to identify a range of skill needs for the individual. ISPs were limited with regard to the number and scope of training objectives designed to help the individual grow and develop his/her skills and independence. Opportunities for instruction were severely limited, and reinforcement for correct responding was not individualized. Engagement remained quite poor. For these reasons, the Facility remained out of compliance for this provision of the Settlement Agreement.	
	(b) Include to the degree practicable training opportunities in community settings.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Facility provided information regarding the number of individuals per home who had traveled into the community. Data from July of 2013 through December of 2013 were reviewed and are summarized below:	Noncompliance

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Unit	Range	Monthly Average
Castner	24 – 83	50.5
Sunrise	129 – 443	250.5
Woodhollow	174 – 492	392

The number of individuals participating in an outing was not specified, nor was it clear whether there was a select group of individuals who most frequently accessed the community. The purpose of the outing and the destination also were not specified. When asked to identify the number of training opportunities that had occurred in the community, the Facility noted that training had occurred at a local restaurant and clothing store. No information regarding the individuals involved or the number of training opportunities was provided.

It should be noted that the Facility had introduced a monthly chart for Out of Home Activities. These identified activities both on campus and in the community for identified individuals. The Director of Education and Training also was introducing an Out of Home Schedule Variance Report that was intended to track the individuals' participation in scheduled activities. If an individual missed a scheduled event, a reason was identified with a plan of correction developed as appropriate.

At the time of the Monitoring Team's visit, training in the community was extremely limited. For this reason, the Facility remained out of compliance with this provision of the Settlement Agreement.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 018, entitled "Most Integrated Setting Practices," dated 10/18/13; o List of individuals referred for placement, undated; o List of individuals who have requested community placement, but have not been referred and related correspondence, undated; o List of individuals not referred due to Legally Authorized Representative (LAR) preference, data pulled from ISPs held 7/1/13 to 12/20/13; o List of individuals transferred to the community since the last onsite review, from 9/5/13 to 1/29/14; o List of individuals discharged pursuant to an alternate discharge, undated; o List of individuals transferred to other SSLCs, undated; o A current list of alleged offenders committed to the Facility, undated; o In response to request for meeting minutes from meetings between the QA Department and the Admissions Placement and/or Transition Specialist staff, notation that two meetings were held, but no minutes were taken; o Over the last one-year period, the unduplicated number of individuals that have participated in Community Living Options Information Process (CLOIP) tours and staff that have participated in CLOIP tours, data collected from 1/4/13 to 1/10/14; o For the last six months, a list of educational opportunities provided to individuals, families, and/or Legally Authorized Representatives (LARs) to enable them to make informed decisions regarding community options, including list of participants, from 7/2/13 to 1/17/14; o Facility and Local Authority staff training curricula related to community living, transition, and discharge, including training materials; o For the past six months, a list of all training and educational opportunities for staff that address community living, including training materials and sign-in sheets; o For the past six months, documents provided to staff to inform them of community living options; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed, undated; o ISPA – Potentially Disrupted Community Transition for Individual #232; o Annual Report: Obstacles to Transition, prepared November 2012; o A printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate; o Sample assessment of potential home for Individual Community Placement: Person Uses a Wheelchair for Mobility; o In response to a request for a list of individuals who returned from a community

	placement since the last review, the statement: "None;" o 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 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, including a brief description of any action the Facility took with regard to any of these occurrences, undated; o In response to a request for information for any individuals had moved to the community since 7/1/09 and who had died, information for Individual #232; o Community Placement Report, for referrals as of 1/27/14, and remaining data from 7/1/13 through 12/31/13; o Community Living Discharge Plan, related assessments, sign-in sheet, most recent ISP, and State Office reviews, as applicable for: Individual #232, Individual #82, Individual #360, Individual #247, and Individual #155; o List of all post-move monitoring visits, including the dates for each of the completed visits, undated; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda, Preferences and Strengths Inventory, Community Living Options Information Process worksheet, skill acquisition and teaching programs, Integrated Risk Rating form, Integrated Health Care Plans, Rights Assessment, last three monthly reviews, ISP Preparation Meeting documentation, ISP Attendance Tracking, Active Treatment Daily Plan, and SAP Tracking Form/Post ISP Reports, as available for: Individual #153, Individual #307, Individual #390, Individual #133, and Individual #405; o ISPs in relation to Living Options Discussions for the following: Individual #417, Individual #195, Individual #160, Individual #403, and Individual #406; o Pre-Move and/or Post-Move Monitoring Checklists for: Individual #155, Individual #82, Individual #360, Individual #232, Individual #247, Individual #115, Individual #101, Individual #428, Individual # 364, and Individual #219; o In response to request for last 10 monitoring tools completed by: 1) the QA Department; and 2) the Admissions Placement Department, one tool the Admissions Placement Coordinator completed, dated 2/11/14; o In response to request for meeting minutes and documentation showing Admissions Placement Department meetings with the Local Authority (LA), statement: "No meeting minutes were documented," with sign-in sheets; o ISP, related assessments, and ISPAs or other documentation related to rescinding the referrals for Individual #269, Individual #102, Individual #109, and Individual #196;

	○ ISPAs related to transition for Individual #98, Individual #15, Individual #133, Individual #32, Individual #59, and Individual #232; ○ Grid showing number of individuals whose teams recommended participation in a community provider tour, and number for whom a tour was completed; ○ Handouts from Admissions Placement Department meeting; ○ Discharge plans and assessments for Individual #379, and Individual #189; ○ Every Member Matters: An Information and Resource Kit Provided by the Austin Interfaith Inclusion Network; ○ Provision Action Information, updated 2/4/14; ○ AUSSLC Self-Assessment, updated 2/4/14; ○ Action Plans for Section T, dated 2/7/14; and ○ Presentation Book for Section T. ▪ **Interviews with**: ○ Sandra Taylor, Director of Family and Consumer Relations (FCR); Nanshill Wilson, Admissions Placement Coordinator; Jamie White, Administrative Assistant; and Diane Thomas, State Office Continuity Services staff member; and ○ Alice Fields, Post-Move Monitor, and Talya Chaney, Post-Move Monitor. ▪ **Observations of**: ○ ISP meeting for Individual #40, on 2/27/14; ○ Post-Move Follow-up visit for Individual #155, on 2/26/14; and ○ Admissions Placement Department meeting, on 2/25/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 2/4/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Facility had considerable work to do with regard to its self-assessment activities for Section T. As discussed with regard to Section T.1.f, the Facility had completed limited monitoring for Section T. This was evident in the Section T Self-Assessment. Although some relevant data from other sources was sometimes included (e.g., data related to number of community education tours), the data was not linked to outcome measures or goals to determine whether or not the Facility was doing well, and at times, it was unclear whether the data were accurate (e.g., for T.1.a, "zero out of 146 (0%) individuals requested to be referred for community placement opposed by IDT," when other data did not show these numbers). The Self-Assessment frequently did not review the quality of supports or activities (e.g., for T.1.b.2, there was no review of the quality of individualized plans to address education on community options). The Facility rated itself as being in substantial compliance with the following sub-sections of Section T: T.1.b.2, which requires the Facility to provide education about available community options to individuals and their families/guardians; T.1.b.3, which requires assessment of individuals for transition; T.1.c.1, related to the CLDP process and coordination with provider staff; T.1.c.2, which requires specifying staff responsible and timeframes for completion of action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.e, which requires the development of comprehensive

	CLDPs and review of pre-move supports; and T.1.h, which requires the Facility to provide a Community Placement Report. The Monitoring Team found the Facility in substantial compliance with the following sub-sections: T.1.c.2, T.1.h, and T.4.
	Summary of Monitor's Assessment: Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community, but some did not. In addition, individuals' ISPs generally included a recommendation from the Facility's team members with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. When team members modified the opinions they had included in their assessments, generally no explanation was provided. Systemic issues that negatively impacted referrals and had not been addressed were gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs. At the time of the onsite review, the State Office had not yet provided its annual report on obstacles to referral and transition, including explanations of how it was working to overcome systemic obstacles. Although obstacles to referral were being identified on an individual basis, they were not consistently accurate, and more work was needed to determine the specific concerns of individuals and their guardians when their choice was the reason for a referral not being made. Individuals frequently did not have plans to address the specific obstacles identified, and the quality of the plans teams had developed to overcome such obstacles remained inadequate. Although plans were measurable, they continued to lack individualization. In addition, although teams were identifying obstacles to transition once individuals' referrals exceeded the 180-day mark, teams were not collecting and reporting information on obstacles to transition throughout the transition process. Anecdotally, issues such as a lack of day/vocational program capacity to support individuals with pica behavior were resulting in teams considering more restrictive options, such as in-home day programs, but this obstacle to transition to the most integrated setting was not captured in the data on obstacles, because individuals' referrals had not exceeded 180 days. In general, Admissions Placement staff reported increased collaboration with the Local Authorities (LAs) over the last several months. One Local Authority was developing a crisis intervention team, and becoming more involved with individuals at AUSSLC with complex behavioral needs in the transition process. The Director of Consumer and Family Relations reported that she met quarterly with State Office Staff and the Local Authorities to discuss obstacles to transition. The Facility was developing a new module on the most integrated setting for New Employee Orientation, and it was anticipated that in April 2014, one of the Local Authorities would participate in providing the training to new employees. In addition, the Local Authority staff reportedly were collaborating more with the Post-Move Monitors in conducting monitoring activities, and follow-up needed. Although most individuals had plans in their ISPs related to educational opportunities on community options, the plans generally were not individualized. The individualization of this process is key to

	ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Efforts to share success stories were needed, particularly for individuals and guardians who were reluctant. On a positive note, for individuals in the process of transition, the Facility was often using a provider interview format. Admissions Placement staff worked with the IDT, including the individual and guardian, and developed questions to ask the community providers. In addition, the Local Authority that was developing a crisis intervention team recently had been involved with facilitating these provider interviews for individuals with complex behavioral needs. The provider interviews and LA's involvement in this process were positive additions to the community provider selection process. The Facility had made some good improvements in the Community Living Discharge Plans (CLDPs), particularly in developing more comprehensive and detailed pre- and post-move supports. However, this was an area that required continued focus, because some key supports continued to be missing. The Facility's review of an individual's death after transitioning to the community had identified some, but not all missing supports from her CLDP. Post-move monitoring documentation did not consistently show that findings were well supported. It is important that clear evidence be provided to support the findings and to increase the likelihood that community providers will respond to them. In addition, action plans should clearly set forth the steps planned for follow-up, and documentation should be maintained to confirm the necessary actions took place.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with	Based on the Community Placement Report, for referrals for community transition as of 1/27/14, and for other data, for the time period between 7/1/13 and 12/31/13, as well as other lists the Facility provided, the transition-related numbers were as follows: ▪ Ten individuals completed transitions (approximately 4% of the population) (since the last review in August 2013, seven individuals had transitioned); ▪ Referrals for community placement: o Twenty-six (26) individuals were on the active referral list (9% of the current census of 280 individuals); o Sixteen individuals were referred since last visit; o Ten individuals had been on list more than 180 days; and	Noncompliance

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	the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	○ Five individuals had been on the list for more than one year; ▪ Reportedly, five individuals had requested placement, but were not referred; ▪ As is discussed with regard to Section T.1.h, the Community Placement Report did not include data regarding the numbers of individuals that would have been referred, except for the preference of the LAR. However, another document included the data for a six-month period of time. For ISPs held between 7/1/13 and 12/31/13, a total of 109 individuals would be referred except for LAR preference (i.e., the IDT would refer); ▪ Seven individuals' referrals were rescinded; ▪ Potentially negative outcomes (the Facility's compliance related to review of these is addressed with regard to Section T.1.f): ○ No individuals had returned from community placement; ○ One death had occurred following community placement; and ○ Two other potentially negative outcomes (e.g., psychiatric hospitalization, ER, police contact, change in community provider or residence); and ▪ Two individuals were discharged pursuant to Section T.4. As is discussed with regard to Section T.1.b.3, the determinations of professionals regarding individuals' transition to the most integrated setting appropriate to their needs continued to be an area requiring focused efforts. Individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. <u>Placement and Referral Not Opposed</u> a. In reviewing the CLDPs and ISPs for four individuals who had been placed (i.e., Individual #232, Individual #82, Individual #360, and Individual #247), four (100%) individuals and/or LARs did not oppose transition to the community. <u>Responding to Individual Requests and Rescinded Referrals</u> b. According to documentation the Facility provided, since the last review, there were four rescinded referrals (i.e., Individual #109, Individual #196, Individual #102, and Individual #269) (Note: the Community Placement report covered some time prior to the previous review, and the number of rescinded referrals above includes those additional three individuals). ▪ Of these, the reasons for the rescinding appeared to be reasonable for two (50%) (i.e., LAR Choice for Individual #102, and Individual Choice due to wanting to finish school for Individual #109). For the remaining two, the reason appeared to be that community supports could not be identified to meet the individuals' complex medical and physical and nutritional supports. Individual #196 had a	

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		guardian, who made the decision, but the decision appeared to be based on a lack of community supports. ▪ Further, an adequate review to determine if changes were needed in the referral and transition-planning processes at the Facility was conducted for none (0%) of the rescinded referrals. The Facility submitted no documentation to show that a critical review had been completed of the rescinding of these referrals. ▪ Because no reviews were conducted, the following indicator could not be completed: Of these reviews, actions were recommended in ___ cases. Of these cases, actions were implemented for ___ (%). c. Reportedly, five individuals requested placement, but were not referred. ▪ Of the five individuals who requested placement, but were not referred, all five individuals had an LAR who made this decision. As a result, the following indicator was not reviewed: Of the remaining ___ individuals, an appropriate review, appeal, and or lack of consensus review was conducted for ___ (%). <u>Systemic Issues</u> d. There were systemic issues delaying referrals (at the State and/or Facility level). Even though there were some, there were actions to resolve some, but not all of them. For example: ▪ Based on review of a sample of 10 ISPs, the lack of or the perception of a lack of supports in the community for individuals with complex medical and/or physical and nutritional management needs (e.g., Individual #307, and Individual #390), and/or complex behavioral needs (e.g., Individual #406) were systemic issue delaying referrals. Based on discussion with Facility staff as well as the Monitor's recent discussions with the parties, systemic actions to resolve these issues were not being implemented. The State did not appear to have developed actions to address the perception and/or lack of supports for individuals with complex medical needs. Based on interview with Admissions Placement Department staff, as well as a conversation with the Associate Director of one of the Local Authorities, work was in the final stages of developing a crisis intervention team. The Local Authority's team was in the process of obtaining certification through a nationally-known program. Although this likely will not resolve all of the capacity issues with regard to supporting individuals with complex behavioral needs in the community, it was a step in the right direction. According to the Admissions Placement staff and the Associate Director, the crisis intervention team had begun to work with individuals on the referral list, and they were involved in a variety of planning activities, such as assisting individuals and/or	

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		guardians to narrow down the list of community providers to ones that could support the individuals' needs, contributing to the planning of the CLDPs, developing crisis intervention plans for implementation in the community, etc. Based on the information provided, it appeared that the crisis intervention team would provide valuable resources to individuals with complex behavioral needs. ▪ For at least one individual in the sample (i.e., Individual #417), the issue that appeared to prevent a referral was the individual's desire to continue living with friends. Although clearly it is appropriate to approach planning for transition on an individual basis, from a normalization perspective, many people choose to live with friends or others with whom they have established relationships, and so for a number of individuals at AUSSLC approaching planning for transition to the community in this manner might also be appropriate. e. Based on review of documentation and interviews with staff, there were potential systemic issues delaying transitions (at the State and/or Facility level). Based on information provided, it did not appear that specific actions had been identified and/or were in the process of being implemented to resolve them. For example: ▪ Individual #133's referral had exceeded the 180-day target. His ISP listed some potential barriers (e.g., Level of Need being rated as a 1, resulting in a low level of funding that would not accommodate his need for specific supports due to history of sexually inappropriate behaviors). Based on ISPAs back as far as May 2013, the team had had difficulty identifying appropriate supports for him. Other than the team continuing to look for a community provider to support his needs, it was unclear that any steps had been taken at the State level to expand opportunities in the community for individuals who were fairly independent, but required intense supports due to histories of behavior that placed them or others at risk. This was an example of where the crisis intervention team discussed above would only be able to provide limited help, and issues related to ongoing funding, and/or the determination of how funding levels are determined would need to be addressed. ▪ As noted above, two individuals' referrals were rescinded due to a lack of community capacity to meet the needs of individuals with complex medical and physical and nutritional support needs. It was unclear what was being done, if anything, to address this concern. f. Funding availability was not cited as a barrier to individuals moving to the community. g. Senior management at the Facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The Admissions Placement Coordinator presented information regularly at the QA/QI Council meetings.	

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		<u>Pace of Transitions</u> h. At the time of the review, transitions were not occurring at a reasonable pace. ▪ Of the seven individuals placed since the time of the last onsite review, four (57%) were placed within 180 days of their referral. ▪ At the time of the review, 26 individuals had been referred for community transition. Ten of these 26 individuals had exceeded the 180-day timeframe. o Of these, five individuals had exceeded one year. Based on the Monitoring Team's observation of the Admissions Placement Department's meeting at which all individuals on the referral list were reviewed, it appeared that thoughtful and reasonable activity and actions had occurred related to the transition and placement the individuals that had exceeded the 180-day time period. During future reviews, the information will be requested to address the following: i. For ___ of the ___ (___%) individuals reasonable activity and actions had occurred related to the transition and placement the individuals that had exceeded the 180-day time period j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for ___of the ___ (%) individuals. k. Adequate justification was provided for the lengthier transition process for ___ of the___ (___%) individuals. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	a. The state policy for most integrated setting practices was recently issued. The Monitoring Team will comment at the next review as to whether the State policy adequately addressed all of the items in Section T of the Settlement Agreement. b. At the time of the review, the Facility did not have a final local policy on the most integrated setting. Facility staff reported that the draft Facility policy had been reviewed at the Executive meeting the week of the Monitoring Team's onsite review. Staff reported that additions were being made in relation to the pilot project, and then it was expected to be finalized and staff trained. The draft provided in the Presentation Book did not include the level of detail necessary for the localization of the State Office policy. It essentially just reiterated the State Office policy. The Facility should have policies and procedures that operationalize/define implementation of the parts of the State policy that are not specific. For this policy, examples include, but are not limited to the way in which community tours are managed, how educational activities are presented to individuals, expectations regarding staff	Noncompliance

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		training on the most integrated setting, how the Admissions and Placement Department staff ensure that all supports and services are included in CLDPs, the expectations regarding quality assurance efforts for this section at AUSSLC, and which staff are to review the CLDP prior to its submission to the Facility Director. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. The Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The specific requirements of this provision are discussed below, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F.1.d, F.2.a.1, and F.2.a.3. As noted in Section F, substantial compliance was not found for F.1.d, F.2.a.1, and F.2.a.3. As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by AUSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner.	Noncompliance

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		Identification of and Plans to Overcome Obstacles to Referral and Transition to Community Regarding referral at the individual level: b. Of the 10 ISPs reviewed, eight should have had obstacles to referral defined (the other two individuals, Individual #133 and Individual #405, were referred for transition to the community). Of the remaining eight ISPs, four (50%) included an adequate list of obstacles to referral (i.e., Individual #153, Individual #195, and Individual #160, Individual #417, all of whom the obstacle was LAR Choice or Individual Choice, and as noted below, although this was accurate, for most, the teams had not identified the specific reasons). The problems associated with the obstacles in the plans included the following: ▪ When guardians or individuals objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #153, Individual #417, and Individual #160). This is very important information to collect and analyze, but it did not appear it was being captured regularly; and ▪ For some individuals, the teams' justifications for identifying some obstacles were not clear [e.g., for Individual #307, the obstacles identified were LAR Choice and Medical Issues, but the current LAR choice was unknown (i.e., a new guardian had been appointed, and the team had not had a discussion with the guardian about community living options), and it was unclear at the time of the ISP meeting, what medical issues were of concern; for Individual #390, the Medical Issues obstacles was checked, but specifics were not provided regarding what services were not available in the community to meet Individual #390's needs; Individual #403 no longer had a guardian, but had one at one point, so she had been deemed unable to make decisions, and in addition, the team indicated Individual #403 had not made a choice, but the obstacles was Individual Choice; and for Individual #406, LAR Choice was an obstacle, but it was unclear why the team also indicated Behavioral Issues were an obstacle]. c. Of the one annual ISP meeting observed (i.e., Individual #40), an adequate list of obstacles to referral was identified for none (0%). The team did not clearly identify what the obstacle(s) were. Although there was some discussion about the individual's choice and the guardian's choice, as well as health issues, the team did not specifically discuss which obstacle(s) were applicable. Of note, the guardian from the private agency left prior to the end of the meeting, and before the final decision was made regarding referral or not to the community. Regarding a plan to address obstacles at the individual level: d. Of the eight ISPs, one (13%) (i.e., Individual #403) included an action plan to address/overcome obstacles identified. Of these one, none (0%) was adequate (i.e., were	

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		individualized, measurable, and comprehensively addressed the obstacles). More specifically, most ISPs did not include plans that addressed the specific obstacle(s) the team had identified, but rather included generic efforts to provide more information to the individual about community options. For Individual #403, the obstacle was Individual Choice – Lack of understanding. The only action step was for Individual #403 to participate in at least three community exposure tours in the next six months. Although the narrative of the ISP indicated the team would meet to discuss her reaction and reevaluate, this was not included as an action step. In addition, given she was refusing to leave her home on campus, the methodology for accomplishing this action plan was unclear. It was not individualized to address her specific needs. e. Of the one annual ISP meeting observed, a plan was included to address/overcome the identified obstacles for none (0%). Because the team did not specifically discuss the obstacles or a plan to overcome them, the following indicator could not be completed: Of the ____ plans, ____ (___%) appeared adequate. In order for plans to be considered "adequate," the written plans would need to be measurable, and individualized. Regarding transition at the individual level: As discussed while on site, the Facility was not yet identifying obstacles to transition from the beginning of the transition process, but only after individuals had been referred for more than 180 days. In the future, the following will be assessed with the expectation that obstacles will be discussed and documented throughout the transition/referral process: f. Of the ____ CLDPs and related ISPAs reviewed, ___ should have had obstacles to transition defined. Of this ___ CLDP and ISPA related to transition, ___ (___%) included an adequate list of obstacles to transition. g. For this ___ individual, ____ of the ISPAs (___%) had action plans to address the obstacle to transition. Preferences of individuals: h. Of the ten ISPs, one (10%) (i.e., Individual #133) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). For Individual #417, the preference of the individual was described, but it was unclear his preferences were based on sufficient information, and it was not clear specifically what the individual's concerns were beyond wanting to continue to live with friends. The team did not appear to have pursued conversation with Individual #417 about options for moving with friends into a community setting. For Individual #160, the team did a good job of describing the individual's wavering regarding community transition, and her reliance on the opinions of her mother and sister. The team recognized they needed	

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		more information, but then did not develop a comprehensive plan to determine the individual's preferences (i.e., only included one action step that was not individualized). i. Of the one annual ISP meeting observed, the individual's preference for where to live was adequately described in none (0%), and this preference appeared to have been determined in an adequate manner for none (0%). The team for Individual #40 did not yet have a good idea of what his preferences were, and the question asked at the ISP meeting was leading: "Do you like living where you are at?" Preferences of LARs: j. Of the six ISPs for individuals with guardians (i.e., Individual #133, Individual #307, Individual #153, Individual #195, Individual #160, and Individual #406), three (50%) included an adequate description of the LAR's preference and how that preference was determined by the IDT (i.e., Individual #133 for whom information was provided in the ISP and ISPA related to the referral, and Individual #195 and Individual #406, for whom the LARs' concerns related to community transition were discussed in some detail). k. Of the one annual ISP meeting observed, the LAR's preference for living setting was adequately described in none (0%), and this preference appeared to have been determined in an adequate manner for none (0%). Although the preference of the guardian from the private agency appeared to be for Individual #40 to remain at AUSSLC, the team did not explore the specific concerns of the guardian regarding transition to the community. The guardian left before the meeting concluded, and so was not present for the final discussion about the possibility of referral to the community. AUSSLC had made limited progress with regard to identifying obstacles to community referral and transition, and more work was needed. Although obstacles were being identified, they were not consistently accurate, and more work was needed to determine the specific concerns of individuals and their guardians when their choice was the reason for a referral not being made. Individuals frequently did not have plans to address the specific obstacles identified, and the quality of the plans teams had developed to overcome such obstacles remained inadequate. Although plans were measurable, they continued to lack individualization. These deficiencies, in addition to ISPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families	<u>Individualized Plans</u> a. In reviewing 10 recently completed ISPs, two individuals (i.e., Individual #133 and Individual #405) had been referred for placement, and were engaged in the CLDP process. For the remaining eight, six (75%) had a plan that addressed education about community options. Those that did not have a plan were Individual #153, and Individual	Noncompliance

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	or guardians to enable them to make informed choices.	#307 (i.e., the only action steps related to living options were for the individual to participate community activities. Given that these activities should be available to an individual wherever he or she lives and they were not tailored in any way to gauge the individual's reaction, etc., they were not considered educational for these purposes). Of these, none (0%) were adequate. Although they were measurable, none were individualized. The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. Many examples of concerns related to the plans have been discussed in previous reports, and little change was seen in this most recent sample of ISPs. As indicated in the Monitoring Team's previous reports, the action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance and/or the team's concerns. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. When teams have questions about availability of supports in community settings, these should be researched. At the time of the review, these types of activities were not included in action plans. Creative ideas and brainstorming within AUSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. <u>Provider Fair</u> b. The Facility had not held a provider fair within the past 12 months. Rather, the Facility had conducted "Provider in the Diner" presentations over a several-day period, including 8/13/13, 8/15/13, 8/20/13, 8/22/13, 8/27/13, and 8/29/13. Although the Facility referred to this as a "Provider in the Diner" provider fair, the Facility provided little information about the numbers of providers available each day. However, it did not appear to meet the intent of having numerous providers available at one time to allow individuals, guardians, family members, and staff to learn about a number of providers without having to attend numerous sessions. It was unclear whether or not participants were asked to conduct evaluations, and if so, if this data was reviewed to determine whether or not changes should be made. The Facility did not present evidence to show that it had measured and evaluated	

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		outcomes, and used the information to make changes for future fairs. Based on data in the Facility's Presentation Book for Section T, six providers participated, and some participated in more than one session. According to information included in the Presentation Book, participants at the August 2013 fair included 30 individuals, four family members or guests of individuals, and 35 Facility staff. Based on an email included in the Presentation Book, it appeared the Facility was planning to host a Provider Fair in March 2014. <u>Local Authority</u> c. The Facility appeared to maintain good communication and a working relationship with the LAs, participated in at least quarterly meetings with the LAs (i.e., based on sign-in sheets, AUSSLC had bi-monthly meetings with the LAs), and based on interview with Admissions Placement staff, ensured relevant topics were on the agenda for the LA meetings. Based on interview with staff (i.e., minutes were not available) and review of sign-in sheets, a group of Facility staff was meeting with Local Authority staff bi-monthly. From the Facility, this generally included the Director of Consumer and Family Relations, the Admissions Placement Coordinator, Placement Coordinators, the Post-Move Monitor(s), and Transition Specialists. Based on interview, the group discussed individuals in the process of transition and any issues encountered, provider fairs, and different ways to offer education about community living options to individuals and their correspondents. <u>Tours of Community Providers</u> d. The Facility did not yet have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, and identified all individuals and whether or not each went on a tour). However, this was a system the Facility was working to develop and implement. Based on review of individuals' ISPs, teams frequently included community tours as an action step to provide individuals with greater exposure to options available in the community. However, as discussed above, such action plans often were not individualized, and so the appropriateness of the tours on which individuals participated could not be assessed. When asked for: "If available, the Facility's tracking grid/report to show number of individuals for whom a tour of a community provider was appropriate/recommended by the IDT, and the number of individuals for whom a tour was completed," the Facility submitted a document that included a partial list, and stated: "We began tracking ISP attendance/assignments January 1, 2014. With that participation we have begun to track whether or not CLOIP tours have been recommended and what obstacles to referral have been identified." This was a step forward in developing and implementing such a system, and will be effective so long as Admissions Placement staff attend all ISP meetings, or a mechanism is put in place to obtain the needed information for meetings they are unable	

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		to attend. Based on data the Facility provided, between 1/4/13 and 1/10/14, 11 community provider tours were conducted. The Facility was able to provide data on how many individuals attended these tours. For example, during this time period, 39 individuals had attended tours, or approximately 14 percent of the individuals residing at AUSSLC. However, because a functioning system for tracking tours required per individuals' ISPs versus tours completed, the following indicator could not be completed: e. Based on the Facility's own report, of the ____ individuals at the Facility for whom a tour was appropriate, ___ (%) went on a tour appropriate to their needs within the past year. On a positive note, the Facility had developed the Community Tour Protocol/Checklist. The document set forth the responsibilities of various departments and staff to ensure that community tours occurred as scheduled. It addressed many of the logistics, such as ensuring that communication about the tour was sent to the appropriate staff, transportation was available, staff were assigned to accompany individuals, etc. f. For the individuals in the sample, the ISPs did not provide sufficient information to determine if an action plan for a community provider tour had been included in the previous ISP and if so, if such a tour(s) had occurred and was tailored to their needs. In addition, because ISP Preparation meetings were not held for most individuals in the sample, such information was not available through ISP Preparation meeting documentation. However, for many individuals, their ISPs indicated they had not been on any community provider tours in the last year (e.g., Individual #406, Individual #403, Individual #160, Individual 195, Individual #390, and Individual #405). The ISP for one individual (i.e., Individual #133) indicated he had been on a community tour, but it was not clear what the specific requirements were in last year's plan. As a result, the following could not be completed: ▪ Of the ___ individuals in the sample for whom their teams had determined a tour was appropriate, ___ (___%) went on a tour tailored to their needs within the past year. <u>Visits to Friends in the Community</u> g. The Facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>Educational Activities at/by Facility for Individual</u> h. Since the last onsite review, based on documentation the Facility provided, other educational activities for individuals did occur during self-advocacy meetings, did not occur during house meetings for individuals, did not occur during family association	

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		meetings, and did occur during other appropriate situations or locations. Some of the education that had occurred included: ▪ For individuals in the process of transition, the Facility was often using a provider interview format. Admissions Placement staff worked with the IDT, including the individual and guardian, and developed questions to ask the community providers. Based on the Monitor's discussion with the Associate Director of one of the LAs, their developing crisis intervention team recently had been involved with facilitating these provider interviews for individuals with complex behavioral needs. The provider interviews were a positive addition to the community provider selection process. ▪ Admissions Placement staff reviewed the ISP schedule and made assignments for Transition Specialists as well as Placement Coordinators and other Department staff to attend ISP meetings. Based on the Monitoring Team's observation of the Department's meeting the week of the onsite review, for March 2014, it was anticipated that an Admissions Placement Department staff would be present at each ISP meeting. This was positive, and had the potential to assist in ensuring that teams, including individuals and their guardians make informed decisions regarding living options. The Admissions Placement Department had a draft book that staff would bring with them to ISP meetings. It included information about community options, including pictures of some sample group homes. ▪ Admissions Placement staff reported that they had sent an invitation to individuals that had moved to the community to come back to AUSSLC for the upcoming music festival. They intended to do the same for the Provider Fair, and to include the families of individuals that had transitioned to the community as well. If individuals or families do attend these events, it will provide opportunities for them to share their experiences with individuals who still reside at AUSSLC or their families. ▪ Based on email correspondence and meeting minutes, the Director of Family and Consumer Relations and the Transition QIDP had presented to the Self-Advocacy Group in February 2014. Another creative idea that the Facility was considering was the use of Provider Roundtable Discussions. This would not only provide an opportunity for individuals, guardians, and staff to learn about community options, but as Facility staff pointed out, also would provide an opportunity for community providers to learn more from each other about options for providing supports, particularly for individuals with more complex needs.	

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		Educational Activities for Staff The Facility was able to provide some information about staff participation in education activities related to community options. For example, the Facility provided data to show that between 7/1/13 and 12/31/13, 30 staff had participated in CLOIP tours. Although the Facility provided a copy of a CLOIP training presentation, no information was provided regarding when the training occurred, and/or how many staff participated. The Facility was developing a new module on the most integrated setting for New Employee Orientation, and it was anticipated that in April 2014, one of the Local Authorities would participate in providing the training to new employees. During upcoming reviews, the Facility will be asked to provide data for the following indicators: ▪ i. % of direct support professionals were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). ▪ j. __ % of clinicians were documented to have participated in one or more activities (e.g., in-service, workshop, community tour) ▪ k. ___ % of managers and administrators were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). l. Since the last onsite review, information had not been shared about successful community placements with: a) individuals who were reluctant to consider community placement; and b) LARs who are reluctant to consider community placement. However, as noted above, the Facility had plans to invite individuals that had transitioned back to the music festival, as well as the Provider Fair to share their stories. Such activities should be individualized, but some additional ideas would include: as appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; individuals who have experienced successful transitions could speak in other forums, such as at the Diner discussion; and newsletter articles could regularly highlight success stories. Although individuals often had a plan in their ISP, the plans were not individualized. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Efforts to share success stories were needed, particularly for individuals and guardians who were reluctant. The Facility remained out of compliance with this provision.	

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	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Facility was implementing the State Office's process to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. The most recent format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. a. Of five ISPs reviewed for which the Monitoring Team requested all assessments (i.e., Individual #153, Individual #307, Individual #390, Individual #133, and Individual #405), for none (0%), all of the assessments included the applicable statement/recommendation. For a number of individuals, multiple assessments were late or not provided, and as a result, the IDTs did not have access to nor could the Monitoring Team confirm that the assessors had made the required recommendations. b. In five of the 10 (50%) (i.e., Individual #160, Individual #417, Individual #153, Individual #307, and Individual #405) written ISPs reviewed, and during one of the one (100%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. c. In none of the ten (0%) written ISPs reviewed, and during none of the one (0%) annual ISP meetings observed, a thorough discussion of living options occurred. d. Four of the 10 individuals' ISPs (40%) a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included (i.e., Individual #133, Individual #405, Individual #153, and Individual #160). Examples of the problems noted are discussed below. e. In 10 of the 10 (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. However, For four of the 10 individuals (40%), adequate justification was provided for the team's recommendation (i.e., for Individual #133, Individual #405, Individual #195, and Individual #160). The following provide examples of the problems identified: ▪ For individual #307, according to the ISP narrative, all discipline team members independently recommended the individual could be supported in a less restrictive environment. However, without justification, the discipline members did not jointly recommend transition to the individual and guardian, and instead concluded that: "There were medical issues which occurred in this past year which appeared that [Individual #307] had some changes within her. The IDT believed that with these medical issues, the LAR should be involved in this	Noncompliance

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		discussion before recommending that [Individual #307] is able to live in a less restrictive setting." However, none of the team members referenced these concerns in their assessment recommendations related to transition, and the ISP narrative did not explain or identify any medical concerns that could not be supported in a community setting. In addition, the team relied on information from a previous guardian in determining that the guardian's opposition to community transition was the reason for not making a referral. Although the narrative of the ISP indicated further follow-up would occur with the new guardian, no related action step was included in the ISP action plans. ▪ For Individual #390, the team's statement was contradictory: "The **facility discipline members…** determined that [Individual #390] can be served in a less restrictive setting, although at this time her health is unstable. [Individual #390] has had multiple hospitalizations in the past year for syncope, labile heart rate and blood pressure of unclear etiology as well as apneic episodes. She needs 24 hour nursing care at this time and needs to be monitored closely by health professionals." Based on a review of the assessments, there was disagreement between assessors (i.e., five said yes, and two said no, and medical was unclear). However, these differences were not reconciled. Individual #390 could not express an opinion about community transition, and she did not have a guardian. The team concluded that she would not be referred, but although they cited medical issues and the need for "24-hour nursing care," the team did not detail what community living situations they had considered, and why they believed 24-hour nursing care could not be provided in a more integrated setting. ▪ For Individual #153, the team indicated that guardian was opposed, so the final recommendation was not to refer. However, the rights assessment indicated that the guardianship had lapsed. ▪ The discipline members indicated Individual #417 could be supported in a more integrated setting. However, there was no discussion documented or reconciliation of the vocational assessor's disagreement with the rest of the team, so it was not clear how the team reached a consensus recommendation. The individual objected to moving, so the team did not recommend referral. However, it appeared that the team did not believe he was competent to make decisions on his own, and although the team did not make a referral for a guardian, the ISP indicated the Facility Director provided consents for Individual #417. ▪ For Individual #195, the section for the discipline members' recommendation indicated that the majority of team members believed Individual #195 could be supported in a more integrated setting, but the vocational team member did not. It appeared the team left it as two different recommendations, and there was no reconciliation of the differences of opinion. The LAR objected to a referral, so one was not made.	

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		▪ For Individual #403, the discipline members did not make one coherent recommendation. Rather the team members' stated: "The **facility discipline members** (independent of the resident and LAR/family) determined that [Individual #403] can be served in a less restrictive setting at this time. This determination is based on her independence in her self-help skills overall health and behavioral stability... [Individual #403] is non-verbal and has not indicated a preference in her living options although she has been refusing to leave her home. The IDT agreed that [Individual #403] would need to be willing to leave her home in order for her to be able to participate in community visits and outings." It was unclear why the Facility discipline members recommended transition if they did not believe it was possible at this point in time. The final team decision for Individual #403, as written, appeared to be based on the individual's choice. However, as noted above, the team previously indicated her choice was unknown, and given she had a guardian in the past, her ability to make informed decisions was questionable. ▪ The discipline members indicated that Individual #406 could not be supported in a more integrated setting "based on his current behavioral issues that pose a safety threat to himself and/or others. [Individual #406] currently requires physical restraint supports that are not provided in the community at this time..." It was unclear: 1) why the team believed individuals requiring physical intervention could not be supported in the community; and 2) given that his team rated him to be a medium risk in relation to behaviors, why Individual #406's behaviors were viewed as so significant to preclude transition to the community. Although the LAR's Choice was listed as a reason for the decision not to refer, as noted above, behavioral issues also were listed as a reason, and the team had not justified this reason. On a positive note, in October 2013, Facility staff identified nine individuals for whom the living options discussions potentially were not thorough and/or accurate, and/or for whom the obstacle(s) that teams identified did not appear to be accurate (e.g., the obstacle was LAR choice, but the individual did not have an LAR). ISPA meetings were held, and the Living Options Discussions were revisited. According to documentation provided five of these nine individuals subsequently had been referred for transition to the community, and for others, additional action steps had been developed to address obstacles. It was positive that the Facility had taken these steps to identify potential issues with Living Options Discussions and to take actions to reevaluate individuals' appropriateness for movement to the most integrated setting appropriate to meet their needs. Teams generally were not having thorough discussions about community living options. Although Facility discipline members generally were making a specific recommendation	

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		independent of the individual and his/her guardian, problems continued with regard to teams documenting a well-supported justification for their decisions. The Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the Monitoring Team's last onsite review, seven individuals had transitioned to the community. Four of these individuals' CLDPs were reviewed (i.e., Individual #232, Individual #82, Individual #360, and Individual #247). This represented 57% of the relevant CLDPs. Based on review of these CLDPs: ▪ The following indicators could not be assessed, because the Monitoring Team did not request ISPA or other meeting documentation. They will be assessed during upcoming review: o ____ of the ___ (___%) CLDPs were initiated within 14 calendar days of referral. o ___ of the ___ (___%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. o ___ of the ___ (___%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). However, based on the CLDP meeting documentation, some concerns were noted. For example, for Individual #232, a number of team members that should have been at the final CLDP meeting were not present, including, for example, the SLP, residential staff, DSP, day program staff. ▪ None of the three (0%) CLDPs or other transition documentation included documentation to show that the Facility worked collaboratively with the LA. Although the LA attended the CLDP meetings, documentation did not clearly indicate what collaboration occurred. General statements were provided, such as "[Individual's] contracted Local Authority… has been involved in the meetings, as well as assisting with education related to the community living options available." The Facility remained in noncompliance with this provision.	Noncompliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community	a. The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Since the last review, the Facility clearly had made efforts to include some more specific supports and services. However, none of the four CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by	Noncompliance

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	living discharge plan and coordinating the community living discharge plan with provider staff.	including documentation to show that all of the activities listed in the following six bullets occurred adequately and thoroughly as appropriate to meet individuals' needs. The following describes examples in which some of these activities occurred for some individuals, as well as example of where they should have occurred, but did not: ▪ Training of community provider staff, including staff to be trained and level of training required: Many of the plans identified the need for training for community provider staff. This had been improved by providing more information about what would be included in the training. However, the plans did not define which community provider staff needed to complete the training (e.g., day and residential staff). Similarly, the CLDPs had begun to identify what level of mastery of the information was required (e.g., demonstration of competence, etc.). However, it was unclear how "competency testing" would be measured, and this was particularly challenging when a list of items was associated with a training support. The specific competency check-off forms or specific methodology to test competence should have been identified. Instead, plans included generic descriptions in the evidence column that did not define exactly how competency would be determined, such as "Signed competency training rosters that indicate satisfactory knowledge of the staff through verbalization and drill questions." In addition, in some plans, teams had decided not to include pre-move required training supports, because training had occurred when the individuals had done visits. This showed a misunderstanding of the need for the CLDPs to document necessary services and supports that met the individuals' needs, regardless of whether they had occurred yet or not. Such supports should be listed, and part of the pre-move monitoring should involve ensuring that they occurred, for example, to confirm that no new staff had come on board that required the training; ▪ Collaboration with community clinicians (e.g., psychologists, PCP, SLP): Some of the plans included collaboration with some, but not all of the necessary clinicians (e.g., Individual #82, and Individual #360), and others did not include any, but should have (i.e., Individual #232). As the Monitoring Team has repeated indicated, such collaboration is essential to ensure ongoing coordination of care. Unfortunately, the team's review after Individual #232's death identified this as a concern, particularly with regard to coordination related to medical care. Clearly, medical care is an important area for such collaboration to occur, but other clinical areas also should be considered as well. For example, Individual #360's plan included a support for the AUSSLC psychiatrist to speak with the community psychiatrist, but a similar expectation was not set forth for the psychologist/behavior analyst. ▪ Assessment of settings by SSLC clinicians (e.g., OT/PT): Based on the documentation, review of the accessibility of the home and/or bathroom/shower would have been appropriate for both Individual #232 and	

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		Individual #82, but did not occur. For Individual #82, the provider reported problems with the shower chair at the pre-visit, but this issue was deferred and the provider was given 45 days in the post-move required supports to have an OT/PT come out and decide on need to make changes, despite a potential safety hazard; ▪ Collaboration between provider day and residential staff: No coordination was specified as needing to occur between current and future residential or day/vocational staff, and for the individuals reviewed, and for these individuals, this would have been an important component. For none of the individuals did it appear the teams had even discussed this as a possible need; ▪ SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community): For Individual #360, AUSSLC Behavioral Health Services staff agreed to be contact in crisis, and use of on-call staff at AUSSLC for this purpose as well. However, for other individuals, it did not appear the teams had even discussed this as a possible need (e.g., Individual #82, who had a diagnosis of dementia; or Individual #232, who had lived in State Facilities since 1952); and ▪ Collaboration between Post-Move Monitor and Local Authority staff: The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, 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. Even though anecdotally this was reported to be occurring, it was not part of the plan. b. Three of the four CLDPs reviewed (75%) (i.e., the exception was Individual #247) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. However, documentation was not included to show that the activities did indeed occur. The Facility remained out of compliance with this provision. Continuing problems were noted with regard to teams' definition and inclusion in CLDPs of comprehensive sets of specific steps that Facility staff would take to ensure smooth and safe transitions for the individuals moving to the community.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Staff Names for All Pre- and Post-move Supports • a. For four (100%) of CLDPs, the Facility identified all Facility staff and other staff (e.g., LA, community provider staff) by name and title for each pre-/post-move support.	Substantial Compliance

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		Completion Timeframes/Dates for All Pre-/Post-Move Supports • b. For four (100%) of CLDPs, the Facility identified specific timeframes/specific dates for completion and/or implementation for each pre-/post-move support.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Evidence of Individual/LAR Participation • a. Based on review of four CLDPs, one (25%) (i.e., Individual #82) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by: o Signatures on CLDP: and/or o Narratives in the CLDP. Problems noted included individuals' signatures not on sign-in sheets, and no explanation for their absence (e.g., Individual #232 and Individual #360); and an individual's guardian providing permission for the meeting to go forward without her, but with other involved family/friends on the telephone, but no documentation to show this occurred (i.e., Individual #247).	Noncompliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessments. Although the Facility had made progress with regard to obtaining timely assessments and some improvement was seen with some assessments, the quality (i.e., comprehensiveness) of most of the assessments was lacking. More specifically: ▪ For none of the four CLDPs reviewed (0%), all necessary assessments were completed. For none of the individuals had the PSI, or IRRF been updated to ensure that their preferences and needs, particularly their needs related to risk, were sufficiently addressed. Other missing assessments included psychiatry for Individual #82, and Individual #360. ▪ For two of the four CLDPs reviewed (50%) (i.e., Individual #232 and Individual #247), all assessments were completed no more than 45 days prior to the date the individual moved to the community. ▪ For one of the four CLDPs reviewed (25%) (i.e., Individual #360), all assessments were available to the Placement Coordinator/Transition Specialist and IDT prior to the final CLDP meeting. ▪ For none of the four CLDPs reviewed (0%), the assessments were of adequate quality. The following summarizes concerns and areas of some improvement: o Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility	Noncompliance

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		provide community providers with a summary of, for example, treatments or plans that have been particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. o On a positive note, some assessments had begun to include more detail regarding the protections, treatments, and supports that individuals needed (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.). Although this remained a work in progress, it was positive that some disciplines were beginning to include more detail. As discussed in further detail with regard to Section T.1.e, of significant concern was the fact that these more detailed recommendations were not consistently being translated into necessary pre- and post-move required supports. o Although some improvement was seen, assessments did not consistently identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. It appeared for Individual #360, the Behavior Health Specialist had made some modifications to the PBSP, which was positive, but it was unclear what process was used to determine what changes were needed. o In addition to specific issues related to transition, as is discussed in other sections of this report, a number of the underlying assessments were not of adequate quality. o Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a	

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		document that could be provided to community medical care providers that would facilitate the transition of this information. The following specific information is repeated here from Section M to provide additional insight in concerns related to assessments. Regarding the nursing documentation for six individuals discharged/ transitioning to the community, a review of the nursing documentation and Nursing Discharge Assessment Summaries for six individuals including: Individual #364, Individual #219, Individual #115, Individual #232, Individual #360, and Individual #155 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. This was because none of the IPNs were included in response to the document request that stated: "For the past six months, nursing documentation for individuals who have transitioned to the community, including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. Since the last review, progress clearly had been made. Admissions and Placement Department and Transition Specialist staff appeared to be working with individuals' teams to expand the scope and definition of pre-move and post-move required supports. Additionally, efforts were underway to improve ISPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. However, to make use of these improvements, teams will need to use the ISPs more effectively when developing CLDPs. Overall, though, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. Moreover, the plans did not consistently	Noncompliance

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	plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	identify preferences of the individuals that might affect the success of the transition. Even when teams identified important preferences of the individuals through assessment or during pre-move site visits, these were not meaningfully translated into pre-move or post-move supports. This lack of comprehensive identification of supports made it difficult to ensure individuals' successful transitions, and for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. a. In none of the four CLDPs reviewed (0%), a comprehensive set of pre- and post-move required supports was identified in measurable/observable terms. The Monitoring Team has provided many examples of concerns in previous reports. The Facility's CLDPs continued to have missing supports. The following provides examples of CLDPs in which appropriate pre- and post-move required supports had been included for some individuals, as well as example of where they should have been, but were not: ▪ 1) <u>The list should be comprehensive and inclusive, demonstrated by</u>: o Sufficient attention should be paid to the individual's past history, and recent and current behavioral and psychiatric problems: ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting. For Individual #360, the plan was described as implementing the PBSP and calling AUSSLC and her parents if a crisis occurred. Given Individual #360 was moving to Dallas, this did not seem adequate. No mention was made of training for the foster care provider on physical intervention. Individual #360 was to sign up for the crisis intervention services that would become available in June 2014, but she moved in November 2013. Similarly, for Individual #82, a plan should have been considered (i.e., the Individual recently had bitten a staff person at AUSSLC), but was not; and ▪ For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle. For the individuals in the sample, teams had identified some medical supports	

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		prior to transition, such as the name and first appointment dates for the PCP and psychiatrists. This was positive, however, other supports, such as involvement of community provider agency behavior analysts from the time of or before the transition were not included as supports, even when this appeared necessary (e.g., for Individual #360 with a number of target behaviors, or Individual #82). o All safety, medical, healthcare, therapeutic, risk, and supervision needs should be addressed: ▪ For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. All four individuals had risks that were not sufficiently addressed in the CLDPs; ▪ For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. Although for some of the health care indicators of the four individuals, supports had been included to measure them (e.g., constipation and weight), a number of such supports were missing, and sometimes parameter for reporting issues to health care staff were present (e.g., for Individual #232 any weight loss or temperatures above or below a certain level), but sometimes they were missing (e.g., weights for Individual #82, or Individual #232, for whom discussion of parameters were documented in the team discussion, but not translated into supports); ▪ With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians. For some individuals either the intensity and/or roles of clinicians were described for some clinicians, but for none of the individuals was this done comprehensively. For example, for Individual #232, no specifics were included regarding the role of nursing, level of nursing needed (except that staff were to report certain	

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		things to nursing); and for Individual #360, although some of the intensity was described (e.g., at least quarterly psychiatric visits with more often if necessary), the qualifications of staff (e.g., "psychologist") most often were not; ▪ In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community. For all four individuals, supports provided at the Facility were removed/not included in the CLDPs, and adequate justifications were consistently missing. In some cases, the reason given was lack of funding, which was not an acceptable justification (e.g., reduction in number of nutritional supplements for Individual #232, or the frequency of dental supports for Individual #82); and ▪ Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). For the two individuals (i.e., Individual #232 and Individual #247), staffing supports were described as "24-hour awake" without any of the necessary definition. For the remaining two individual, no staffing supports were included. o What was important to the individual should be captured in the list of pre-/post-move supports. As noted above, the PSI was not one of the assessments updated for the CLDPs, and for the sample of four individuals, there was no evidence such information was used to ensure that the individuals' preferences were consistently and meaningfully incorporated into CLDPs. Occasional references were made to preferred activities (e.g., going to church, attending an Art Studio, etc.), but clear reference to what was important to the individual was generally missing.	

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		o The list of supports should address thoroughly the individual's need/desire for employment, and/or other meaningful day activities. ▪ Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component. Although it was clear that efforts had been made to include some of these pieces for some of the individuals, for none of the four individuals was this level of detail provided. Individual #360 was in school, but no coordination with the school was defined. On a positive note, for Individual #82, there was some description of the plans that needed to be implemented at the vocational workshop (e.g., communication dictionary, PBSP, etc.). o Positive reinforcement, incentives, and/or other motivating components to an individual's success should be included in the list of pre-/post-move supports. Other than global supports related to involving individuals in preferred leisure activities, supports that integrated individualized positive reinforcement of incentives were missing from the three plans reviewed. o There should be pre-/post-move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. Some efforts to include these were noted (e.g., Individual #360). o There should be pre-/post-move supports for the provider's implementation of supports, including, for example, the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue: ▪ As appropriate, teams should identify as post-move supports the implementation of current plans (e.g., nursing	

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		care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications should be made to the methodology for providing these supports, with the end result being the individual's need for the support being met. Based on review of the four plans, generally PBSPs were referenced as needing to be implemented, but other plans, such as nursing care/IHCPs often were not, and it was unclear if all components of PNMPs had been translated into supports, or clear justification provided for not including them; ▪ CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community. For the three individuals for whom this appeared to be applicable (i.e., Individual #232 for ENT and obtaining a guardian; Individual #82 for ENT, and Individual #360 for glasses and an EKG), follow-up action steps were included as post-move supports; o All recommendations from assessments should be included, or if not, a rationale should be provided. For many recommendations for all four individuals, corresponding pre- or post-move required supports were included. However, for each of the four individuals, there were recommendations that were not included, and for which adequate justification had not been provided for not including them. ▪ 2) <u>The wording of every pre-/post-move support should be in measurable, and observable terms</u>: Most supports were measurable. However, for each of the four individuals, supports were included that were not measurable (e.g., "encourage to eat slowly," or monitor for skin breakdown without providing a frequency). ▪ 3) <u>Every pre-/post-move support should include a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur</u>: For each support, evidence was listed. However, as noted above, sometimes without a frequency listed, and/or with multiple supports listed within one block, it was difficult to tell what evidence was expected for which supports. In summary, since the last review, important improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. Although the CLDPs continued to be missing a number of necessary protections, services, and supports, it was positive that the Facility had focused on improving the quality and comprehensiveness of the CLDPs, particularly the pre- and post-move required supports.	

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		<u>Essential Supports in Place on the Day of the Move</u> The Facility did not submit any reports from the Local Authority (previously Mental Retardation Authority) as assurance that pre-move supports were in place prior to an individual's transition. As noted in previous reports, the LA's review appeared to be a general safety assessment as opposed to an individualized assessment based on the pre-move supports identified by the team. As noted in previous reports, the Facility was having the Post-Move Monitors conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. In its pre-review document request, the Monitoring Team asked for: "For the last six months, all completed pre-move and post-move monitoring checklists and any related documentation for the last 10 individuals (unless the reviews for these individuals were included in the document production for the Monitoring Team's previous reviews) who moved to the community from AUSSLC, including additional documentation, if any, that reflects follow-up activity taken by the PMM, IDT, or the Facility in response to issues identified in the post-move monitoring checklists." However, the Facility did not provide any pre-move monitoring documentation. As a result, the Monitoring Team could not assess the following: ▪ b. For the ___ of ___ individuals (___%), a pre-move site review was conducted by the Facility. ▪ c. Of these ___ individuals' pre-move site reviews, ___ (___%) were done timely and completely. ▪ d. Of these ___ individuals' pre-move site reviews, ___ (___%) indicated that all of the essential supports were in place prior to the individual's move. ▪ e. The following indicator was not completed, because the Monitoring Team did not observe any pre-review site visits: For___ of __ (%) pre-move site visits observed by the Monitoring Team (if any), the pre-move site visit was conducted thoroughly. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. The Facility did not provide the Monitoring Team with documentation to review with regard to confirmation of pre-move required supports. In addition, although improvement had occurred with the delineation of the pre- and post-move required supports in individuals' CLDPs, a number of protections, supports, and services continued to be missing from the CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans	a. There was not a written policy or written process for quality assurance to ensure the: a) development; and b) implementation of CLDPs. As discussed above, at the time of the review, the Facility did not have a final local policy on the most integrated setting. Facility staff reported that the draft Facility policy had been reviewed at the Executive	Noncompliance

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	are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	meeting the week of the Monitoring Team's onsite review. Staff reported that additions were being made in relation to the pilot project, and then it was expected to be finalized and staff trained. The draft provided in the Presentation Book did not include the level of detail necessary for the localization of the State Office policy. It essentially just reiterated the State Office policy. It did not define the specific procedures the Facility would use to conduct quality assurance activities related to CLDP, and the Facility's implementation of them. b. Data were not collected consistently. The Facility submitted just one completed monitoring tool for a CLDP. In addition, the data were not being collected reliably, and it was unclear that the data were valid. The tool being used did not define the standards used, and did not result in valid findings. Inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. Although the Admissions Placement Coordinator reported that she planned to work with the QA Department on establishing inter-rater reliability. c. The QA Department and Admissions Placement Department had not been meeting monthly to review data, because monitoring had not been completed, and so data was not available. Until valid data are available, the following indicators cannot be assessed in any meaningful way: Data **were/were not** reviewed, summarized, and analyzed. Actions **were/were not** taken as a result of analysis of the data. The data **were/were not** included in the Facility's QA program. d. The following was not applicable, because no one had returned to the Facility: For __ of the ___ individual (__%) who returned to the Facility after a failed community placement, an adequate review **was/was not** conducted to determine if changes in the referral and transition planning processes at the Facility should be made. As a result of no actions being recommended in relation to the referral and transition process, the following indicators were not completed: Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). e. One individual (i.e., Individual #232) that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the Facility should be made for none (0%) of the cases. Of these reviews, actions were recommended in one case. Due to the recent completion of the review, the following could not be assessed: Of these ___ cases, actions were implemented for ___ (%). Although the team met and conducted an ISPA for Potentially Disrupted Community	

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		Transition, the team only identified some of the pertinent issues. It was positive that the team identified a number of corrective actions, including the need to inform community providers and include as supports in the CLDP the need for AUSSLC clinicians to contact their community counterparts, based on the individuals needs; require as post-move supports that providers notify the Facility of changes to agreed-upon supports as well as unusual behavior of the individual; ensure guardianship discussions are taking place during ISP meetings; learning more about provider medical protocols during interviews or tours; and developing a "Quick Reference Sheet" to accompany the CLDP. However, based on the Monitoring Team's review of Individual #232's CLDP, a number of supports were missing. For example, for this individual who had a number of risk areas and medical/nursing needs, the CLDP did not reflect a plan with the clinical intensity necessary to meet her needs. The role of nursing was only minimally defined, and mostly in reference to what direct support staff needed to report to nursing. The IHCP and nursing plans that should have been in place were not carried forward through the transition planning process, and the level of nursing/qualifications of nursing staff were not defined. However, despite this individual's death, the team did not conduct a comprehensive critical review of the CLDP to identify these missing supports. As noted above with regard to Section T.1.c and T.1e, other supports were missing from her CLDP, but the team did not identify many of the missing supports. f. The information the Facility provided was not sufficient to determine the following: Over the past year, of the ____ individuals transitioned, ____ (___%) experienced one or more potentially negative outcomes since transition. Of the ____ individuals not previously discussed, there was an adequate review conducted for none (___%) of the cases to determine if changes in the referral and transition planning processes at the Facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). Based on the information provided, however, there were two deaths, one police contact, three psychiatric hospitalizations, eight ER visits, and two transfers to other locations. From the information provided, it did not appear for many of these that ISPA meetings were held, and when the Facility was asked for all documentation of meetings for Potentially Disrupted Transitions, the only information provided was for Individual #232, as discussed above. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should increase and improve its monitoring activities for CLDPs, including modifying, as appropriate, the monitoring tool to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In	

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		addition, as valid monitoring results are obtained, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. It is also essential that the Facility conduct critical reviews of the CLDP development and implementation processes for individuals that experience potentially negative outcomes.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	a. The Facility maintained a list of individuals whose referrals had exceeded 180 days, and the obstacles teams had identified. Although the Facility had a system to collect information about obstacles to transition, it was not adequate, because it only collected information about obstacles after the individual's referral had exceeded 180 days. Based on discussions with staff, they were not collecting data on obstacles to transition throughout the transition process. As one example, staff reported that day programs that could support individuals that required a pica-safe environment were generally not available. Facility staff reported that teams were considering in-home day programs as a result of this lack to community capacity to meet individuals' needs. However, if this obstacle did not push individuals' referrals past the 180-day point, then it would not be documented as an obstacle. As discussed during the onsite review, reported obstacles should include both issues that prevent transition as well as "compromises" to meeting the individual's needs and/or preferences as outlined by the IDT. The use of an in-home day program for an individual for whom an out-of-home pica-safe day program environment cannot be located would be such a compromise. Other examples of compromises would include the individual "settles" for a day habilitation program because the vocational program that the team recommended or that the individual preferred was not available in the part of the state in which the individual/guardian wanted to live; or the individual moved to an area of the state that was not the original preference because clinical services were not available close to family or in a part of the state that the individual preferred. It will be important as a system for collection of obstacles to transition is finalized to include these types of obstacles. This is essential to ensure that State Office has information to identify areas in which community capacity should be expanded. On February 26, 2013, DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. In its last report, the Monitoring Team provided detailed comments on the Obstacles report, which explained both the positive aspects of this report, as well as the reasons for ongoing noncompliance. At the time of the Monitoring Team's most recent onsite review, the annual obstacles report had not yet been updated, and, therefore, no new comments are provided here. As	Noncompliance

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		noted in the Monitoring Team's last report, improvements in data collection and analysis, implementation of revised ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained. During future reviews the following indicators will be assessed: ▪ b. The Facility **did/did not** have an annual narrative that showed it had: a) conducted a comprehensive assessment of obstacles; and b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. ▪ c. The State **did/did not** present an annual narrative that showed it had: a) conducted an analysis of the Facilities' data; b) taken appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities; and c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to,	The Facility did not provide an accurate Community Placement Report for six months prior to the onsite review. Although the Facility provided a report that included the following information: ▪ Number and names of individuals transitioned to the community; and ▪ Number and names of individuals on the active referral list. The following information was not included in the Community Placement Report: ▪ Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference. The list included in the Community Placement Report was entitled: "LAR Preference to Remain at SSLC-Regardless of Preference of Individual." This list was different than the category of those individuals whose IDTs would have referred them, but they were not solely due to LAR preference. However, the Facility provided a list (TX-AU-1402-XVI.4) that provided this information for the previous six months. As a result, it was clear that the Facility had the data, but for an unknown reason had not included it in the Community Placement Report. Because this was a change in the requirements for this subsection pursuant to the Protocol and Metrics for Section T, the Facility was found to be in substantial compliance rating with this provision. However, the Facility must implement the following **mandatory recommendation** in order to maintain the substantial compliance rating during the next review: the Facility should correct the Community Placement Report to include the list of individuals that would have be referred by the IDT, but were not due	Substantial Compliance

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	medical, housing, employment, and transportation. Community services do not include services provided in a private nursing Facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	solely to LAR preference. In addition, during future reviews, the Facility will be expected to provide a Community Placement report for six months ending on the week prior to the onsite review.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for ten individuals who had transitioned from AUSSLC to the community and for whom since the last review, the Post-Move Monitors had conducted post-move monitoring (i.e., Individual #155, Individual #82, Individual #360, Individual #232, Individual #247, Individual #115, Individual #101, Individual #428, Individual # 364, and Individual #219). For these individuals during the time period reviewed, the AUSSLC Post-Move Monitor should have conducted 23 reviews. Of the 23 required visits, 18 (78%) had been documented as having been completed on time. The following problems were noted: the 45-day review for Individual #232 was late by four days; documentation was not provided for the 45-day review for Individual #360, or the 90-day review for Individual #247; and the 45-day review for Individual #247 was dated the same day as the seven-day review. <u>Visits to All Sites</u> It generally appeared that visits had been made to both the residential and day sites of the individuals, and that this was documented in the reports. <u>Content of Checklists</u> Based on a review of nine post-move monitoring reports for five individuals (i.e., Individual #82, Individual #364, Individual #115, Individual #232, and Individual #360), one (11%) was completed thoroughly (i.e., the one for Individual #82, for whom thorough descriptions were included to confirm that all pieces of the supports were in place, and also described the quality as opposed to just the presence of items). The following problems were noted: ▪ For most individuals in the sample, little evidence was provided to support the	Noncompliance

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		findings, and as a result, the findings were not substantiated. ▪ In some cases, it appeared the list of evidence included in the CLDP had just been reiterated without actual evidence to show what was found when the reviews were conducted. ▪ The quality of supports was often not assessed. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the five individuals reviewed, five of them had needs identified for follow-up to be conducted to ensure supports were implemented. ▪ For none of the five individuals (0%), documentation was presented to show that adequate action had been taken. The following summarizes the concerns: o Although for Individual #82, there were good action plans listed, documentation was not presented to show that the issues were resolved, or followed through to completion. For other individuals, similar issues with documentation of follow-through were noted (e.g., Individual #364). o Action plans were sometimes not written (e.g., Individual #115), or they did not address the specific issues (e.g., seven-day for Individual #364). o Changes that community providers had made to agreed-upon supports either were not brought back to the team for review (i.e., Individual #360), or the team approved them without providing adequate justification (i.e., Individual #232). It is essential for the Post-Move Monitors to provide clear evidence in the reports. In addition, as the CLDPs continue to include more detailed protections, services, and supports, care will need to be taken to ensure that monitoring adequately confirms the existence and quality of the supports. When concerns are identified, clear action plans, and documentation to confirm completion of action plans should be maintained. The Facility remained out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately	For the week of the onsite review, a post-move monitoring visit was on the schedule the Facility submitted. On the morning of the visit, shortly prior to the group's departure for the visit, State Office staff informed the Monitor that the visit was not a full post-move monitoring visit, but was a follow-up visit to review the completion of a couple of specific issues identified during the previous review. Although it was helpful for the Monitor to observe the Post-Move Monitors conduct a follow-up visit, because it was not a full	Not Rated

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	10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	review and did not result in a written report addressing all of the pre- and post-move supports, the Monitoring Team could not rate this subsection. On a positive note, generally, it appeared that the Post-Move Monitors conducted thorough follow-up on the previously identified issues.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC. Since the last review, two individuals had transferred from AUSSLC to another SSLC (i.e., Individual #379, and Individual #189). Based on a review of the discharge summary completed for Individual #189, it contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. This summary appeared to "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plan appeared to meet the minimal CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge	Substantial Compliance

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	expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ **If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause:** Based on the information provided, in one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., being closer to family). ▪ **The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies):** Based on the information provided, for one out of one individuals (100%), reasonable time was given to prepare. ▪ **At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status:** The final summary included each of these components, and for one of the one individual (100%), the information was adequate. ▪ **With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies:** For one of the one individual (100%), AUSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility (i.e., the discharge summary narrative identified information that was shared). ▪ **The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment:** Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for one of the one individual (100%) adequately described the key supports that the individual would need in his new setting. As appeared to be the intent of this subsection of the Settlement Agreement, the same standards for an adequate plan found in other subsections of Section T were not applied here. As a result, the Facility was found to be in substantial compliance with this provision.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Prioritized List of Those in Need of a Legally Authorized Representative (LAR), revised January 2014; o List of individual for whom guardians have been obtained, including letters of guardianship; o Over the six months preceding the monitoring visit, documentation showing the activities the facility took to obtain LARs or advocates for individuals needing them; o Draft Individual Rights Assessment with instructions, dated February 2014; o Presentation Book for Section U; o Self-Assessment for Section U, updated 2/4/14; and o Action Plans: Section U, updated 2/7/14. ▪ **Interviews with**: o Keith Robinson, Human Rights Officer; and o Desiree Martinez, Human Rights Officer.
	Facility Self-Assessment: The parties agreed the Monitoring Team would conduct a limited review of Section U (i.e., updates only). Therefore, the Facility Self-Assessment was not assessed.
	Summary of Monitor's Assessment: For individuals for whom guardianship appeared necessary, with the leadership of the Human Rights Officers, teams had begun to complete the Facility's prioritization tool again. It was good that this tool would now be reviewed annually, because as Facility staff recognized individuals' needs change, and, to the extent possible, the limited guardianship resources need to be targeted to the individuals with the highest priority need. The Facility had a Guardianship Committee that began functioning again within the last few months. It played an important role in reviewing and further prioritizing the need for guardianships. The Facility continued to have a strong relationship with the probate court, and this had a number of benefits to assist in obtaining and maintaining guardians for individuals that need them. The recent addition of a certified guardian to the pool of potential guardianship resources also is helpful. A significant remaining issue was that the list of individuals requiring guardians was not based on a valid process for determining individuals' functional decision-making capacity. As Facility staff recognize, guardianship is an extremely restrictive practice. A draft assessment process had been shared with the Facility. Once such a process is finalized, individuals' teams will need to assess individual's capacity, and this should include identification of less restrictive supports that might assist some individuals to make decisions.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ For individuals for whom guardianship appeared necessary, with the leadership of the Human Rights Officers, teams had begun to complete the Facility's prioritization tool again. It was good that this tool would now be reviewed annually, because as Facility staff recognized individuals' needs change, and, to the extent possible, the limited guardianship resources need to be targeted to the individuals with the highest priority need. As part of the ISP Preparation meetings, teams were completing the tool for individuals without guardians. The Human Rights Officers calculated the actual scores. ▪ The Facility had a Guardianship Committee that began functioning again within the last few months. It met in July and August 2013, and then had resumed meeting on January 29, 2014. The plan was for it to meet the second Wednesday of every month. It played an important role in reviewing and further prioritizing the need for guardianships. The Committee reviewed the priority list twice a year. The review involved review of the tools the teams had completed. The Committee identified the seven to 10 individuals with the highest need for a guardian. ▪ Staff from AUSSLC had gone to another SSLC to learn about their Guardianship Committee. They had come back with some ideas that they were pursuing, including, for example, looking into whether community members could participate on the Guardianship Committee. As discussed, such involvement could potentially provide new resources for guardianship. ▪ A significant remaining issue was that the list of individuals requiring guardians was not based on a valid process for determining individuals' functional decision-making capacity. As Facility staff recognize, guardianship is an extremely restrictive practice. A draft assessment process had been shared with the Facility. Once such a process is finalized, individuals' teams will need to assess individual's capacity, and this should include identification of less restrictive supports that might assist some individuals to make decisions.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ The Facility continued to have a strong relationship with the probate court, and this had a number of benefits to assist in obtaining and maintaining guardians for individuals that need them. Recent contacts had occurred in December 2013 and January 2014. ▪ The recent addition of a certified guardian to the pool of potential guardianship resources also is helpful. This former staff member had become the guardian for one individual, and was considering petitioning to become the guardian for other individuals. ▪ The current waitlist for the private, nonprofit guardianship agency in the area was approximately two to three years. As noted above, the Guardianship Committee was making efforts to identify individuals with the highest priority need so that when opening became available or other resources were identified, individuals who had a priority need already would be identified. ▪ A total of 23 individuals had been referred for guardianship. ▪ The Human Rights Officers had met with the Director of Community Relations. They were partnering to develop a presentation that could be used in various arenas (e.g., with civic groups, in churches, etc.) to explain the need for volunteers, including advocates and guardians.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Active Record Order and Guidelines, revised 4/5/13; o Table of Contents for Master Record, printed 1/24/14; o Individual Notebook and Guidelines, revised 10/22/12; o Table of Contents for Facility Policy Manual, dated 12/23/13; o New/Updated Policy Training Checklist; o Self-Assessment for Section V, updated 2/4/14; o Action Plans: Section V, updated 2/7/14; and o Presentation Book for Section V. ▪ **Interviews with**: o Bailey Kessler, Unified Records Coordinator; o Lori Mayer, Unified Records Clerk; o Annabelle Cantu, Unified Records Clerk; and o Holly Lindsey, Director of Quality Assurance.
	Facility Self-Assessment: Facility Self-Assessment: The parties agreed the Monitoring Team would conduct a limited review of Section V (i.e., updates only). Therefore, the Facility Self-Assessment was not assessed.
	Summary of Monitor's Assessment: The Records Department had reviewed all of the Individual Notebooks to ensure they were current and organized. In addition, the Records Department had continued to audit active records, and had focused on making sure necessary documents were present in the records. When issues were found, a process was in place to request corrective action, and to follow-up with supervisory staff, if corrections were not made. This data also was now being looked at on an aggregate level, with some Corrective Action Plans developed and underway, and some others slated for development. A pilot project had proved successful in increasing staff's compliance with signing in and out records, and returning them at the end of the day. Facility staff self-identified that the next area of focus for audits would be on correcting some of the quality components of the records, such as legibility. The Facility recognized the need to continue efforts to localize State Office policies, and revise older policies. Although this has been somewhat slow, progress was made since the last review, and a plan is in place to move forward with this process.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ The Records Department reviewed all of the Individual Notebooks to make sure they were current and organized. The Special Considerations list was discontinued, so it was removed from the Individual Notebooks. ISPs were moved into the Individual Notebooks with a reference sheet in the Active Record. ▪ To improve the quality of the Active Records, using the data from the monthly audits, emails were sent asking responsible staff to make needed corrections. Staff had two days to make corrections. Each week, the Director was sent a list of outstanding requests. In addition, on a monthly basis, the Records Department staff sent a trend report to discipline leads showing the numbers of specific documents missing from the records. The Facility's focus had been on the completeness of the records, and current documents being in the records. Some tracking of the quality of the documents was occurring, but the Facility identified this as the next area requiring focused efforts. ▪ To increase the use of the correct forms, the Records Department had developed folders in the Shared Drive in which they maintained the most recent versions of forms. ▪ The Records Department had added a third column to the Active Records Order and Guidelines Tool. To this column, they added comments or descriptions to elaborate on the meaning of what should be included in the specific sections of the record, and to localize the Guidelines to reflect documents at AUSSLC. This appeared to assist in the Clerks' understanding. ▪ A Corrective Action Plan had been implemented to secure the records in each of the residences. Locked cabinets had been installed in each residence, and staff were issued keys. Records Department staff indicated challenges continued to exist with keeping the cabinets locked, but efforts were being made in this regard.	Noncompliance
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ In December 2013, the Facility had revised its policy related to policies. It established a process for the development and approval of policies, including a standardized format for policies. After the QA Department's review, the Executive Leadership Team was responsible for review and approval of policies, and could request corrections prior to finalization. The policy also set forth mechanisms for the issuance and communication of new/revised policies, and training and tracking of training of staff. A New/Updated Policy Training Checklist was being used, and appeared to include relevant information, including, for example, who needed to be trained, and the level of training needed, as well as responsibilities for certifying staff had completed training. The Executive Leadership also approved the training requirements. The Quality Assurance Department and Competency and Training Department shared responsibility for tracking training. The policy also required annual review of policies, and updating, as necessary. Review of the policy showed it included the necessary components. ▪ Facility staff reported that many of the current policies were out-of-date. They had prioritized policies for development, review, and/or updating based on reasonable factors, including, for example, those policies needed to respond to corrective actions the Regulatory Department were requiring, as well as ones the Systems Committee had identified as necessary.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ The Facility continued to conduct audits of records using a sampling methodology that included five percent of the records each month. As noted with regard to Section V.1, some of the data was being used to identify and follow-up on issues needing corrective action. In terms of documents missing from the records, the Records Department sent emails to responsible staff requesting corrections, and sent trend reports to discipline heads. As discussed above, the Facility Director received a weekly email with a list of outstanding requests related to individual records. Discipline data was shared at QA/QI Council monthly. ▪ The Records Coordinator planned to meet with the QIDP Director to discuss the	Noncompliance

#	Provision	Assessment of Status	Compliance
		need for an action plan to address the many documents for which QIDPs were responsible that were missing regularly. ▪ The Records Department had identified a problem due to full colonoscopy reports having been purged. A plan was put in place, and work done to retrieve the purged documents, and ensure they were now maintained in the Active Records for 10 years. ▪ The Records Department worked with the QA Department to determine when Corrective Action Plans were needed. ▪ The Records Department intended to begin focusing efforts on improving legibility and ensuring staff signatures were present and legible. ▪ The Records Department had created the Active Records File Tracking form that Clerks used to document the dates of the receipt and filing of documents. This information then was maintained in the Shared Drive and used as part of the record audits. Clerks also used a specific stamp to show when a document was filed. These procedures provided accountability by confirming when documents were or were/not submitted.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ To ensure records were available when needed, the Facility had taken steps to tighten its check-out/check-in processes. One residence for each Clerk had been identified, and each day, the Clerk checked to determine if the records were accounted for properly. This had worked well for the pilot residences, and it was anticipated the project would expand to include other residences. ▪ The Facility staff indicated that the use of records had been incorporated into the Section F tool, but recognized that other efforts were needed to determine if records were being used in making clinical and training decisions.	Noncompliance

List of Acronyms

Acronym/ Symbol	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Automatic Defibrillator
AED	Antiepileptic drug
AFO	Ankle Foot Orthoses
AMA	Annual Medical Assessment
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia/Enteral Nutrition
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ART	Administrative Review Team
ASH	Austin State Hospital
ASHA	American Speech-Language-Hearing Association
ASL	American Sign Language
AT	Assistive Technology
ATPC	Active Treatment Program Coordinators
AUSSLC	Austin State Supported Living Center
BCBA	Board Certified Behavior Analyst
BHA	Behavior Health Assessment
BHS	Behavioral Health Services
BHS 5/QA	Behavioral Health Services 5/Quality Assurance
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
CAP	Corrective Action Plan
CAPPS	Comprehensive Assessment Program Planning System
CBC	Complete Blood Count
CBT	Competency-based Training
cc	Cubic Centimeter
CDC	Centers for Disease Control
C-Diff	Clostridium difficile
CE	Continuing Education

CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid
CNE	Chief Nursing Executive
CoS	Change of Status
COTA	Certified Occupational Therapy Assistant
CPAP	Continuous Positive Airway Pressure
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency Training and Development
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DARS	Texas Department of Assistive and Rehabilitative Services
DCS	Direct Care Staff
DD	Developmental Disabilities
DEXA	Dual-energy x-ray absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DPN	Dental Progress Note
DRO	Differential Reinforcement
DRR	Drug Regimen Reviews
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EDWR	Estimated Desired Weight Range
EGDs	Esophagogaastroduodenoscopies
EKG	Electrocardiogram
EMS	Emergency Medical Services
ENT	Ear, Nose, and Throat
EPS	Extrapyramidal Motor Side Effects
ER	Emergency Room
F12	Fluoride
FAIF	Functional Assessment Interview Form
FAST	Functional Assessment Screening Tool
FBA	Functional Behavior Assessment

FDA	Federal Drug Administration
FNP	Family Nurse Practitioner
FSA	Functional Skills Assessment
FTE	Full-time Equivalent
GA	General Anesthesia
GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-J	Gastrojejunostomy
gm	Grams
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
Hgb	Hemoglobin
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HT	Habilitation Therapy
I and O	Intake and Output
I-Book	Individual Notebook
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICD	International Statistical Classification of Diseases and Related Health Problems
ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
IU	International Unit
IV	Intravenous
J-tube	Jejunostomy Tube
L	Liters
LA	Local Authority
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
LOS	Level of Supervision
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study

MD	Medical Doctor
MDRO	Multi-drug resistant organism
mg	Milligrams
MH	Mental Health
MHMR	Mental Health Mental Retardation
ml	Milliliters
MMC	Mealtime Management Committee
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
NEO	New Employee Orientation
NG	Nasogastric
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nursing Operations Officer
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OIG	Office of Inspector General
OJT	On-the-Job Training
OOH	Out of Hospital
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Assessment of Living Skills
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PE	Psychological Evaluation
PEG	Percutaneous Endoscopic Gastrostomy
PFA	Personal Focus Assessment
pH	Potential Hydrogen
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMT	Physical Nutritional Management Team
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PO	By mouth
POI	Plan of Implementation
PP	Patient Population

PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Aide
q	Every
QA	Quality Assurance
QABF	Questions About Behavioral Function
QDDP	Qualified Developmental Disability Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QID	Four times a day
QIDP	Qualified Intellectual Disabilities Professional
REACT	Respiration, Energy, Alertness, Circulation, and Temperature
RD	Registered Dietician
RN	Registered Nurse
R/O	Rule Out
ROM	Range of Motion
RT	Respiratory Therapist
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAMS	Self-Administration of Medications
SAP	Skill Acquisition Program
SES	Skills Engagement Specialist
SFAR	Structural and Functional Assessment Report
SFBA	Structural and Functional Behavior Assessment
SGD	Speech Generating Device
SIA	Systems Improvement Agreement
SIB	Self-Injurious Behavior
SL	Speech Language
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment and Plan
S/P	Status Post
SPO	Specific Program Objective
SSLC	State Supported Living Center
STD	Sexually-transmitted disease
TB	Tuberculosis

TF	Trust Fund
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UA	Urinalysis
UGI	Upper Gastrointestinal
UTI	Urinary Tract Infection
VPA	Valproic Acid
VNS	Vagus Nerve Stimulators
VRE	Vancomycin-Resistant Enterococci
VRI	Viral Respiratory Infection
VS	Vital Signs