United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Review: April 5 through 9, 2010

Date of Report: June 11, 2010

Submitted By: Maria Laurence, MPA

Monitoring Team: Elizabeth Jones, MS
Victoria Lund, Ph.D., MSN, ARNP, BC
Susan Thibadeau, Ph.D., BCBA-D
Nancy Waglow, MS, MEd

Table of Contents

Introduction 2
- Background 2
- Methodology 3
- Organization of Report 5

Executive Summary 6

Status of Compliance with Settlement Agreement
- Section C: Protection from Harm – Restraints 15
- Section D: Protection from Harm - Abuse, Neglect and Incident Management 27
- Section E: Quality Assurance 55
- Section F: Integrated Protection, Services, Treatment and Supports 59
- Section G: Integrated Clinical Services 71
- Section H: Minimum Common Elements of Clinical Care 73
- Section I: At-Risk Individuals 76
- Section J: Psychiatric Care and Services 84
- Section K: Psychological Care and Services 85
- Section L: Medical Care 101
- Section M: Nursing Care 102
- Section N: Pharmacy Services and Safe Medication Practices 122
- Section O: Minimum Common Elements of Physical and Nutritional Management 133
- Section P: Physical and Occupational Therapy 164
- Section Q: Dental Services 173
- Section R: Communication 179
- Section S: Habilitation, Training, Education, and Skill Acquisition Programs 191
- Section T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs 200
- Section U: Consent 219
- Section V: Recordkeeping and General Plan Implementation 225

Health Care Guidelines 231

List of Acronyms 235

Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers (SSLC), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Austin State Supported Living Center.

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in a section of the report for which another team member had primary

responsibility. For this baseline review of Austin SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Elizabeth Jones reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance; Victoria Lund reviewed nursing care, dental services, and pharmacy services and safe medication practices; Susan Thibadeau reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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

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 April 5th through 9th, 2010, the Monitoring Team visited Austin State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

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

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

community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

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

(c) **Observations –** While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, PSP team meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews –** The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

On April 6, 2010, the Monitor had the opportunity to meet with members of Austin State Supported Living Center's Family Association. During this meeting, the families and guardians in attendance provided the Monitor with information about the Facility, and their and their family members' experiences with the protections, supports and services offered by AUSSLC. The family members present at the meeting shared many positive stories regarding the supports offered their loved ones. In recognizing the hard work of many staff at the Facility, a number of the family members expressed the desire to ensure that staff were adequately compensated for their work, and had the supports necessary to do their jobs.

It was a pleasure for the Monitor to meet the families who attended the meeting, and listen to their input. Their family members who live at AUSSLC are fortunate to have them as strong advocates. The Monitor

looks forward to continuing to hear from family members at upcoming monitoring visits during which it is hoped similar sessions will be scheduled for the purpose of offering families and other stakeholders the opportunity to provide information to the Monitor.

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, and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the Facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each Facility, this section will highlight, as appropriate, areas in which the Facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the Facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA and each of the chapters of the HCG, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;

(b) **Summary of Monitor's Assessment:** Although not required by the SA, 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;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the Facility undertook to assess compliance and the results thereof. The Facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the Facility self-assessments for reviews beginning in July 2010;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July 2010; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Austin State Supported Living Center for their welcoming and open approach to their first monitoring visit. It was clear that the State's leadership staff and attorneys, as well as the management team at Austin SSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between AUSSLC and the Monitor's Office.

The issue of greatest concern at Austin SSLC was the critical shortage of staff, resulting in a heavy reliance on overtime, the use of agency staff, and the use of "pulled" staff from other programs on campus to cover for staff vacancies and/or absences. According to a report, dated 2/24/10, provided by the Administration, the annualized turnover rate in FY 2010 "Year-to-Date through 2010-01" for Mental Retardation Assistants was 68.3 percent. At the time of the review, there was a vacancy rate of over 15 percent.

It is essential to note that the Monitoring Team met many staff members throughout the Facility who appeared capable and committed. Despite serious issues related to staffing coverage, a number of staff persons were observed working diligently and effectively to provide essential services and supports. Interviews with many staff during the baseline review showed evidence of a commitment to the safety and habilitation of the individuals to whom they were providing

supports. Unfortunately, the extensive use of involuntary overtime resulting from significant staff shortages and turnover appeared to have created a serious staff morale problem.

During the baseline review, a number of other factors were identified that had the potential to place individuals served by AUSSLC at risk of harm. Some of these were likely related to the instability in staffing. For example:

- In certain residential units, there were repeated observations of the failure to attend sufficiently to individuals with significant needs for support. For example, in some residences, there was a serious failure to monitor behavioral issues as required by Behavioral Support Plans.
- There was frequently a lack of interaction between individuals and staff, including individuals who appeared to have a need for support being left unattended for periods of time. This was particularly pronounced during periods such as mealtimes and morning routines.
- Dehumanizing practices were observed, such as extremely shortly cropped haircuts for women with no individualization, a lack of home-like environments, and individuals wearing clothing that clearly did not fit. As has been illustrated throughout the history of this field, when practices such as these are allowed, there is a high risk that staff will view individuals as less than human, and treat them as less than human, resulting in abuse, neglect, and other harm.
- There were some inappropriate groupings of individuals with very different, often unique, needs for support. For example, it was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space.

In order to protect individuals from harm and in order to comply with the Settlement Agreement, decisive action will be required to address the critical staffing shortages, and improve the quality of life issues at AUSSLC. At the time of the review, an Interim Director had been in place for approximately seven weeks. It was clear from the Monitoring Team's interactions with her, as well as interviews with other staff, that she already had begun to make needed changes, and was empowering her management team to do the same. It is the Monitor's understanding that since the Monitoring Team's onsite review was completed, a new Director has been identified. It is the Monitoring Team's hope that with this stabilization of the management team that the positive changes begun by the Interim Director and her team will continue to positively impact outcomes for individuals served at Austin State Supported Living Center, as well as for staff working there.

At the time this report was issued, information was not available with regard to the Facility's status with Section J of the Settlement Agreement that addresses Psychiatric Care and Services, or Section L of the SA that addresses the provision of Medical Care. The Monitor apologizes for any inconvenience that this may cause.

As is illustrated throughout this report, AUSSLC had a number of good practices in place, and in a number of the areas in which a need for improvement was identified, the Facility had plans in place to make needed changes. In addition, AUSSLC's management team and staff generally appeared to be open to making additional changes as needed.

The following provides some brief highlights of some of the areas in which the Facility was doing well and others in which improvements were necessary:

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

Protection from Harm – Abuse, Neglect, and Incident Management

- The Monitoring Team met many staff members throughout the Facility who appeared capable and committed. Despite serious issues related to staffing coverage, a number of staff persons were observed working diligently and effectively to provide essential services and supports.
- At AUSSLC, the Quality Enhancement Department had a process in place to test staff's competence with regard to the requirements and processes for reporting abuse and neglect. Each month, Facility monitors randomly selected staff from each unit, and gave them a quiz. If staff did not attain a score of 100 percent, immediate refresher training was provided. This is a positive practice that both addresses issues on a staff-specific basis, but also provides the Facility with system-wide data.
- The Facility had begun to implement effective methods for monitoring injuries, the use of restraints, and allegations of abuse and neglect. The appropriate staff attended the Incident Management Review Team (IMRT) meetings, and information was presented in a clear and organized manner.
- An extremely positive practice at the Facility was the Self-Advocacy group, and the staffing supports that were dedicated to providing this group with the assistance it needed. This group was involved in numerous activities, a number of which involved learning about and exercising their rights.

Quality Assurance

- Staff responsible for Quality Enhancement at the Facility acknowledged that a number of efforts were just beginning to be implemented. Some monitoring protocols had been developed. There was evidence of the collection of valuable data, and the development of trending and tracking analyses.

Psychological Supports and Services

- At the time of the review, the Facility's Director of Behavioral Services, and one Psychologist I were Board Certified Behavior Analysts (BCBAs). The DADS Coordinator of Behavioral Services who had BCBA certification also provided additional support to AUSSLC, as well as all of the other SSLCs.

Most Integrated Setting

- The post-move monitoring that had been completed identified some issues with regard to the provision of services at the community sites. The follow-up to rectify issues identified appeared to be rigorous, and included notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community Mental Retardation Authority staff of the need for follow-up.

Guardianship

- AUSSLC was in the process of attempting to identify guardians for individuals who needed them, and had access to some valuable resources to assist them in accomplishing this, including: a) a private, nonprofit guardianship agency called Family Eldercare to which referrals could be made. Unfortunately, the waiting list for this program was approximately two years; b) through the Travis County Probate Court, a Guardianship Assistance Program that allowed family members who wanted to petition the court for guardianship to do so at no cost; and c) a strong relationship with the Travis County Probate Court that enabled the Facility to set up a "Guardianship Day," on which the Court with some regularity came to AUSSLC, and held guardianship hearings onsite.
- As a result of these efforts, since July 2009, 10 individuals had obtained guardians. Since 12/09, an additional 29 individuals had been referred for guardianship.

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

Protection from Harm – Abuse, Neglect, and Incident Management

- If there is to be compliance with the requirements of the Settlement Agreement, the reporting and investigation process for both the Department of Family and Protective Services (DFPS) and AUSSLC will require significant attention. Numerous problems were noted in the review of investigation reports and in discussions with Facility staff.
- Internal mortality reviews were being conducted, and deaths also were being reviewed by the survey and certification entity. Although the Facility had responded to some of the recommendations resulting from these reviews, a number of the underlying issues identified through the death review process had not been adequately addressed. As a result, individuals at the Facility continued to be at risk due to the potential for the recurrence of problems that clearly had been identified in these reviews.

Quality Assurance

- Staff had identified problems that impeded Quality Enhancement efforts. These problems included: fragmentation of follow-up activities; poor documentation; time constraints; delays in reporting; lack of support for the role of Quality Enhancement staff; and significant problems with staff turnover and staff shortages. Effective resolution of these critical problems will require a systemic approach.
- The ultimate measure of the effectiveness of the Quality Enhancement processes must be sustained improvement of the protections, services, and supports in the residential units. For example, regular and thorough monitoring of mealtimes is important, but improved outcomes likely will require that individuals be grouped in much smaller numbers with sufficient, properly trained staff.

Integrated Protections, Services and Supports

- The biggest challenge for AUSSLC with regard to Personal Support Plans appeared to be with regard to ensuring that team meetings included interdisciplinary discussions that resulted in one comprehensive, integrated treatment plan for each individual. As is noted in other sections of this report, issues with regard to adequate assessments impacted teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans.
- Quality Enhancement activities with regard to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.

At-Risk Individuals

- The current risk assessment tools used by AUSSLC did not provide an adequate comprehensive risk assessment for any of the areas addressed, and did not result in the appropriate identification of clinical risk indicators or risk levels for the individuals reviewed. Standardized statewide tools with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals' risk levels are appropriately identified.
- Once an appropriate risk identification system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and supports for at-risk individuals.

Psychological Services and Supports

- Although as noted above two psychology staff were BCBAs, given that 276 individuals residing at the Facility had behavior support plans, this was an insufficient complement of psychology staff with demonstrated competence in Applied Behavior Analysis (ABA).
- Information provided by AUSSLC's Director of Behavioral Services indicated that for only 41 individuals had some form of assessment of behavioral function been completed. This was only 15 percent of the individuals

with identified behavior support plans. Without an informed understanding of the possible function of identified problem behaviors, plans designed to effect positive behavior change are likely to fail to effectively address the behavioral issues.

- The behavior support plans that were in place provided a wealth of information about the individual. Most contained operational definitions of the target behaviors, a description of the hypothesized function of the same found under "Rationale for Current Intervention," and guidelines for staff to follow to prevent and address problem behaviors. It should be noted that in most cases, it was unclear how staff had identified the hypothesized function, because a formal Functional Behavior Assessment had not been completed. Other areas in need of improvement included identifying functional equivalent replacement behaviors, and enhancing the reinforcement strategies designed to promote positive change.
- It is essential that the data collection system that is used to monitor and evaluate individual progress be improved. As currently designed, this system lent itself to inaccuracies.

<u>Nursing Care</u>

- AUSSLC had 124 positions allotted for Nursing, and at the time of the review, had 25 vacancies. Of the 25 vacancies, 15 were for Registered Nurses (RNs) and 10 were for Licensed Vocational Nurses (LVNs). In order to meet minimum staffing ratios, the Facility used the services of six agencies. The lack of consistent nursing staff needs to be addressed to facilitate the provision of adequate clinical care, and positive outcomes for the individuals being served at the Facility.
- There were a number of significant problematic issues found regarding complete and adequate nursing assessments related to symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to the off-site medical center, as well as upon return to the Facility.
- The Nursing Care Plans at AUSSLC did not include appropriate and measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions.
- The medication administration system at AUSSLC needs to be critically reviewed and revised to ensure that nurses are following standards of practice when administering medications. The Medication Administration Observations should be conducted quarterly for all nurses who administer medications.

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

- At the time of the review, the Facility had a recent vacancy for a clinical pharmacist. Consequently, they were behind regarding the completion of the quarterly Drug Regimen Reviews (DRRs) for six homes. Once this position is filled, the Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is

specific supporting documentation that the recommendation was implemented by the physician or practitioner, or that clinical justification is documented for recommendations that are not implemented.

- The Facility had conducted drug utilization evaluations (DUEs) in November 2009 for Levothyroxine; and in February 2010 for Clopidogrel, and Clozapine. Although conclusions and recommendation were generated for each DUE conducted, there was no indication if these had been appropriately implemented.
- The Facility appeared to have a significant problem regarding the underreporting of medication errors. The Facility's own QE data indicated that significant issues existed regarding the medication administration, and error/variance systems. Nursing staff at the Facility did not consistently agree on what constituted a medication error that needed to be reported.

Physical and Nutritional Management

- Habilitation Therapies staff were working to build a foundation for a physical and nutritional support delivery system, but these supports were not being consistently implemented due to overriding staffing issues at AUSSLC.
- The Nutritional Management Team (NMT) membership was not stable from meeting to meeting. The Facility needs to review the membership of the NMT to identify a consistent group of clinicians and staff, and ensure these individuals have demonstrated competency in working with individuals with the most complex physical and nutritional management needs.
- Comprehensive assessments were not completed for individuals with complex physical and nutritional support needs. The NMT should provide integrated, comprehensive assessments for those individuals with the most complex physical and nutritional support needs. Such assessments should lead to the development of support strategies to minimize or remediate health concerns. There should be written, measurable, functional outcomes to be achieved.
- Mealtime errors observed by the Monitoring Team placed individuals at risk during mealtimes. There was a need to analyze dining plans within each home to determine the appropriate staffing ratio to ensure implementation of dining plan strategies.

Dental Services

- From the records reviewed, it appeared that beginning in mid-2009, individuals at AUSSLC generally were being seen at least every six months, and more frequently for restorative/preventative care. Prior to this time, there had been significant lapses in care.
- A system needs to be developed and implemented to accurately identify individuals who refuse dental care, and/or other reasons for missed appointments.
- From review of the dental documentation, AUSSLC uses both restraint and pre-sedation for a large majority of the individuals when providing dental services. Although the Facility was in the process of establishing programs to decrease the use of these methods, there were other SSLCs that have significantly lower usage, especially regarding the use of restraint. Consideration needs to be given to developing a statewide dental

committee that includes the Dental Directors of each of the Facilities to promote collaboration and consistency in policies and practices among the SSLC dentists.

Communication

- Seventeen (17) percent of the individuals living at AUSSLC had an augmentative device (low tech or high tech). Per observation, there were a significant number of individuals who needed communication systems, but did not have them.
- At the time of the review, individuals had been admitted to AUSSLC who were deaf, but they were not receiving appropriate communication supports and services. Although the Lead Speech Pathologist and Interim Director had been working to procure needed services, they were not available. Significant bureaucratic barriers had delayed individuals from having access to the use of a videophone. In addition, there were challenges to providing interpreters for individuals who used sign language as a primary method of communication.
- Multiple observations demonstrated that staff did not assist or encourage individuals to use generic communication systems that were available throughout campus. The Speech Department, in collaboration with administration and programmatic staff, will need to establish strategies to ensure functional communication becomes a priority initiative for the individuals living at AUSSLC.

Habilitation, Training, Education, and Skill Acquisition

- Individuals were frequently observed to be sitting idly with no interesting materials or activities to keep them engaged.
- Training objectives designed to meet the identified needs of the individuals will need to be written so that the staff have a clear understanding of the goal, schedule for implementation, needed materials, steps involved in teaching, and data collection systems. Progress on all objectives should be reviewed on a regular basis, and plans should be put in place to ensure maintenance and generalization of all learned skills.

Most Integrated Setting

- The Community Living Discharge Plans (CLDPs) reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Although it appeared from the narrative portions of the CLDPs that teams had discussed thoughtfully many of the essential supports required by individuals, teams did not consistently translate this discussion into a clearly identified set of essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.
- Post-move monitoring had not been completed for all of the individuals who had transitioned to the community. For the sample of five individuals reviewed, 25% of the required visits had occurred.

Guardianship

- DADS Central Office was still in the process of developing a policy on guardianship and consent. AUSSLC did not have a specific guardianship policy, but had a number of policies that referenced guardianship and/or consent.

None of these provided a description of the processes to be used for: 1) determining an individual's capacity to make informed decisions; or 2) identifying an individual's level of priority for pursuing guardianship.

- Moreover, the assessment tools being used by the Facility were inadequate to assist teams in identifying an individual's specific capacities or incapacities for providing informed consent in various areas, and/or in identifying supports that could potentially increase an individual's decision-making capacity.

Recordkeeping

- During the review, issues were noted with regard to the availability and quality of the individual records. This had the potential to impact staff's ability to utilize records in making medical treatment and training decisions. The Facility's QE staff had identified a number of similar issues. The QE Department was making efforts to inform appropriate staff about problems identified in specific individuals' records, and was developing a monthly summary report that aggregated information for the records reviewed. However, the QE reports did not appear to result in systemic actions being developed and implemented to correct existing problems.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy No.: 001: Use of Restraint, dated 8/31/09; o AUSSLC Policy: Medical Restraints, dated 8/07; o AUSSLC Policy: Limitation of Restraint as a Crisis Intervention, dated 11/24/09; o Restraint Documentation Guidelines for SSLCs, dated 11/08; o Incident Management Review Team meeting minutes for 7/09 through 3/8/10, and 3/15/10; o AUSSLC Incident Trending Report—Restraints, dated 6/09 through 9/09, and 12/09 through 2/09; o Restraints Entered Report, dated 12/1/09 through 2/28/10; o Medical records for the following individuals: Individual #406, Individual #421, Individual #139, Individual #435, Individual #19, Individual #395, Individual #396, Individual #83, Individual #103, Individual #350, Individual #276, Individual #210, Individual #446, Individual #179, Individual #333, Individual #202, Individual #89, Individual #401 Individual #344, Individual #374, Individual #156, Individual #77, Individual #283, Individual #284, Individual #233, Individual #342, Individual #30, Individual #160, Individual #304, and Individual #75; o Facility's list of Individuals for whom chemical and emergency restraints had been used, since July 1, 2009; o Facility's Restraint Analysis data for February 2010; o Facility's restraint data and trends analyses for 2010, year-to-date; o Behavior Support Plans for the following individuals: Individual #332, Individual #305, Individual #175, Individual #210, Individual #160, Individual #32, Individual #152, Individual #217, Individual #108, Individual #358, Individual #263, Individual #372, Individual #339, Individual #53, Individual #424, Individual #406, Individual #94, Individual #374, Individual #246, Individual #304, Individual #328, Individual #206, Individual #284, Individual #42, Individual #123, Individual #276, Individual #448, Individual #335, Individual #135, Individual #238, Individual # 409, Individual #326, Individual #182, Individual #364, Individual #378, Individual #299, Individual #167, Individual #350, Individual #75, Individual #212, Individual #389, Individual #2, Individual #124, Individual #170, Individual #344, Individual #360, Individual #341, Individual #95, Individual #195, Individual #219, Individual #86, Individual #56, Individual #98, and Individual #73; and o AUSSLC Restraints, dated 3/17/10

	▪ **Interviews with**: o Tammy Snyder, Director of Quality Enhancement; o Candace Guidry, State Office Coordinator for Quality Enhancement; o Jack Holcomb, Incident Manager Coordinator; o Adrian Watson, Investigator; o Aubrey Johnson, Investigator; o Jose Levy, Director of Behavioral Services; o Bruce Weinheimer, DADS Coordinator of Behavioral Services; o Rebecca Hall, RN, Chief Nurse Executive (CNE); o Carolyn Harris, RN, Nurse Operations Officer (NOO); and o Kim Sweeney, RN, Quality Enhancement (QE) Nurse ▪ **Observations of**: o QMRP Meeting, on 4/5/10; o Residential Services Meeting, on 4/6/10; o Behavior Therapy /Peer Review Committee, on 4/6/10; o Timber Creek Unit Meeting, on 4/8/10; o Human Rights Committee (HRC) Meeting, on 4/8/10; o Incident Management Review Team meetings, on 4/5/10 through 4/8/10; o During unannounced site visits, activities underway in the following sites: Residential sites 501, 727, 732D, 732E, 772 A, 772B, 791, 792, 793, 794, 796, 797, and 779, and Workshop building 544. In general, site visits included observation of the environment, interactions between employees and individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, as well as informal discussions with employees and some of the individuals; o During site visits, repeated heightened observations were made of the individuals living on 772A and 732D, as well as Individual #251, and Individual # 213
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: At AUSSLC, there appeared to be a clear intent to reduce the use of restraint. However, according to the AUSSLC FY 10 Trend Analysis Report for 2/1/10 to 2/28/10, during the month of 1/10, 223 restraints were documented. This was a significantly higher rate than in 12/09, when the monthly total was 62 incidents of restraint, or in 2/10, when the monthly total was 47. During the month of 1/10, a number of individuals had restraint usage exceeding three or more incidents in a rolling 30-day period. As AUSSLC continues to try to reduce restraint, Facility-wide issues that have the potential to cause a lack of adequate treatment should be identified and analyzed. For example, the high turnover rate and the frequent use of "pulled" staff, who may not be properly trained on individuals' Behavior Support Plans (BSPs), need to be analyzed to determine their potential impact on the use of restraint. In addition, the grouping and congregation of individuals at certain program sites also should be examined closely to determine if these sites provide adequate treatment to individuals with severe

	behavior concerns. Intensive efforts are required to address the use of restraints with individuals who present especially challenging behavioral issues. The Facility had begun to implement effective strategies to monitor the use of restraint. These strategies should be continued and supplemented with other proactive approaches to supporting positive behaviors.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The AUSSLC Policy Limitation of Restraint as a Crisis Interventions stated that prone restraint was prohibited, and the Facility reported that prone restraint was not used. Based on a review of 90 restraint records involving eight individuals (Individual #406, Individual #421, Individual #139, Individual #435, Individual #19, Individual #395, Individual #83, and Individual #103), there was no indication that prone restraint was used. The AUSSLC Policy referenced above required that the use of restraint be limited "to acute emergencies that place the individual or others at serious threat of violence or injury and only after less restrictive measures have been determined to be ineffective or not feasible." The policy listed examples of less restrictive interventions, including: redirection, changing staff, removing the source of irritation, and the use of non-threatening communication. According to Facility policy, restraint was prohibited for disciplinary purposes, for the convenience of staff or others, or as a substitute for effective treatment or habilitation. For 90 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 16 contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. For example, documentation of a restraint involving Individual #421 on 1/25/10, included documentation to substantiate an appropriate use of restraint. In the remaining 74 episodes, the documentation on the Restraint Checklists did not reflect the events leading to the restraint episode, but rather the resulting behaviors, such as aggression. Thus the reviewer was not able to determine if the restraints were being used for the convenience of staff or as punishment. For example, documentation of a restraint involving Individual #406 on 2/17/10, did not include adequate documentation. The policy explicitly prohibited certain types of restraint, specifically prone restraints and physical restraints where the individual is supine. Any restraint that secures an individual to a stationary object while the individual is in a standing position; causes pain that restricts an individual's movement; obstructs the individual's airway; impairs the individual's breathing; interferes with the individual's ability to communicate; extends	

#	Provision	Assessment of Status	Compliance
		muscle groups away from each other; uses hyperextension of joints; uses pressure points of pain; is prohibited by the individual's medical orders or individual service plan; or violates the individual's rights also was prohibited. In addition, any use of restraint must be for the shortest amount of time necessary, and must use the minimal amount of force or pressure necessary to ensure safety. At AUSSLC, restraint use was being monitored on a daily basis at the Incident Management Review Team meeting. The meeting minutes tracked the reasons for the use of restraint. Rationales for the use of restraint, and the use of alternative interventions were discussed for the individuals involved in the restraint incidents. The minutes showed that enhanced levels of supervision frequently were used to attempt to reduce the potential for restraint by providing additional supports to the individual to prevent the escalation of behavior. Individuals at risk of potentially problematic behavior were sometimes assigned one-to-one (1:1) staffing. The use of staff as substitutes for restraint was commendable. However, the high staff turnover rate, and the heavy reliance on "pulled staff" lessen the likelihood of a consistent response from staff, thereby increasing the likelihood of an individual's behavior escalating, resulting in restraint. During a situation with the possibility to escalate rapidly, staff working in Residence 772A used effective and calming interventions with an individual who was upset about the unforeseen delay in serving dinner. More specifically, when the individual threw a table in a small area that was crowded with individuals and staff, staff calmly de-escalated the situation, resulting in the least restrictive means being used to address the behavior, and avoiding the potential need for restraint. The Settlement Agreement prohibits use of restraint "in the absence of or as an alternative to treatment." As AUSSLC continues to try to reduce restraint, Facility-wide issues that have the potential to cause a lack of adequate treatment should be identified and analyzed. For example, the high turnover rate and the frequent use of "pulled" staff, who may not be properly trained on individuals' Behavior Support Plans (BSPs), need to be analyzed to determine their potential impact on the use of restraint. In addition, the grouping and congregation of individuals at certain program sites also should be examined closely to determine if these sites provide adequate treatment to individuals with severe behavior concerns. It was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a	

#	Provision	Assessment of Status	Compliance
		setting with fewer individuals that afforded individuals additional personal space. All of these factors should be considered as the Facility continues its efforts to reduce restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	At AUSSLC, the restraint checklist documented the length of the restraint, and the criterion for the individual's release. A restraint monitor was responsible for arriving at the site of the restraint, and completing the face-to-face assessment form. On the top of page 2, the restraint checklist had a section entitled Event Codes and Action/Release Codes. In the cases referenced below, the code number "7" was used as the release code. This number 7 meant that the individual was "Quiet/calm." Another option was the letter "L" that would mean that the individual was "released immediately when no longer immediate and serious risk of harm." This was not used in the records reviewed, and with the use of code "7," there was no indication as to how long the individual was calm and quiet and, therefore, whether release from restraint was timely. More specifically, the assessment forms for the last three physical restraints provided to the Monitoring Team indicated: ▪ The restraint of Individual #276 lasted from 9:45 a.m. until 10: 18 a.m. The restraint was used after the Individual became angry, kicked staff, and threw furniture. The restraint monitor arrived at 9:48 a.m. He documented that the restraint was applied correctly. The criterion for the release from restraint was documented as the time the individual became calm. ▪ On the same day, a second restraint of Individual #276 lasted three minutes from 7:57 p.m. to 8:00 p.m. The restraint monitor arrived five minutes after the restraint ended, and completed the assessment form. The nurse noted a bruise on the individual's upper arm. The criterion for the release from restraint was documented as the time the individual became calm. ▪ The third restraint form submitted documented that a restraint was initiated for Individual #374 at 11:25 a.m. until 11:31 a.m. after the individual bit another individual on the leg for no apparent reason. The restraint monitor arrived four minutes after the restraint was concluded and completed an assessment form. This individual's release was marked as when she stopped "being a danger to self or others." In summary, in two incidents, the release from restraint was documented as the time the individual became calm. This is not necessarily the same as no longer presenting a danger to self or others as required by the Settlement Agreement. The third individual's release was recorded as when she stopped "being a danger to self or others," however, it was not clear what behavioral criteria were used to determine this. Criteria for release from restraint should make it clear to staff that release is based on safety considerations, not on an individual being calm and quiet.	

#	Provision	Assessment of Status	Compliance
		These restraints were reported at the Incident Management Review Team meeting held the following day. In addition, an Interim Staffing meeting was held to discuss the use of restraint for Individual #276. The team recommended that the level of supervision be increased to better monitor behavior, and prevent the escalation of targeted behaviors. A psychiatric consultation also was scheduled on an urgent basis. An additional review was conducted of 90 incidents of restraint involving eight individuals (Individual #406, Individual #421, Individual #139, Individual #435, Individual #19, Individual #395, Individual #83, and Individual #103). The documentation on the Restraint Checklists indicated that for all episodes reviewed the individuals were released as soon as they were noted to be calm or if experiencing any type of distress.	
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 AUSSLC policy on restraint use is described above with regard to Section C.1 of the SA. The policy specified the mechanical restraints that were permitted, including mittens, helmets, belts, and arm splints. It also listed the mechanical restraints that were prohibited, including metal wrists or ankle cuffs; rubber bands, ropes and cords; long ties and leashes; restraining sheets; padlocks; papoose/restraint board; restraint chair; camisoles; transport jackets; strait jackets and barred enclosures with tops. This list of prohibited practices/restraints is appropriate. The policy required that all staff responsible for applying restraint receive competency-based training in approved verbal intervention and redirection techniques, approved restraint techniques, and adequate supervision to any individual in restraint. The training curricula were reviewed. The curricula clearly outlined the less restrictive interventions to be applied prior to the use of restraint, and the limitations governing restraint usage. The actual documentation of staff training will be examined during the next monitoring visit.	
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	The AUSSLC policy limits the use of all restraints, other than medical restraints, to crisis intervention. In the three restraint episodes described above with regard to Section C.2 of the SA, there was clear documentation in the two episodes involving Individual #276 that restraint was used as a crisis intervention. Alternatives to restraint were attempted for both episodes. However, there were a greater variety of alternatives (e.g., prompted	

#	Provision	Assessment of Status	Compliance
	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.	replacement behavior, verbal prompt, redirection, changed environment, removed dangerous object) attempted in the episode beginning at 7:57 p.m. than in the earlier episode that day at 9:45 a.m., when only a verbal prompt was utilized. In the episode involving Individual #364, a verbal prompt, physical blocking and redirection were attempted. In this episode, the restraint used was specified in a safety plan. Various reports showed various numbers of restraints that were employed in January 2010. According to the Restraints Entered Report from 12/1/09 to 2/28/10, during the month of 1/10, there were 212 incidents of restraint used within the Facility. This was a significantly higher rate than in 12/09, when the monthly total was 62 incidents of restraint. However, this report only documented the name of the restrained individual, the restraint date, the date entered and the location of the restraint use. There was no descriptive information indicating the type of restraint, or any analysis as to why the number of restraints had jumped so dramatically. The FY 10 Trend Analysis Report for Emergency/Programmatic Restraints during the month of January 2010 provided a different number of restraints for January 2010. It indicated that there were 60 emergency or programmatic restraints. According to this report, there were eight individuals involved in these restraint episodes; the majority of the restraints (49 episodes) occurred in residence 795. There was no analysis of restraint use included in this documentation. Finally, in the AUSSLC FY 10 Trend Analysis Report for 2/1/10 to 2/28/10, 223 restraints were documented for January 2010. It was concerning that consistent numbers were not reported. It also was concerning that in none of these documents was a thorough analysis of these restraints provided.	
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	The restraint monitoring forms for the last three restraints that had occurred prior to the Monitoring Team's review documented that a restraint monitor conducted a face-to-face assessment within fifteen minutes from the start of the restraint. A restraint monitoring form was completed for each restraint use. Furthermore, nursing personnel documented vital signs. In the second restraint of Individual # 276, vital signs were taken 30 minutes after the release from restraint. As noted above with regard to Section C.2 of the SA, a bruise was discovered and documented on Individual #276's upper arm. An additional review of 90 episodes of physical restraint for eight individuals (Individual #406, Individual #421, Individual #139, Individual #435, Individual #19, Individual #395, Individual #83, and Individual #103) found that there were significant problematic issues regarding the required documentation completed by nursing staff. More specifically:	

#	Provision	Assessment of Status	Compliance
	and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	▪ In only 18 episodes (20%) were the vital signs taken or attempts made to take them every 30 minutes from the start of the restraint. ▪ In only 14 episodes (16%) was there an appropriate mental status documented. The majority of episodes contained inappropriate documentation of the mental status such as noting the individual "refused," which is not appropriate since cooperation is not warranted to assess an observation of mental status. Several other episodes noted the individual's mental status was "usual self," which again is not an appropriate assessment of mental status. ▪ In addition, the documentation for only 21 episodes (23%) demonstrated an adequate assessment of injury after the restraint episode. ▪ In only 17 of the 90 episodes (19%) of restraint was the name and title of the nurse documenting on the Restraint Checklist legible. A review of 51 chemical restraints for 15 individuals (Individual #374, Individual #75, Individual #421, Individual #156, Individual #139, Individual #276, Individual #77, Individual #283, Individual #284, Individual #233, Individual #342, Individual #30, Individual #160, Individual #304, and Individual #344) found that there were problematic issues regarding the required documentation conducted by nurses in each instance. The problems found included the following; ▪ The emergency medication was not consistently documented in the nurses' progress notes. ▪ The emergency medications that were documented in the progress notes did not consistently include the name of the medication administered, the dosage, the route, and the site of the injections. ▪ The Restraint Checklists did not consistently contain the medication given. ▪ The effectiveness of the medication was not consistently documented, or was only noted as "effective" without any behavioral description of the individual. ▪ Injury assessments on the Restraint Checklist were frequently left blank or not adequately completed. ▪ A number of the forms noted "usual self" when describing mental status. Post chemical restraint assessments were frequently inadequate, and not timely conducted.	
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	The information documented regarding the last three restraints that had occurred prior to the Monitoring Team's review did not indicate that there were any opportunities for exercise, toileting or fluids. This may be due to the relatively short length of time in which restraint was used. The restraint monitoring form used at AUSSLC closely followed the requirements outlined in the Restraint Documentation Guidelines for State Mental Retardation Facilities issued in November 2008. The restraint monitoring forms reviewed for Individual #374,	

#	Provision	Assessment of Status	Compliance
	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.	Individual #350, and Individual #56 were completed as required. The form for Individual #406 did not list the event codes for a 3/12/10 incident; the post restraint assessment for Individual #139 was not documented for an episode on 3/11/10; and the 3/12/10 restraint form for an episode beginning at 7:07 p.m. for Individual #276 did not list the interventions attempted to avoid chemical restraint. As noted above with regard to Section C.5 of the SA, the documentation for only 21 episodes out of 90 (23%) demonstrated an adequate assessment of injury after the restraint episode. Examples of inadequate assessments included restraint checklists that had the injury section left blank. In addition, in episodes where an injury was found, most of the documentation contained no specific description of the injury such as exact location of the injury, or description of the specific injury, such as length of scratches or bruises. Adequate examples were ones that included a specific description of injuries, or a notation that the individual was checked and none were found.	
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:	The Incident Trending Report-Restraints did not include information about individuals with more than three incidents of restraint use within any rolling 30-day period. However, the Restraints Entered Report from 12/1/09 to 2/28/10 documented restraint use on an individual basis. This Report listed restraint use by individual, date and location. It did not indicate the type of restraint or the reason for its use. In 1/10, Individual #435, who lived in Residence 795, had 49 incidents of restraint. In 1/10, three or more restraints also were documented for Individual #342 (three), Individual #421 (35), Individual #401 (five), Individual #350 (nine), Individual #74 (34), Individual #139 (50), Individual #108 (five), Individual # 406 (five), Individual #395 (three), and Individual #360 (six). No further detail was provided in this report or other documentation provided by the Facility regarding any follow-up activities. A review of restraints for February 2010 was completed. A total of 13 individuals, including Individual #406, Individual #78, Individual #435, Individual #396, Individual #283, Individual #395, Individual #299, Individual #405, Individual #389, Individual #83, Individual #74, Individual #360, and Individual #139, were found to have three or more restraints in this 29-day period (excluding medical restraints). Of these 13 individuals, behavioral assessments (either structural or functional) had been completed for only two individuals (15%), with both assessments completed in 2007.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	As noted above with regard to Section C.7 of the SA, timely assessments had not been completed for 13 individuals who had been restrained three or more times in a 30-day period.	

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	As noted above with regard to Section C.7 of the SA, timely assessments had not been completed for 13 individuals who had been restrained three or more times in a 30-day period.	
	(c) review or perform structural assessments of the behavior provoking restraints;	As noted above with regard to Section C.7 of the SA, timely assessments had not been completed for 13 individuals who had been restrained three or more times in a 30-day period.	
	(d) review or perform functional assessments of the behavior provoking restraints;	As noted above with regard to Section C.7 of the SA, timely assessments had not been completed for 13 individuals who had been restrained three or more times in a 30-day period.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	As noted above with regard to Section C.7 of the SA, timely assessments had not been completed for 13 individuals who had been restrained three or more times in a 30-day period. Without proper assessments having been completed, appropriate PBSPs could not be developed or revised for these individuals	
	(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	At the time of the monitoring visit, it was clear that Positive Behavior Support Plans were not implemented with a high degree of treatment integrity. Both direct support professionals, and psychology department staff acknowledged that plans were not implemented as written, largely due to the shortage of adequately trained and experienced staff. As noted elsewhere in this report, staff turnover was extremely high, and this had a direct impact on the quality of supports provided to the individuals served.	

#	Provision	Assessment of Status	Compliance
	settings and fully as written upon each occurrence of a targeted behavior; and	One case reviewed at the Human Rights Committee meeting involved Individual #304. The discussion of this individual's situation illustrated some of the problems with treatment integrity at the Facility, and their potential impact on the increased use of restraint. Individual #304 had received emergency medication due to high rates of agitation. Further discussion focused on the fact that the staff member working with her had worked a total of 12 hours. Once this staff member was relieved, the individual calmed. While it is not possible to know whether the critical variable was the medication and/or the change in staff, a member of the HRC noted that Individual #304 was supposed to work with a different staff member every four hours. Another comment made regarding this incident was that Individual #304 often gets emergency medication when there are environmental variables that could be easily resolved.	
	(g) as necessary, assess and revise the PBSP.	As noted in the section of this report that addresses Section K of the SA, the data used to assess the success or failure of a Positive Behavior Support Plan did not appear to be either valid or reliable. Until the data collection can be improved, there will continue to be an inability to assess the efficacy of a plan, and revise it accordingly.	
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 Incident Management Review Team discussed restraint use at its daily meeting. A review of 29 episodes of emergency restraint for eight individuals (Individual #406, Individual #350, Individual #276, Individual #210, Individual #333, Individual #202, Individual #401, and Individual #89) found that all the PST interim staffing meetings were timely conducted. However, there was no indication that the interdisciplinary team recommendations were actually implemented. For example, Individual #401 had identical recommendations noted on the interim staffing meeting forms for three episodes of emergency restraint that occurred within a four-week period. However, there was no indication that these recommendations were actually being implemented. In addition, some of the interim staffing meeting forms only noted that the use of an emergency restraint was warranted without any type of recommendations geared toward preventing the further need for restraint.	

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

1. As AUSSLC continues to try to reduce restraint, Facility-wide issues that have the potential to cause a failure to provide adequate treatment should be identified and analyzed. For example, the high turnover rate and the frequent use of "pulled" staff who may not be properly trained on individuals' Behavior Support Plans (BSPs), need to be analyzed to determine their potential impact on the use of restraint. In addition, the grouping and congregation of individuals at certain program sites also should be examined closely to determine if these sites provide adequate treatment to individuals with severe behavior concerns.
2. Immediate attention should be given to those individuals for whom restraint is employed frequently, such as Individual #435. This should

include a review of the individuals' Behavior Support Plans, with revisions made accordingly. Ongoing review of data is essential, and should occur as part of the systems developed to reduce the overall use of restraint. Independent external consultation should be considered in the review of individuals with a continuous pattern of restraint or challenging behavior, including self-injurious and aggressive behavior.

3. Criteria for release from restraint should make it clear to staff that release is based on safety considerations, not on an individual being calm and quiet.
4. It would be helpful if there was clear documentation of the identity, location and behavioral needs for support of any individual with three or more restraint incidents within any rolling 30-day period.
5. The psychology staff should complete Functional Behavior Assessments (FBAs) for all individuals who have Positive Behavior Support Plans, with an emphasis placed on those who experience frequent restraint (either mechanical, physical, or chemical), and for those who are experiencing an increase in problem behavior. Priority status should also be given to those who display pica behavior, or other potentially life threatening behaviors.
6. The Facility should develop and implement monitoring instruments addressing the elements in this requirement to ensure appropriate practices and documentation regarding the use of restraints and initiate plans of correction addressing problematic trends.

<table>
<tr><th>SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management</th><th></th></tr>
<tr><td>Each Facility shall protect individuals 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:
o Centers for Medicare and Medicaid (CMS) deficiency statements for 2/20/09, 10/09/09, 10/30/09, and 11/23/09;
o Human Rights Committee (HRC) agenda and supporting documents for 4/8/10 meeting;
o Human Rights Committee meeting minutes for 9/2/09 through 3/4/10;
o Incident Management Review Team meeting minutes for 7/09 through 3/8/10, and 3/15/10;
o DADS Policy Number 002.1 entitled Protection from Harm—Abuse, Neglect and Incident Management, dated 11/06/09;
o DADS Policy Number 006 entitled At Risk Individuals, dated 10/05/09;
o AUSSLC policies relating to Individual Abuse and Neglect, including:
• Notification Protection, dated 2/10;
• Temporary Work Duty Assignments, dated 4/8/09;
• Hiring/Staff Training, dated 9/09;
• Incident Management Process, dated 10/08;
• Administrative Actions, dated 2/10; and
• Investigative Nursing Peer Review, dated 4/06;
o AUSSLC policies relating to Individual Injury, including:
• Client Injury Overview, dated 11/08;
• Serious Client Injury, dated 3/07; and
• Critical Response Team, dated 9/08;
o AUSSLC policy on Human Rights Committee, dated 2/04;
o AUSSLC policy relating to Criminal History and Registry Clearance Checks, dated 8/09;
o Seventy-one (71) Investigation Reports involving 37 individuals;
o Investigator Training Curricula, undated;
o List of employees who worked 60 or more hours in a week for the time period between 1/3/10 and 4/3/10;
o FY 10 Fill and Turnover Report, dated 2/24/10;
o Staff vacancy report, dated 4/5/10;
o Allegations of Abuse and Neglect Reports for 7/09 through 3/10; and
o Employee Action Report with Termination Reason Code for 7/01/09 through 4/07/10
▪ Interviews with:
o Libby Allen, Interim Director;
o Jenna Heise, Assistant Superintendent of Programs;</td></tr>
</table>

	o Tammy Snyder, Director of Quality Enhancement (QE); o Candace Guidry, State Office Coordinator for Quality Enhancement; o Jack Holcomb, Incident Manager Coordinator; o Adrian Watson, Investigator; o Aubrey Johnson, Investigator; o Bill Monroe, Assistant Superintendent of Administration; o Dr. Fred Bibus, Medical Director; o Joanne Villasana, Ombudsman o Rebecca Hall, Chief Nurse Executive; and o Kim Sweeney, Quality Enhancement Nurse ▪ **Observations of**: o Incident Management Review Team (IMRT) meetings, on 4/5/10 through 4/8/10; o Human Rights Committee meeting, on 4/8/10; o During unannounced site visits, activities underway in the following sites: Residential sites 501, 727, 732D, 732E, 772 A, 772B, 791, 792, 793, 794, 796, 797, and 779, and Workshop building 544. In general, site visits included observation of the environment, interactions between employees and individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, as well as informal discussions with employees and some of the individuals. o During site visits, repeated heightened observations were made of the individuals living on 772A and 732D, as well as Individual #251, and Individual # 213.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The Monitoring Team met many staff members throughout the Facility who appeared capable and committed. Despite serious issues related to staffing coverage, a number of staff persons were observed working diligently and effectively to provide essential services and supports. Interviews with many staff during the baseline review showed evidence of a commitment to the safety and habilitation of the individuals to whom they were providing supports. Unfortunately, the extensive use of involuntary overtime resulting from significant staff shortages and turnover appeared to have created a serious staff morale problem. According to a report, dated 2/24/10, provided by the Administration, the annualized turnover rate in FY 2010 "Year-to-Date through 2010-01" for Mental Retardation Assistants was 68.3 percent. As of 3/29/10, there was an overall vacancy rate of over 15 percent for 1,023 Full-time Equivalents (FTEs). These staffing shortages were having an impact of staff morale. Throughout the week of the review, staff were interviewed as the Monitoring Team visited various homes and day programs. Additionally, members of the Monitoring Team met with 13 direct support professionals, representing three different shifts across 12 different residences. In general, staff repeatedly expressed the same theme, either onsite or in the

	meeting. Staff reported that staffing levels were insufficient for completion of one's job responsibilities. They reported being overly stressed, and not appropriately compensated when working long hours well beyond their scheduled shifts. Repeatedly, staff reported that "mandatory holdovers" created undue stress in their lives and cited this as the primary reason for high staff turnover. Individual feedback included the following: ▪ "I ask to take a day off and I'm told no." ▪ "If you don't use your comp time by a certain date, you lose it." ▪ "If I state that I can't work the shift, I'm accused of insubordination." ▪ A woman reported that she has been written up two to three times for leaving at the end of her shift to go to school to take an exam. She stated further that she pays too much for her education to not complete the course. ▪ Another woman reported that she had lost day care services because she was held over at work on too many occasions. ▪ One person noted that feedback was provided only when it was bad. ▪ Another person stated that individuals served have asked the staff person whether he/she will be returning the next day. ▪ When asked what was one thing that would help improve the situation, one woman responded, "Let me go home at the end of my shift." ▪ On one of the units, a staff member reported that the weekend on-call system was not working. She reported calling the psychologist repeatedly only to be told to follow the behavior support plan. Whether or not these are all accurate reports, the direct support professionals clearly did not feel supported in their efforts. When staff members are tired because they have been required to work many shifts of overtime, working with individuals with complex behavioral issues or complex medical needs becomes more challenging. This situation places both individuals and staff at risk for abuse, neglect, injury, or other harm. From an incident prevention perspective, there were a number of practices identified during the baseline review that had the potential to place individuals served by AUSSLC at risk for abuse, neglect, serious injury, or other harm. For example: ▪ In certain residential units, there were repeated observations of the failure to attend sufficiently to individuals with significant needs for support. For example, in some residences, there was a serious failure to monitor behavioral issues as required by behavioral support plans, physical and nutritional management plans, and other essential supports. For example: o Individual #251 did not have her protective mittens on her hands when observed on three out of five times. o On 4/5/10, the use of "pulled" staff appeared to have resulted in the failure to ensure the correct implementation of dining plans during the dinner meal for individuals living in 732D and 732E. o In Homes 772A and 732D, there were a number of individuals with very specific needs for either behavioral or health-related interventions requiring skilled and consistent staffing.

	The environments were crowded, and the environment in 772A was sterile. Meaningful activities were lacking at both sites. As a result, individuals were noted to be unattended and unengaged in 732D, and wandering aimlessly in 772A. The adequacy of staff and the grouping and number of individuals requires immediate review. ▪ There was frequently a lack of interaction between individuals and staff, including individuals who appeared to have a need for support and monitoring being left unattended for periods of time. This was particularly pronounced during periods such as mealtimes and morning routines. For example: o In Residence 732D, the Monitoring Team observed individuals left unattended without meaningful engagement. o In Residence 779R, prior to breakfast, Individual #334, Individual #186 and Individual #16 were left unattended in the hallway without any staff in the immediate area. Individual #16 repeatedly cried out for someone to "take me up front." o Individual #265 was in his room with three other individuals, but without staff. He was observed slapping his head repeatedly. ▪ Dehumanizing practices were observed. For example: o There were extremely shortly cropped haircuts with no individualization noted for a number of women living in Residence 732D; o There were other individuals noted to have dirty hair; o A number of individuals were wearing clothing that was poorly fitting and/or worn, and many of the clothing protectors that individual were using during mealtimes were threadbare; o There were grates on the windows in some of the homes; o The Infirmary was shabbily furnished, and provided little opportunity for privacy; o General conditions at the Facility were found to be poor, with some homes lacking all but basic furniture, and others being in disrepair or poorly kept, and what appeared to be vacant buildings with broken windows. As has been illustrated throughout the history of this field, when practices such as these are allowed, there is a high risk that staff will view individuals as less than human, and treat them as less than human, resulting in abuse, neglect, and other harm. ▪ There were some inappropriate groupings of individuals with very different, often unique, needs for support. For example, it was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space. For example: o In Residence 772A, the combination of nine men with challenging behavioral needs in such confined space increased the risk of harm. Although during one observation staff was attentive and effective in redirecting potentially problematic behavior, there was little

	to occupy the attention of the men who lived in this residence. The environment in Residence 772A was sterile, and this residence offered little common space for the men to spend time. ▪ There also were a number of staffing constraints at AUSSLC, making it difficult to consistently provide a safe environment. While absolutely essential, the mandated reassignment of any alleged perpetrator also required flexible staffing, which at the time of the review, did not exist due to the high turnover rate and the high use of overtime. All of these factors made it difficult to ensure a stable complement of staff who were knowledgeable about the strengths and needs of each individual. To ensure consistent staffing on the residential units, the underlying structural issues leading to the unstable staffing patterns in evidence at the time of the review will need to be resolved. In order to protect individuals from harm and in order to comply with the Settlement Agreement, decisive action will be required to address the critical staffing shortages, and improve the quality of life issues at AUSSLC. In order to protect individuals from harm, it is essential that staff report any suspicions of abuse or neglect. At AUSSLC, the Quality Enhancement Department had a process in place to test staff's competence with regard to the requirements and processes for reporting abuse and neglect. Each month, Facility monitors randomly selected staff from each unit, and gave them a quiz. If staff did not attain a score of 100 percent, immediate refresher training was provided. This is a positive practice that both addresses issues on a staff-specific basis, but also provides the Facility with system-wide data. The Facility had begun to implement effective methods for monitoring injuries, the use of restraints, and allegations of abuse and neglect. The appropriate staff attended the Incident Management Review Team meetings, and information was presented in a clear and organized manner. Discussion primarily focused on the individuals who had fallen, been restrained, required medical care, or experienced injury. However, there appeared to be little analysis of systemic issues/causes that might exist across the residential units. An extremely positive practice at the Facility was the Self-Advocacy group, and the staffing supports that were dedicated to providing this group with the assistance it needed. This group was involved in numerous activities, a number of which involved learning about and exercising their rights. If there is to be compliance with the requirements of the Settlement Agreement, the reporting and investigation process for both the Department of Family and Protective Services (DFPS) and AUSSLC will require significant attention. Numerous problems were noted in the review of investigation reports and in discussions with Facility staff, including: ▪ Reportedly, it could take up to an hour before a call to the abuse/neglect reporting telephone number was answered by a person who could conduct the intake of the allegation. This delay is potentially a strong disincentive for staff reporting abuse and neglect or other serious incidents. ▪ The investigation reports were noted to lack significant information. Repeatedly, the history of alleged perpetrators was not reviewed to determine whether other allegations had been made or

	confirmed. The reports were disorganized. There were extraneous pages and repetitious information. Very few recommendations for corrective action or improvement were noted. When recommendations were made, they were most often directed towards the individual rather than Facility-wide concerns. ▪ Additionally, in many investigation reports, it was not clear that sufficient supervisory or administrative review had occurred as required by the Settlement Agreement. ▪ It was also difficult to determine the actions taken as a result of peer review of allegations involving clinicians. This information was not included in the final investigation file, even when DFPS had made a referral back to the Facility for this to occur. As noted in investigation reports at one other Facility, it would be helpful to include the letter or statement of disciplinary personnel action, if any, in the final investigation report. It is difficult to determine whether personnel actions are taken in a timely manner against employees who are confirmed as perpetrators. As reported by Facility staff, DFPS had referred a number of incidents back to the Facility for investigation. Reportedly, by the time the Facility received the incident for investigation, several days may have elapsed. The Facility's investigators then were under increased pressure to complete the investigation within the time frame required by the Settlement Agreement. Individuals known to make repeated unfounded allegations were being identified by DFPS. At the time of the review, there were at least four individuals at AUSSLC who were known to make repeated allegations of abuse and neglect that could not be confirmed. The way in which the Facility and DFPS addresses this issue will be critical to ensuring the protection of the individuals. While the number of such allegations can be a challenge to the system, there must be ongoing objectivity about reports of abuse and neglect from or about these individuals. At the time of the review, their allegations most often were referred back to the Facility for investigation, making it difficult to ensure objectivity. Furthermore, the criteria used by DFPS for "streamlining " an investigation were not clear. Close coordination with DFPS, as well as individuals' Personal Support Teams (PSTs) to develop individualized approaches to address allegations that repeatedly are not confirmed or disproved needs to occur, and be documented. Internal mortality reviews were being conducted, and deaths also were being reviewed by the survey and certification entity. Although the Facility had responded to some of the recommendations resulting from these reviews, a number of the underlying issues identified through the death review process had not been adequately addressed. As a result, individuals at the Facility continued to be at risk due to the potential for the recurrence of problems that clearly had been identified in these reviews.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that	The DADS policy on abuse, neglect and incident management was completed on November 6, 2009. The policy was reviewed, and found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are	

#	Provision	Assessment of Status	Compliance
	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.	noted under the corresponding section below. The DADS abuse, neglect and exploitation rules and incident management policy stated that abuse, neglect, and exploitation are prohibited. The SSLCs are required to comply with these State policies and rules. The Facility had issued policies relating to the reporting and investigation of abuse and neglect, for example, policies on Administrative Actions; Notification/Protection; and Hiring/Staff Training. The only direct statement that the Facility would not tolerate abuse and neglect was found in the policy entitled "Client Abuse and Neglect: Hiring/Staff Training." This policy stated that: "New employees/agents who will provide direct services to persons or will routinely perform services in proximity to persons served will receive the following training prior to beginning work and annually thereafter: …an explanation that abuse, neglect and exploitation of persons served is prohibited." There were more explicit statements that the Facility would not tolerate abuse of neglect included in the training materials regarding the mandatory reporting of abuse and neglect. As is discussed below with regard to Section D2 of the SA, based upon interviews with a small sample of staff, staff appeared to understand their responsibility to report abuse, neglect and serious incidents.	
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:	The following Facility-wide policies regarding individual abuse and neglect had been issued: ▪ Notification Protection, dated 2/10; ▪ Temporary Work Duty Assignments, dated 4/8/09; ▪ Hiring/Staff Training, dated 9/09; ▪ Incident Management Process, dated 10/08; ▪ Administrative Actions, dated 2/10; ▪ Investigative Nursing Peer Review, dated 4/06; ▪ Client Injury Overview dated 11/08; ▪ Serious Client Injury, dated 3/07; and ▪ Critical Response Team, dated 9/08. Copies of these policies were reviewed during the baseline visit. As relevant, specific comments regarding their adequacy are provided below. Each of these policies was consistent with the intent of the Settlement Agreement. However, the Facility might consider consolidating these policies into one document with the copies of any requisite reporting forms attached. An overall policy statement that clearly states that abuse and neglect will not be tolerated would underscore the Facility's intent to comply with the provisions of the Settlement Agreement. The Monitoring Team will continue to evaluate the Facility's implementation of these policies.	

#	Provision	Assessment of Status	Compliance
	(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.	According to the AUSSLC policy entitled "Hiring/Training" cited above, employees were to be instructed at orientation and annually thereafter that abuse and neglect must be reported. Reportedly, the procedures for reporting were explained at that time. Review of the training curriculum revealed that it did instruct staff in the requirements for reporting. Also, there was a policy entitled "Individual Abuse and Neglect: Notification/Protection" that outlined the required actions for reporting by the Facility Director or his/her designee. During informal discussions with staff, they acknowledged and appeared to understand the requirements for reporting abuse, neglect, and serious incidents. The Incident Management Review Team meeting minutes documented that incidents, restraints and allegations have been considered on a daily basis since at least 7/09. A comparison of selected investigations against the minutes for the Incident Management Review Team documented that incidents involving Individual #97, Individual #2, Individual #336 and Individual#167 were reported as required. Of significant concern was the length of time it could potentially take to report abuse and/or neglect. Reportedly, it could take up to an hour before a call to the abuse/neglect reporting telephone number was answered by a person who could conduct the intake of the allegation. In the case of Individual #350, on 4/7/10, the caller waited forty minutes to report physical abuse. This delay is potentially a strong disincentive for staff reporting abuse and neglect or other serious incidents. The State reported that the average wait time during this fiscal year was 7.2 minutes. During upcoming reviews, the Monitoring Team will request additional information about the mode, as well as activities underway to reduce the wait time. With regard to the reporting of other significant incidents, the policy entitled "Incident Management Process," dated 10/08, listed the types of unusual incidents, including serious injury and death, which must be reported. The timeframe and process for reporting were described. This policy was consistent with the requirements of the Settlement Agreement.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any,	DADS policy at 002.1.IV.A.1 required immediate action to protect the individual upon notification of an allegation of abuse or neglect. This included action to stop the abuse, protect the individual, and ensure the alleged perpetrator was removed from contact with the individual. The review of investigation reports and the summary charts regarding allegations of abuse and neglect document that the Facility routinely reassigned alleged perpetrators to work areas that did not involve direct contact with individuals. Informal discussions with staff confirmed this practice. In the investigation reports, it was noted that nursing	

#	Provision	Assessment of Status	Compliance
	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.	staff completed injury assessments, and that staffing levels were adjusted, as needed, to protect the individual from further harm. The Incident Management Review Team meeting minutes documented that incidents, restraints and allegations had been considered on a daily basis since at least 7/09. Based on an interview with the QE Director, one of the roles of the IMRT was to review the incidents that had occurred within the preceding 24 hours, including information about protective measures that had been taken, and to ensure that appropriate immediate follow-up had occurred. The Monitoring Team observed Incident Management Review Team (IMRT) meetings during the week of the onsite visit. In these meetings, staff discussed protective measures that had been or should be taken to reduce the occurrence of serious incidents. Representatives from the residential sites were responsible for sharing these discussions with staff working directly with the individual of concern. Generally, staff persons attending the IMRT meetings were knowledgeable about the individuals whom they supported, and were responsive to suggestions about individual cases. However, during the baseline review, there was little discussion about Facility-wide problems, such as staffing concerns or the number of individuals placed in a particular residence. These problems have a direct effect on the reduction of risk for all individuals residing at AUSSLC.	
	(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.	Although the actual training was not observed during the baseline review, AUSSLC policy indicated that training was required for all staff at orientation and annually thereafter. Based on review of the training curricula, it stated the requirements for reporting; the potential signs and symptoms of abuse, neglect and exploitation; the steps to be followed in the reporting process, as well as the investigation process. The training curricula included written tests that an employee must complete. These tests required responses to basic questions about the requirements for reporting abuse and neglect. During upcoming monitoring visits, reviews will be conducted of training records to ensure that staff is successfully completing the competency-based training on a yearly basis. The quality of the competency-based training also will continue to be reviewed, including review of training materials, and if possible, through observation of the actual training. Of note, program auditors at the Facility were required to complete two quizzes a month at each house in their assigned unit. The quizzes tested staff's knowledge with regard to the reporting requirements and processes. Staff was to be selected randomly for participation in the quiz, and all shifts must be represented each month. Staff must score 100 percent on the quiz or participate in-service refresher training immediately. The	

#	Provision	Assessment of Status	Compliance
		completed quizzes were submitted to the Director of Quality Enhancement for review and any remedial action. There was a report for February 2010 that summarized the results of the 12 quizzes for that period. This is a positive practice that should continue. It encourages staff to be knowledgeable about reporting requirements, and provides for immediate corrective action for staff who do not meet the set criteria. It also provides the Facility with system-wide data on staff's knowledge in this area. During the next baseline review, a random sample of the quizzes for the various units will be reviewed to confirm that this practice is being implemented as described, and that any trends as a result of the quizzes are being identified and addressed.	
	(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 discussed above, according to Facility policy, staff were being informed of the reporting requirements at orientation, and annually thereafter. A blank copy of the statement to be signed by an employee was included with the training curricula. During the next review, a sample of completed statements will be requested from the Facility. The investigation reports examined during the baseline review did not indicate any failures by staff to comply with the reporting requirements.	
	(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.	This requirement was not examined during the baseline review. The DADS Policy No. 002.1 entitled Protection from Harm – Abuse, Neglect and Incident Management required that each Facility provide training and a resource guide regarding the recognition and reporting of abuse, neglect, and exploitation to the individuals, their primary correspondents, and their Legally Authorized Representative. The standardized format for the investigation reports included information about the notification of the LAR when an allegation was reported. There also was evidence that individuals were being assessed for and, as necessary, provided victim counseling.	

#	Provision	Assessment of Status	Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	At the State-level, the DADS policy on abuse, neglect and exploitation did not appear to require a rights posting. A brief and easily understood statement regarding individual rights was placed on bulletin boards and walls in residential sites, and in the workshop program in Building 544. However, these posters often were partially covered up by other information. For example, the poster in Residence 779 was obscured by the state holiday schedule. A statement of rights prepared by the Ombudsman was noted on one bulletin board. It was more visually compelling. The Facility should consider posting both statements in a prominent place in each residence. The intent of Sections D.2.e and D.2.f of the SA would not appear to be just the posting of statements about individual rights at the Facility. An extremely positive practice at the Facility was the Self-Advocacy group, and the staffing supports that were dedicated to providing this group with the assistance it needed. The Monitoring Team spoke with the Acting Ombudsman, who was the staff advisor to the group, as well as several members of the group. This group was involved in numerous activities, a number of which involved learning about and exercising their rights. The Acting Ombudsman also discussed outreach activities that the group was involved in to include a greater number of individuals at the Facility. This is a group that should continue to be supported. Not everyone will choose to participate in a self-advocacy group. In order to ensure that information about rights is provided in a format that is "easily understood" by individuals at the Facility. Concerted efforts should be made to assist individuals in learning about their rights, and about how to exercise them. Such efforts could take many forms, including, for example, learning objectives related to the exercise of rights; regular house meetings in which individuals are not only taught about their rights, but encouraged to exercise rights such as choice making about foods or activities; posting in homes or day programs about a "right of the month" with ongoing discussion with individuals about that right and how they could exercise it. The Monitoring Team recognizes that the concept of rights can be a difficult one to understand, but there are many concrete aspects to rights such as choice-making, use of the telephone, ability to choose with whom one spends time, etc., that many individuals at AUSSLC could understand and begin to or continue to exercise. Other individuals supported by AUSSLC could understand more complex rights such as the right to vote, or the right to refuse treatment. Efforts to educate individuals about their rights should be individualized, as appropriate. Additionally, staff should be cautioned not to exclude individuals from self-advocacy initiatives because of complex physical disabilities. For example, Individual #213, who resides in 779F, had very significant physical disabilities. In conversation with the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team, however, he was surprised to hear of the self-advocacy initiatives at the Facility and expressed great interest in being included in them. His name was forwarded to the Ombudsman for follow-up attention.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement were evident in the Facility's policies and training curricula. In addition, the standardized format for investigation reports included this notification requirement. The DADS policy entitled Protection from Harm – Abuse, Neglect, and Incident Management states: "The Director or designee will immediately notify the law enforcement agency for investigation and collection of evidence for any suspicion of criminal activity." However, more specific criteria for notifying law enforcement were not specified in either the AUSSLC policy entitled "Individual Abuse and Neglect: Notification/Protection," or "Incident Management Process." Rather, this decision appeared to be the responsibility of the Facility Director or his/her designee. According to the "Individual Abuse and Neglect: Notification/Protection" policy, in the case of suspected rape or sexual assault, if the examining RN, physician or nurse practitioner suspected, or found evidence of penetration or sexual assault/activity, the examination would be immediately terminated, and the police notified. However, the policy does not state who is responsible for the notification of law enforcement. The examination of investigation reports conducted during the baseline review did not indicate the involvement of law enforcement to any significant extent. When law enforcement was notified, as appropriate, in Incident #100122, and Incident #100120, any report or findings were not included in the final investigation report. Therefore, it was difficult to evaluate the results of these referrals. The Office of Inspector General (OIG) was involved in the investigation of Incident #100124. This incident involved an allegation of physical abuse. Reportedly, the alleged perpetrator pulled Individual #2 by his arm to his wheelchair that was over five feet away. The OIG's preliminary investigation found evidence of criminal activity. The subsequent DFPS investigation found that "there is a preponderance of evidence that shows that (the alleged perpetrator) used an 'inappropriate' 'bodily restraint' on client (Individual #2) which was "not in compliance with federal and state laws and regulations." The allegation was confirmed. However, the DFPS investigation found that the alleged perpetrator "was exhibiting signs of stress and may have acted out of character." It was recommended that he be in-serviced on the correct procedures to transport the individuals in the home, specifically Individual #2. This recommendation appeared to be inconsistent with the OIG's findings of criminal activity. The two sets of findings did not appear to be reconciled in the final investigation report.	
	(h) Mechanisms to ensure that any	The AUSSLC policy entitled "Individual Abuse and Neglect: Notification/Protection" did	

#	Provision	Assessment of Status	Compliance
	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.	not reference any prohibition of retaliation for the reporting of an allegation of abuse or neglect. However, the training curriculum did instruct staff on the process for reporting retaliation. The details for reporting and a clear statement that retaliation is prohibited were not included in the training materials provided during the baseline review. In reviewing documentation, there was no evidence found about any specific retaliation against any staff person, individual, family member or visitor who reported an allegation of abuse or neglect. Informal discussions with staff indicated that some thought they were identified as an alleged perpetrator because of problems with one or more of their co-workers. However, there was no factual basis for this perception found in documentation reviewed during the baseline review. There were no concerns about retaliation raised by the Facility investigators.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Although no evidence of semi-annual audits was found, the Facility had the capacity to track injuries through several reports. None of these reports indicated whether the injuries were investigated, or whether the information from these reports was used to identify serious injuries that needed to be referred for investigation. For example, there was an injury report for the period from 12/01/09 to 3/09/10 that specified the number and nature of injuries received per individual. A total of 69 injuries were documented for this time period. Two of these injuries, both for Individual #202, were described as serious. The two injuries were documented as a serious abrasion and a serious cut. A report detailing the number and type of falls was available for the same time period. There were 20 falls. A report describing peer-caused injuries documented the individuals involved, and the type of injury incurred for the period from 7/1/09 to 3/12/10. Fractures were reported for the period from 7/11/09 to 3/11/10. There were 13 fractures. Trending and Tracking Reports for the First Quarter of 2010, and the months of January through February 2010 documented the number and type of injuries by individual, and by location. There was no information regarding the number of injuries reported for investigation. The Facility acknowledged that it was just beginning to develop its trending and tracking capacity. It was clear that a number of injuries had been investigated. For example, the Facility submitted the final investigation reports for the three most recent incidents involving injuries to individuals, including Individual #159, Individual #29, and Individual #202. The Facility had completed these investigations. The following provides information about each of these: ▪ The Facility's investigation indicated that Individual #159 tripped over another individual's walker and sustained a "Dento Alveolar" fracture with lower lip	

#	Provision	Assessment of Status	Compliance
		bruising with four loose teeth. An oral surgeon extracted her four teeth. No abuse or neglect was suspected; staff was found to have acted promptly and notified proper personnel to assist the individual with her injuries. Her supervision level was increased, and staff was to be instructed to keep walkers and other equipment out of the areas where staff and individuals walk. ▪ After refusing his prescribed medication and through self-injurious behavior, Individual #29 sustained a laceration to his forehead hairline area. He was transported to the Hospital, and the wound was closed with three staples. No abuse or neglect was suspected. The residence was to be monitored frequently through unannounced visits, and staff was to be in-serviced in ways to work with this individual, so he would take his medication as prescribed. ▪ Reportedly, Individual #202 refused to be redirected by staff to another location, fell to the floor, and sustained a laceration on his left eyebrow, when he struck a cabinet. A protruding door hinge contributed to the injury. Individual #202 received five staples to close the wound. No abuse or neglect was suspected. His level of supervision remained the same. The door hinge was repaired.	
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:	DADS had issued policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury and other incidents involving individuals living at the SSLCs. This policy was entitled: Protection from Harm—Abuse, Neglect and Incident Management, Policy #002.1 dated 11/6/09. In the sections that follow, any concerns related to the DADS policy are noted as appropriate.	
	(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.	Section III.E of the DADS policy required Incident Management Coordinators and Primary Investigators to complete Labor Relations Alternative's (LRA) course entitled: "Fundamentals of Investigations Training" within six months. Section III.D of the State policy required that all investigators have expertise and demonstrate competence in conducting investigations. However, the policy did not make it clear that both DFPS and Facility investigators must have training in working with people with developmental disabilities. It also was not clear that the investigations must be carried out by persons who are outside the direct line of supervision of the alleged perpetrator At the time of this review, the credentials of the investigators for DFPS were not reviewed. This will be reviewed during the next onsite review. With regard to the Facility investigators, documentation was provided regarding the	

#	Provision	Assessment of Status	Compliance
		training of the Incident Management Coordinator, and for one Facility investigator. The investigator was experienced in working with individuals with an intellectual and/or developmental disabilities. The Incident Management Coordinator volunteered that he did not have such experience, and it was not clear if he had been provided with training on working with individuals with intellectual and/or developmental disabilities. Recently, a second investigator was assigned to the Facility. This staff person has extensive experience working with individuals with an intellectual or developmental disability. During upcoming monitoring visits, training records will be requested for both DFPS and Facility investigators to determine if they have been provided with adequate training on working with people with developmental disabilities. Because at AUSSLC the investigators were part of the Incident Management Department, it reduced the likelihood that an investigator would be within the direct line of supervision for any staff person alleged to have perpetrated abuse or neglect.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, referred at I.D to cooperation with DFPS, and Section V.A.2.d referred to cooperation with DFPS in the conduct of investigations. Based on review of investigation reports from the survey and certification agency, the Facility appeared to cooperate with the surveyors who inspected AUSSLC for compliance with Medicaid regulations. There also was documentation in the investigation reports that the Facility cooperated with DFPS in its investigations.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS policy at Section V.D referred to reporting to and coordination with law enforcement. The Facility policy entitled "Individual Abuse and Neglect: Notification/Protection" required, following the initiation of an investigation, that the Shift Coordinator and Department Head take actions to secure evidence as needed. In cases of suspected rape or assault, if the examining RN, physician or nurse practitioner suspected, or found evidence of penetration or sexual assault/activity, the examination was to be terminated immediately and the police notified. The police would make the decision to complete a rape exam. These are the only references, in this policy, to ensuring that there was no interference with any law enforcement investigation. As referenced above with regard to Section D.2.g of the SA, there was very little evidence of law enforcement's involvement in investigations at the Facility. The details of any such involvement were not documented in the investigation reports. During interviews with Facility staff, there were no concerns raised about the relationship with local law enforcement.	

#	Provision	Assessment of Status	Compliance
	(d) Provide for the safeguarding of evidence.	The Investigator's Training Manual did not provide requirements for safeguarding of physical evidence. There was no evidence of a Facility policy statement that explicitly stated what must be done to safeguard evidence. However, in the curricula used for training staff about the requirements of reporting any suspected abuse and neglect, there was a module in which staff was instructed about the safeguarding of any evidence. Review of the investigation reports received during the baseline review indicated that there were routine assessments by nursing or medical personnel of any injuries or allegations of sexual or physical abuse.	
	(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.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, Section VIII.B specified documentation requirements. Specifically, it stated that investigations must commence within twenty-four hours or sooner. Section VIII.D required the SSLC to complete an investigation report within 14 calendar days (10 calendar days after 6/1/10.) The Facility policy also included a requirement that investigations be initiated within 24 hours or sooner of the incident being reported. There were 71 investigation reports received as part of the document request for the baseline review. Of those, 24 (34%) were analyzed to determine timeliness. This was complicated by the fact that DFPS had referred 16 incidents back to the Facility for investigation. In those cases, the Facility was not able to initiate an investigation within the required 24-hour timeframe. One investigation was completed by the OIG, and the timeframe for the initiation of the investigation could not be determined. Of the seven investigations retained for investigation by DFPS, four (57%) were initiated within 24 hours. There were significant delays documented with regard to the remaining three investigations, and it was unclear if there were extraordinary circumstances for which the supervisor granted an extension. For example: ▪ Incident #100310, an allegation of neglect, was reported on 3/3/10. The investigation began two days later with an interview of Individual #217. However, staff interviews did not begin until 3/16/10, 13 days after the incident report. ▪ In an incident involving Individual #2, the investigation began three days after the incident report of 1/29/10. ▪ The third case involved an allegation of physical abuse. The incident was reported on 2/17/10, but the interview with the Individual #108 was not attempted until two days later. Also of note, this investigation was determined to be unfounded, but its cause was the Individual's anger at the lack of available staffing that precluded the individuals in that house from being able to go anywhere. The lack of staffing was not addressed in the section on	

#	Provision	Assessment of Status	Compliance
		recommendations. In the cases referred back to the Facility, the investigation was commenced within 24 hours of the receipt of the referral in eight of the 16 (50%) reports reviewed. Timeliness in the completion of reports was assessed for six investigations completed by DFPS. Two were completed within 14 days; two required an extension; and two could not be determined because the final investigation report was not provided. Sixteen investigations completed by the Facility were evaluated for timeliness. As is discussed further below with regard to Section D.3.f of the SA, in at least four cases, it appeared that the timeliness of these investigations was impacted by the length of time between the incident and the referral back to the Facility by DFPS.	
	(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	In general, the investigation reports were noted to lack significant information. Repeatedly, in both DFPS and Facility investigations, the history of alleged perpetrators was not reviewed to determine whether other allegations had been made or confirmed. For both DFPS and the Facility, the reports were disorganized. There were extraneous pages; pages that had headings, but contained no information; and repetitious information. In both DFPS and Facility investigations, very few recommendations for corrective action or improvement were noted. When recommendations were made, they were most often directed towards the individual rather than Facility-wide concerns. The most recently closed case sent back to the Facility from DFPS was reviewed. This case, #100316, was one of 18 investigations for Individual #77 provided as part of the document request during the baseline review. During the course of the investigation, Individual #77 recanted her allegation of sexual harassment. The investigation met all of the Settlement Agreement requirements for timeliness, interviewing of witnesses, and review of documentation. However, the investigation did not offer any recommendations. Individual #77 was described as a "chronic" caller. It is understandable that there is frustration with this behavior. Nonetheless, it is important that the Facility take a number of steps to address situations in which individuals make repeated allegations that are found to be inconclusive, unconfirmed, and/or the individual retracts their original statement. In order to protect individuals, allegations should never be ignored. However, the Facility should work closely with DFPS on how such investigations should be handled. The individual's team also should complete a full assessment of the situation, including, for example, a functional assessment to determine the function of the individual's repeated calls, and, as appropriate, the development of a behavior support plans to address the behavior, and teach the individual a replacement behavior. There should be other considerations as well to protect staff as well as the individual, for example, ensuring staff are never alone with an individual who has a history of making allegations that are not confirmed.	

#	Provision	Assessment of Status	Compliance
	perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The investigation report for an allegation of neglect for Individual #14 was completed by DFPS (#100321). The allegation was that the individual was left unsupervised, and became tangled in his oxygen cord. It was unconfirmed. The investigation met the requirements of the Settlement Agreement with one exception; there was no evidence in the investigation report that a supervisor had reviewed the findings. The report for the most recently closed case investigated by the OIG (#100209) concerned an allegation of neglect involving Individual #306. The individual's fall from her wheelchair originally was thought to be an accident. Upon investigation, it was determined that a staff person failed to properly secure the individual's seatbelt. As a result, the allegation of neglect was confirmed. The investigation report met the requirements of the Settlement Agreement except for the requirements that: 1) all sources of evidence be reviewed, including previous incidents for the victim and the alleged perpetrator; and 2) there was supervision/review of the final report. A report was provided to the Monitoring Team entitled Employee Action Report with Termination Reason Code, for the period of 7/01/09 through 4/07/10. There was no evidence that the perpetrator in Case #100209 was terminated, despite the confirmation of neglect. In fact, this report documented the termination of only one employee out of six confirmed cases of abuse, neglect or exploitation reviewed for this baseline report. One employee was terminated for taking a shirt from Individual #121. Thirty-seven (37) individuals were represented in the 71 investigation reports reviewed for this baseline report. In order to determine whether the requirements of the Settlement Agreement were being met, at least one investigation report was reviewed for 21 (57%) of the individuals. A total of twenty-four investigations were analyzed for compliance. One incident (#100111) was investigated by the OIG. This case involved an allegation of exploitation, and the disappearance of Christmas gifts purchased for the residents. There was no criminal activity found by the OIG. There was no evidence in the record provided that any other action was taken by the Facility, and there was insufficient information provided to evaluate compliance with the Settlement Agreement. Six investigation reports were completed by DFPS. Of these, two were completed within the 14-day period currently required by State policy, two required an extension, and two could not be determined because the final report was not provided. One allegation of physical abuse against Individual #2 was confirmed (#100124). As is discussed above with regard to Section D.2.g of the SA, the OIG was involved in investigating this incident as well. Although criminal activity was cited, there was no evidence provided that the	

#	Provision	Assessment of Status	Compliance
		perpetrator was terminated from employment. The interviews conducted in this case were not timely; the first was documented 11 days after the allegation was reported. Such lag times in conducting interviews increase the likelihood that witness statements will be inaccurate. Three of the six cases were determined to be either unfounded or unconfirmed, including #100322, #100310 and #100211. None of these three cases included a review of the previous incidents for the alleged perpetrators. It is anticipated that DFPS will initiate reviews of prior case histories beginning on June 1, 2010. A seventh investigation was reopened by the Facility after DFPS completed its investigation. It was determined that there were additional witnesses to be interviewed about this allegation of neglect (#100301). All of the above DFPS reports followed a standardized format. The allegation was stated; the names of the witnesses, victims and alleged perpetrators were provided; interviews were summarized; documents were enumerated, and it appeared that relevant records were reviewed. The investigator's findings were clearly stated, and there appeared to be a clear basis for the findings. The most significant shortcoming in each of these reports was the lack of any recommendations for corrective action or for improved performance at the Facility. The Facility investigated 16 incidents of the 24 selected for review. All of these investigations were referred back to the Facility by DFPS. Of these 16, eight of them involved "streamlined" investigations, including two incidents for Individual #19; two for Individual #167; three for Individual #77; and one for Individual #175. Each of these investigations had been "streamlined" because of repeated unfounded allegations. Concerns regarding this process are discussed above with regard to Section D.2.f of the SA, and a recommendation is offered below. It appeared that the increasing volume of incidents referred back to the Facility for further investigation had begun to strain the Facility's ability to complete investigations in a timely manner. Recently, a second investigator was assigned to the Facility. In four of the 16 cases investigated by the Facility, the timeliness of the investigation was impacted by the length of time between the incident and the referral by DFPS to the Facility. Two of the investigations were completed within fourteen days. The timeliness could not be determined for two investigations due to missing information. Each Facility investigation followed a standardized format. In general, each investigation report described the allegation; identified the victim, the alleged perpetrator and the witnesses; summarized the witness statements; and gave a basis for the conclusion.	

#	Provision	Assessment of Status	Compliance
		Because signatures were lacking, it was not always clear that a supervisor had reviewed the final report. In addition, as stated above, there were few recommendations provided. For example: ▪ In one case, a staff person was "pulled" or rotated from his assigned work site to another residence that had a shortage of staff. The failure to provide this staff person with adequate information about an individual's needs for support was referenced only as a problem in this particular case, rather than as an overall systemic problem known to exist at this Facility. The lack of analysis of the potential causes for the incidents, leading to recommendations for timely corrective action was of significant concern. Four individuals were designated as "chronic" callers, and any incidents involving them typically were "streamlined," and referred back to the Facility for review. However, the resulting investigations did not consistently recommend actions to address the individuals' documented history of making unfounded allegations. For example: ▪ One of these individuals, Individual #19, was referred for community placement by his team in 11/09. His placement was described as pending. However, there did not appear to be further recommendations to ensure his team was appropriately addressing, for example, the function of his behavior. ▪ According to the Facility investigator familiar with this individual, through unfounded allegations of abuse, Individual #167 consistently expressed her anger at the restrictiveness of her placement at the Facility. Yet, she had not been recommended for community placement. ▪ Individual #77 was the subject of 18 (25%) of the 71 investigation reports received during the baseline review. There had been no recommendations for significant changes in her programming or placement. ▪ Individual #167 and Individual #77 were both placed in the same house at AUSSLC. There was no indication that alternative placements, placements that might provide more positive role models or more individualized activities, were recommended for consideration for either individual as a means to reduce their undesired behaviors of making unfounded allegations.	
	(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	Section XII.C of the DADS policy stated that the Incident Management Coordinator was responsible to review all investigations to ensure that they were thorough and complete, and that the report was accurate, complete and coherent. Any deficiencies must be corrected promptly. As discussed above, there was a written report for each investigation. It was not evident that a supervisor had reviewed each investigation. This requirement could be confirmed in two of the 24 investigations reviewed (8%), including #100310 and #100124. It would be helpful if a checklist could be attached to each investigation report. The	

#	Provision	Assessment of Status	Compliance
	or areas of further inquiry in the investigation and/or report shall be addressed promptly.	checklist could certify that the Settlement Agreement requirements have been met. Also, it would be helpful if extraneous pages were removed, and if the reports were organized in a consistent manner.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Section IX. A of the DADS policy stated that an Unusual Incident Report (UIR) was required for each incident and investigation. The final UIR must be in the approved State Office format reviewed and approved by the Director or their designee within five working days of the date the State Center learned of the incident. As directed by policy, the Facility was required to investigate unusual incidents, including client injuries. When completed, these investigations utilized the same reporting format as that described above. Periodically, DFPS referred incidents back to the Facility for review with the notation that a full investigation was not required. There were four such incidents included in the 24 investigation reports analyzed during the baseline review. A full investigation was conducted in one case (100312) involving Individual #22. The remaining three referrals were not investigated in the detail required under subparagraph g. One of these incidents involved an allegation of neglect of Individual #336 who evidenced a swollen and bruised hand. There was no final report or recommendations provided for this incident, even though there were four previous allegations of neglect recorded for this Individual. Routinely, the Medical Director and nursing staff were reviewing deaths. Nursing staff were conducting a review of the 72 hours preceding the individuals' death for individuals who died at the Facility, and/or the 72 hours prior to the hospitalization for individuals who died at the hospital. During the baseline review, members of the Monitoring Team met with the State Medical Director, the Facility Medical Director, the Chief Nurse Executive and the Quality Enhancement Nurse to discuss the review of deaths at AUSSLC. Important information was provided about the process for reviewing deaths, and the actions that had been taken at the Facility to improve nursing practice and supervisory oversight. For example, as a result of certain deaths, the Chief Nurse Executive had taken steps to improve documentation and communication among nursing staff; end-of-life planning was being discussed in individual cases; and, after a death, there was greater involvement of the Chaplain in the counseling of individuals and staff. However, concerns related to the completeness, and effectiveness of this follow-up is discussed in further detail below with regard to Section D.3.i of the SA. This meeting identified issues and areas of practice requiring increased attention. For example, the lack of trending of information related to deaths was cited as a potential weakness. In addition, the State Medical Director was planning to implement a mortality	

#	Provision	Assessment of Status	Compliance
		and morbidity review process at the State level that would include more external review of deaths. This is an important component to the mortality review process that should occur as soon as possible. During the baseline review, there were no DFPS investigations of deaths received for review. The actual investigation of deaths will require continuing review in future monitoring visits to ensure that there is independence in the review of deaths, and that any recommendations for follow-up are implemented. It was also difficult to determine the actions taken as a result of peer review of allegations involving clinicians. This information was not included in the final investigation file, even when DFPS had made a referral back to the Facility for this to occur. For example, Individual #22 was admitted to the hospital for aspiration pneumonia. The DFPS investigator found that a nurse failed to assess the individual despite reports from staff that the individual was not swallowing very well. The case was closed by DFPS, without a finding, and referred back to the Facility for review by the appropriate peer review committee. The results of the peer review were not included in the final investigation file, or otherwise referenced.	
	(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.	Section XIII.B of the DADS policy included this requirement. A report was provided to the Monitoring Team entitled Employee Action Report with Termination Reason Code, for the period of 7/01/09 through 4/07/10. There was no evidence that the perpetrator in Case #100209 was terminated, despite the confirmation of neglect. In fact, this report documented the termination of only one employee out of six confirmed cases of abuse, neglect or exploitation reviewed for this baseline report. One employee was terminated for taking a shirt from Individual #121. During upcoming monitoring reviews, the Monitoring Team will review the Facility's adherence to its "no tolerance" for abuse, neglect or exploitation in greater detail, specifically with regard to the criteria used to make decisions regarding appropriate disciplinary action. Insufficient information was requested/provided about the full complement of disciplinary action taken as the result of the investigations reviewed during the baseline monitoring visit. This issue will require more in-depth review during the next monitoring visit. During the monitoring visit, efforts were made to track the follow-up activities related to the death of Individual #407 that occurred in September 2009. The survey and certification team had investigated this death, and made a number of recommendations. As a result, the Facility has issued the requirement that a nurse must respond to a call from a residential program with a site visit within two hours, or immediately for urgent	

#	Provision	Assessment of Status	Compliance
		issues. Methods for paging nursing personnel had been changed to a centralized system through the Facility operator. The requirements for reporting critical care issues at shift changes had been reviewed and Facility-wide instructions had been promulgated. However, based on review of the various records related to the death of Individual #407, there were a number of significant problematic clinical issues related to nursing that had not been fully addressed. They included the following: ▪ Lack of adequate and timely assessments by nursing for an individual who was experiencing a change in status as reported by direct support professionals; ▪ Lack of a full set of vital signs that did not include a temperature for an individual who was found to have a temperature of 107.6 when sent to the community emergency room; ▪ No documented neurological checks, mental status, or head-to-toe assessment prior to the individual's transfer to emergency room on 8/23/09; ▪ No documentation indicating how the individual was transported to hospital, exact time of transfer, who accompanied individual, what information was sent, or if the receiving Facility was notified of individual's condition; ▪ Nurses' signatures illegible in record; ▪ No adequate tracking of nursing staff assignments to identify the nurse who documented the inadequate assessment; ▪ No documentation by an RN who was noted in the progress notes to be involved prior to the individual's transfer to the hospital; and ▪ No documentation that physician was notified of changing status and symptoms. Based on interviews with the Medical Director, Chief Nurse Executive, and QE Nurse, an internal mortality review was conducted. The Medical Director stated that due to liability issues, no medical care findings were documented on Mortality Reviews. Nursing reported that they conducted an initial review on 9/20/09, but the QE Nurse indicated that she conducted an additional review on 10/12/09. Based on a review of the Death Review Investigation-ADDENDUM from Nursing Services dated 10/12/09, it indicated that when the direct support professional documented changes in the individual's status and that a nurse was notified, the name of the nurse was not included in the note. There was no indication that the direct support professional was interviewed to find out which nurse was actually notified. However, the report named a nurse that was apparently working during that shift and "would have been on the home at the very least between 0630 and 0730 to pass medications…" In the 10/12/09 report, the QE Nurse noted that: "according to the schedule," this particular nurse was working at a specific building. However, attempts to page her on 10/12/09 were unsuccessful, since the original pager number was found to be not a working number, and the hospital operator called a second pager number for which there was no return call from this nurse. The 10/12/09 report indicated that the QE Nurse then called the Nursing	

#	Provision	Assessment of Status	Compliance
		Operations Officer and an interim Nurse Manager who reported that the nurse she had been trying to contact had initially come to work, but had gone home during the shift. No further attempts to contact this nurse to discuss the significant problematic issues regarding Individual #407 were documented in the report. In addition, the report indicated that when the direct support professional found the individual "clammy and pale and the nurse checked the individual out and told staff to call 6200," that the nurse was "probably an agency nurse." There was no further documentation indicating that attempts were made to find out who the nurse was, and address the significant problematic issues regarding Individual #407. At the time of the review, Nursing had no additional documentation or information indicating that the specific nurses involved in this case were actually accurately identified and provided appropriate interventions, such as counseling/retraining to prevent these issues from happening again. The Recommendations generated from the Death Review Investigation-ADDENDUM for Nursing Services were as follows: ▪ The term "notified" should only be used if the direct support professional talked directly to a nurse. The direct support professional should document the name of the nurse with whom they spoke, and should document the name of the nurse, and time, if a nurse was paged. ▪ Direct support professionals should notify a nurse again if the nurse does not respond to a page within 15 minutes, and notify another nurse and the shift coordinator. (This item was included in the Facility's Plan of Improvement for QE monitoring) ▪ There should be specific time frames for when an individual should be assessed by a nurse, depending on if it is minor or non-urgent (within two hours) or urgent (immediately, without delay). (This item was included in the Facility's Plan of Improvement for QE monitoring) ▪ Nursing should take a full set of vital signs, when assessing individuals. ▪ Wood Hollow needed a system for filing nursing shift reports. ▪ Consideration should be given to a better paging system for LVNs. The pager number should be assigned to the home rather than the LVN. As noted above, at the time of the review, some procedures had been changed to address the issues identified. However, the underlying issues had not been addressed adequately. This is evidenced by the findings with regard to Section M.1 of the SA that are based on a review of individuals who were seen at the community hospital or emergency room. Specifically, many of the issues that were identified with regard to the failures in the nursing care provided to Individual #407 were still issues for individuals served by AUSSLC. In addition, as mentioned previously, the Nursing Department had no	

#	Provision	Assessment of Status	Compliance
		additional documentation or information indicating that the specific nurses involved in this case were accurately identified, and provided appropriate interventions such as counseling/retraining to prevent these issues from happening again. There was no system put in place to ensure that an accurate list of nurses working in each designated area was maintained. Although the QE Nurse took the initiative to conduct an additional review of Individual #407's case, a number of significant issues were not addressed, and those that were addressed were not addressed adequately to prevent the reoccurrence of these clinical nursing issues.	
	(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.	Section VIII.L of the DADS policy states this requirement regarding the maintenance of and access to investigation records. AUSSLC's procedures for the maintenance of investigation records were not examined during the baseline review. This requirement will be assessed during the next monitoring visit.	
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.	Section XIII of the DADS policy stated the requirements for tracking, analysis and corrective action. There was evidence that the Facility had begun its trending and tracking of unusual incidents and investigation results. During the baseline visit, a Trend Analysis report was reviewed for the First Quarter of FY 2010, and the first two months of the Second Quarter. The reports detailed the total number of incidents by type; the staff alleged to have caused the incident; the individuals involved in the incidents; the probable causes; and the locations and times during which the incidents occurred. These reports did not summarize the status or outcomes of any investigations. As noted above, there was evidence that not all serious incidents had been investigated fully by either DFPS or the Facility. The Facility had begun to track the investigation reports for abuse and neglect; and the outcome of each investigation was specified. This information was included in a report entitled "Allegations of Abuse/Neglect." Based on an interview with the QE Director, the Facility was in the process of refining the tracking and trending process, and the resulting reports and follow-up activities. The QE Director provided some examples of some trends that had been identified, including scratches, issues related to osteoporosis, and falls. For some of these issues, such as falls, a group had been brought together to discuss issues, and put processes in place either to gather additional information and/or take specific actions to address underlying causes.	

#	Provision	Assessment of Status	Compliance
		In other instances, such as the large numbers of scratches, plans were underway to bring an interdisciplinary group together to focus on the issue, potential causes, and potential activities that could help to reduce the occurrence of such injuries. One area that the QE Director, Incident Management Coordinator, and Director of the Facility had recently discussed was the need to enhance the process for follow-up on recommendations resulting from investigations. The Facility is encouraged to continue to expand its efforts with regard to the tracking, trending, and analysis of information related to incidents, allegations, and recommendations related to investigations. As issues are identified, action plans should continue to be developed and implemented to address underlying causes.	
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.	Criminal background checks are required for all employees and ongoing volunteers. Although the State policy on Abuse, Neglect and Exploitation does not contain information on prerequisites to allowing staff or volunteers to work directly with individuals, Section 3000 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers at section 3200.3. The DADS Operational Handbook, Revision 09-21 Effective 10/29/09, at Part E, Section 19000 requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff of volunteers to work directly with individuals. The Monitoring Team requested that the Facility submit documentation of the background checks completed for the last three employees completing their orientation period. Upon review of the information submitted by AUSSLC, background checks had been completed, and each of the three employees was cleared. The background checks for volunteers were not examined during the baseline review. This will be addressed in the next monitoring review.	

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

1. In order to address the protection from harm issues identified during the course of the AUSSLC review, the State should analyze the numerous factors that could be contributing to this issue and develop plans to address the underlying issues. In doing so, the State and the Facility should consider the following activities:
    a. Continue the steps it was taking to strengthen management oversight at the Facility through the identification of a permanent Director;

b. Develop and implement a plan to decrease the numbers of individuals with intense behavioral issues living together in various residences, including providing these individuals with additional personal space;
c. Stabilize staffing at the Facility, including decreasing the use of overtime, and "pulled" staff;
d. Consider a differential in pay for direct support professionals, nurses, and others as appropriate, to make such jobs attractive given the reportedly highly competitive market for similarly paying jobs in the Austin area;
e. Decisive action must be taken to improve the quality of life in certain residential units, including, for example 772A and 732D. The adequacy of staff and the grouping and number of individuals requires immediate review; and
f. Increase the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations.

2. With regard to the Facility policy:
   a. Although the Facility policy sets out circumstances when reporting is required as well as the results of failure to report, a strong statement of commitment that abuse and/or neglect will not be tolerated should be added. This commitment to not tolerate abuse and/or neglect should be reflected in the disciplinary action that is taken with staff confirmed to have been the perpetrators of abuse and/or neglect.
   b. It should be revised to specify the criteria for referral of allegations and incidents to law enforcement.
   c. It should clearly identify the procedures to be followed when law enforcement entities are involved to avoid any negative impact on law enforcement's investigation.
   d. It should clearly prohibit retaliation against staff, individuals, families, and others who in good faith report and/or participate in the investigation of a serious incident, or allegation of abuse and/or neglect.
3. Posters that explain individuals' rights should be placed in areas in the homes and day programs that are clearly visible to individuals. For example, they should not be placed on crowded bulletin boards or behind other materials. The Facility should consider posting both the Ombudsman's poster, as well as the rights poster in each residential and day/vocational setting on campus.
4. The staffing and other supports currently provided to the Self-Advocacy group should continue to be provided.
5. Concerted efforts should be made to assist individuals in learning about their rights, and about how to exercise them. Such efforts could take many forms, including, for example, learning objectives related to the exercise of rights; regular house meetings in which individuals are not only taught about their rights, but encouraged to exercise rights such as choice making about foods or activities; posting in homes or day programs about a "right of the month" with ongoing discussion with individuals about that right and how they could exercise it. Efforts to educate individuals about their rights should be individualized, as appropriate.
6. AUSSLC should develop and implement an auditing system to ensure that serious injuries are being appropriately referred for investigation.
7. The expectations with regard to the safeguarding of evidence should be added to the Investigator's Manual.
8. Requirements about training of investigators on working with individuals with developmental disabilities should be included in the DADS policy on Abuse/Neglect/Exploitation, or if these requirements are elsewhere in state policy, reference to their location should be provided in the A/N/E policy. The DADS policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.
9. The following recommendations are offered with regard to DFPS as well as Facility investigations:
   a. A checklist should be used to ensure that each investigation report contains the information required pursuant to the Settlement Agreement
   b. Extraneous pages should be removed and repetitious information eliminated, as appropriate;
   c. Dated signatures should be included for each of the reviewing officials;
   d. Any reports prepared by law enforcement or the OIG should be included in the final report;
   e. Greater attention is required to the section of the investigation report addressing recommendations. Recommendations need to be included for Facility-wide problems identified, as well as for individual issues; and

f. When peer review of a clinical issue is recommended as a result of a DFPS investigation, the documentation of the findings of the peer review should be included as part of the final investigation file.

10. The Facility should take a number of steps to address situations in which individuals make repeated allegations that are found to be inconclusive, unconfirmed, and/or the individual retracts their original statement. In order to protect individuals, allegations should never be ignored. At a minimum:
    a. The Facility should work closely with DFPS on how such investigations should be handled. The process for designating an individual as a "chronic caller" eligible for a streamlined investigation by DFPS needs to be clearly defined and stated in a policy. The process for a streamlined investigation also needs to be clearly defined. Any modification to the investigation process should require a team meeting, and an individualized investigation approach based on an interdisciplinary team decision about the particular needs of the individual.
    b. Individuals' teams should complete full assessments, including, for example, a functional assessment to determine the function of the individual's repeated calls, and, as appropriate, the development of a behavior support plans to address the behavior, and teach the individual a replacement behavior.
    c. There should be other considerations as well to protect staff as well as the individuals, for example, ensuring staff are never alone with an individual who has a history of making allegations that have not been confirmed.
11. The Facility needs to ensure that all significant incidents are reviewed, and a report written as required by the Settlement Agreement.
12. The State's plans to develop a statewide mortality committee, including the involvement of members external to the State system, should continue, and such a committee should be empowered to review deaths as soon as possible.
13. The valuable information being obtained through the nursing quality enhancement death review process needs to be thoroughly analyzed, and plans developed and implemented to address areas of concern. Such plans should address underlying issues to prevent their recurrence.
14. The Facility is encouraged to continue to expand its efforts with regard to the tracking, trending, and analysis of information related to incidents, allegations, and recommendations related to investigations. As issues are identified, action plans should continue to be developed and implemented to address underlying causes.
15. Staff providing direct supports should become a more integral part of the reform effort at AUSSLC. They have many concrete suggestions for change. For example, mentoring of new employees should be strengthened. There also should be a thorough review of the support provided to direct support professionals and nursing staff. Such a review, and any resulting plan of action should be designed with the outcome of reducing the high turnover rate.

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 Centers for Medicare and Medicaid (CMS) deficiency statements for 2/20/09, 10/09/09, 10/30/09, and 11/23/09; o DADS Policy Number 003: Quality Enhancement; o Trending and Tracking Reports for the First Quarter of FY 2010, and the first two months of the Second Quarter; o Reports detailing injuries and falls from 12/01/09 through 3/09/10, and fractures and peer-related injuries from 7/09 through 3/10 ▪ **Interviews with**: o Tammy Snyder, Director of Quality Enhancement; o Candace Guidry, State Office Coordinator for Quality Enhancement; o Libby Allen, Interim Director; and o Jenna Heise, Assistant Superintendent of Programs ▪ **Observations of**: o Mealtimes and other activities of daily living in residential units
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Staff responsible for Quality Enhancement at the Facility acknowledged that efforts were just beginning to be implemented. There was evidence of the collection of valuable data and the development of trending and tracking analyses. Staff had identified problems that impeded Quality Enhancement efforts. These problems included: fragmentation of follow-up activities; poor documentation; time constraints; delays in reporting; lack of support for the role of Quality Enhancement staff; and significant problems with staff turnover and staff shortages. Effective resolution of these critical problems will require a systemic approach. The ultimate measure of the effectiveness of the Quality Enhancement processes must be sustained improvement of the protections, services, and supports in the residential units. For example, regular and thorough monitoring of mealtimes is important, but improved outcomes likely will require that individuals be grouped in much smaller numbers with sufficient, properly trained staff, and on the basis of strengths not weaknesses.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends	There were initial efforts underway to gather and track reliable data. For example, the Facility had the capacity to track the presence of injuries through several reports,	

#	Provision	Assessment of Status	Compliance
	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.	including: ▪ There was an injury report for the period from 12/01/09 until 3/09/10 that specified the number and nature of injuries received per individual. A total of 69 injuries were documented for this time period. ▪ A report detailing the number and type of falls was available for the same time period. There were twenty falls. ▪ A report describing peer-caused injuries documented the individuals involved, and the type of injury incurred for the period from 7/1/09 to 3/12/10. ▪ Fractures were reported for the period 7/11/09 through 3/11/10. There were 13 fractures. ▪ Trending and Tracking Reports for the First Quarter of 2010, and the months of January through February 2010 documented the number and type of injuries by individual, the staff alleged to have caused the incident; the individuals involved in the incidents; the probable causes; the locations and times during which the incidents occurred. ▪ The Facility had begun to track the investigation reports for abuse and neglect; and the outcome of each investigation. This information is included in a report entitled "Allegations of Abuse/Neglect." According to the QE Director, the Facility was also tracking other information related to mealtime monitoring; Personal Support Plans (PSPs), including the timeliness of assessments, team members' participation in PSPs, and a tool had been developed to monitor the quality of PSPs with an increased focus on the living options section; restraints; staff's ability to articulate the requirements and process for reporting abuse and neglect; engagement; and individuals' records. The Facility acknowledged that it was just beginning to develop its data collection, trending and tracking capacity. There was an interest in looking at individual case issues on a continuous basis, and in addressing falls across all residential sites. Specifically, the QE Director indicated that a number of additional monitoring protocols were being developed.	
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)	In addition to the information referenced above, there was some documentation available to illustrate the Facility's initial efforts to monitor, and then develop corrective action plans. Trend analysis reports for incidents, for example, included an action plan component. However, as was recognized by the Facility QE Director, and the State Office QE Coordinator, these action plans needed further refinement, because they lacked sufficient detail. Mealtime monitoring had been started, and recommendations were being issued to the residential units. However, actual action plans had not been developed, including the actions that had been agreed upon as necessary to correct underlying issues, the party responsible for completion of the action steps, the anticipated outcomes, or timelines for	

#	Provision	Assessment of Status	Compliance
	responsible; and the time frame in which each action step must occur.	completion. The Facility staff also indicated that benchmarks had not been set. The Facility indicated that its efforts to develop monitoring tools, as well as trending and tracking reports have been impacted by the monitoring visits by survey and certification surveyors that occurred from 10/09 through 12/09, and the follow-up that was necessary to address a number of serious concerns identified by the survey team(s). In discussing current priorities, it was reported that through its Slip/Trip/Fall Committee, the Facility planned to further analyze information related to falls across the residential units. The need to more carefully track and analyze medication errors also was cited as a major priority. It was noted that a meeting on trending and analyzing data was planned with the Directors of Quality Enhancement at the Facilities and the State Office Coordinator for Quality Enhancement. Reportedly, DADS reviewed Trend reports that were currently produced.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Recommendations resulting from mealtime monitoring were being forwarded to the Unit Director, the dietician, and the Assistant Director for Programs with requests for corrective action. However, as discussed above with regard to Section E.2 of the SA, corrective action plans regarding mealtimes had not yet been developed.	
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	As noted above, the Facility was at the initial stages of developing and implementing corrective action plans for many issues, and even for investigations, the Facility did not have a standardized process for monitoring the implementation of recommendations through to completion.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	There was no evidence that corrective action plans were being developed regularly. As a result, it was too early in the process to determine if they were being modified as necessary.	

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

1. The QE Department should finalize the development of the Quality Enhancement Plan, including the development of review tools that will be used, schedules for monitoring, processes for analyzing data, identifying trends, and developing, implementing and monitoring corrective action plans. The roles of other departments and staff in the QE monitoring process, as well as the implementation of corrective action plans should be defined.
2. Part of the development of the QE system should include the establishment of benchmarks. Benchmarks should target improvements in the quality of protections, supports, and services provided to individuals, including as a priority the quality of active treatment on the residential units. The ultimate measure of the effectiveness of the Quality Enhancement processes must be sustained improvement outcomes for

individuals served by the Facility. For example, monitoring mealtimes is important, but improved outcomes will require that individuals are grouped, in much smaller numbers, on the basis of strengths not weaknesses, and supported by adequate number of staff who are competent to address their needs.

3. As problematic trends and/or individual issues are identified, the Facility should develop, implement and monitor corrective action plans.

<table>
<tr><th>SECTION F: Integrated Protections, Services, Treatments, and Supports</th><th></th></tr>
<tr><td rowspan="2">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Agenda for Person Directed Planning (PDP) Training for Qualified Mental Retardation Professionals (QMRPs), April 9 and 14, 2009, and related training handouts/materials;
o Agenda for PDP Training for Professional Staff, May 1, 2009, and related training handouts/materials;
o Agenda for Personal Support Teams: PDP Process, October 14, 2009, and related handouts/training materials;
o PDP Training Pre-Test, undated;
o Personal Support Plan (PSP) Meeting Monitoring Checklist, revised 3/10/10;
o QMRP Meeting Agenda, for meeting on 4/5/10;
o Community Living Options Discussions handout from QMRP meeting on 4/5/10;
o Draft Positive Adaptive Living Skills (PALS) Summary handout from QMRP meeting on 4/5/10;
o Guidelines for Conducting PSP Addendums (PSPAs), dated 4/10;
o Personal Focus Worksheet (PFW): Individualized Assessment Screening Tool, revised 7/31/09;
o Dates of Admission, Most Recent PSP, and Previous PSP, dated of 4/8/10;
o Six completed PSP Meeting Monitoring Checklists, various dates between 1/21/10 and 3/12/10; and
o Most recent PSPs, PSPAs, related assessments, Specific Program Objectives (SPOs), and monthly/quarterly reviews for the following individuals: Individual #177, Individual #393, Individual #146, Individual #8, Individual #459, Individual #276, Individual #218, Individual #339, Individual #401, Individual #277, Individual #242, Individual #360, Individual #233, Individual #94, Individual #93, Individual #291, Individual #263, Individual #409, Individual #32, and Individual #68
▪ Interviews with:
o Tammy Snyder, Director of Quality Enhancement, and Acting QMRP Coordinator;
o Individual #459;
o Individual #133; and
o Individual #291
▪ Observations of:
o QMRP Meeting, on 4/5/10</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
</table>

	Summary of Monitor's Assessment: The biggest challenge for AUSSLC with regard to PSPs appeared to be with regard to ensuring that team meetings included interdisciplinary discussions that resulted in one comprehensive, integrated treatment plan for each individual. As is noted in other sections of this report, issues with regard to adequate assessments impacted teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans. One area where all plans reviewed could benefit from additional attention was with regard to "community participation." While most plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. In addition, the Facility will need to be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking and realistic community safety skills, become a regular part of training programs for individuals served. Quality Enhancement activities with regard to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The DADS policy for this section had not been developed at the time of this review, and so could not be reviewed. AUSSLC also did not have a policy to address interdisciplinary teams or the planning process.	
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.	Based on interview, the QMRP was identified as the facilitator of the team process, including ensuring that team members participated in assessing each individual, and in developing, monitoring, and revising treatment, services, and supports. However, as noted above, this was not memorialized in policy. At the time of the review, neither the State nor the Facility had a policy to address the interdisciplinary team process. Members of the Monitoring Team observed the QMRP Meeting that occurred during the week of the monitoring visit. The Director of Quality Enhancement, who was the Acting QMRP Coordinator due to a recent vacancy in this position, led the meeting. This appeared to be a valuable forum for QMRPs to share information, as well as for QMRPs to receive in-service training and updates. For example, during the meeting, the new Post-Move Monitor shared a document with the group entitled "Community Living Options Discussions." The Post-Move Monitor shared information about changes and expectations from State Office, and led a discussion about ways in which the Community	

#	Provision	Assessment of Status	Compliance
		Living Option Discussions during individuals' PSP meetings could be improved, and become more integrated with the overall planning process. A number of QMRPs contributed to the discussion by offering suggestions based on successes they had had with various individuals and families. Particularly because the QMRPs were not all supervised by one person, it is important for these types of meetings to continue to ensure that there is continuity in the ways plans are developed, monitored, and revised. In terms of QMRP staffing, at the time of the review, it was reported that there were 16 QMRPs. There were 28 residential sites on campus. QMRP caseloads ranged from 22 to 32 individuals.	
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.	According to the QE Director, the Facility was at the beginning stages of implementing a system to track participation in annual planning meetings. This system was not evaluated, but will be reviewed during upcoming monitoring visits. Based on reviews of PSPs, QMRPs were present at the annual meetings. Other team members who participated varied and included nurses, direct care professionals, Legally Authorized Representatives (LARs), psychologists, day/vocational staff, Occupational Therapists (OTs), Physical Therapists (PTs), and other disciplines. Generally, physicians, including psychiatrists were not present. For a sample of nine PSPs (Individual #94, Individual #233, Individual #93, Individual #242, Individual #277, Individual #401, Individual #291, Individual #177, and Individual#8), team membership could not be determined for four (44%), because no sign-in sheets were provided; appropriate team membership was not found for three (33%); and appropriate team membership was present for the remaining two individuals (22%). Examples of issues noted with regard to team members' attendance included: ▪ Individual #242 had a dining plan, and used adaptive equipment. He also had communication difficulties. However, at his 3/18/10 PSP meeting, no participation was noted from an OT, PT, and/or Speech Language Pathologist. ▪ Individual #291's 9/9/09 PSP identified him as being at high risk due to weight. His weight was 158 pounds (90%) over his Desired Weight Range (DWR) of 139 to 174 pounds. He had a diagnosis of hypertension, was at risk for dehydration, and was prescribed multiple psychotopic medications. None of the following were present at his PSP meeting: physician, psychiatrist, nurse, or dietician.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the	Most of the PSPs reviewed contained assessments of health, residential living, often the Positive Adaptive Living Skills; behavior, including psychological evaluations; speech; OT/PT; nutrition; self-administration of medication; audiological screening; dental; and other assessments based on specific needs. Vocational evaluations were in some, but not all, files. Few plans included a "Personal Focus Worksheet" (PFW) that gathered	

#	Provision	Assessment of Status	Compliance
	individual's strengths, preferences and needs.	information on the individual's preferences. Most plans included the DADS-authorized assessment forms for various potential risks such as aspiration, weight, nursing risks, and polypharmacy. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs.	
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.	There was not always a clear connection between the assessments and the PSP. For example: ▪ The Personal Focus Worksheet was not available in all plans reviewed, but where it was, it showed promise for shaping plans that attend to the interests of the individual across disciplines. ▪ Many of the examples provided F.2.a.2 and F.2.a.3 below illustrate that assessment results, such as from nursing assessments, or PNMPs, were not being integrated into individuals' PSPs. ▪ As is discussed in further detail regarding Section S of the SA, functional assessments were not being completed regularly. As a result, findings from such assessments were not yet being integrated into the BSPs and/or PSPs.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each	As stated previously, the DADS policy for this section had not been developed at the time of this review, and so could not be reviewed. AUSSLC also did not have a policy to address interdisciplinary teams or the planning process.	

#	Provision	Assessment of Status	Compliance
	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;	Lists of prioritized needs were not found in the plans reviewed. At the 4/5/10 QMRP Meeting, a draft summary sheet for the PALS assessment was provided to the group for comment. According to the QE Director who ran the meeting, one of the intentions of modifying the form was to provide a tool for QMRPs and teams to better prioritize individuals' needs. Plans generally identified lists of individuals' strengths and preferences. Some of these lists were substantial, and showed that the teams knew the individuals well. However, there often was not a clear connection between these preferences and strengths, and the supports and services being provided to the individual. Some examples of how these preferences and strengths could have been better integrated are provided below. Another area where all plans reviewed could have benefitted from additional attention was with regard to "community participation." While some plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Most simply stated that the individual would "have the opportunity to participate in off campus activities at least" for a stated number of times per month. Goals that easily could have been implemented in community settings and probably would have been more meaningful if they had been did not specifically state that they would be implemented in the community. For example: ▪ Individual #233's 5/19/09 PSP indicated that she would be given opportunities for off campus activities three times a month. She had a money management goal of stating the names of coins. This goal could have become much more functional if it was implemented in the community, where there could be a linkage made between coins and purchases. Her personal preferences that her team had listed also could have been utilized to further enhance this goal. For example, she could have used coins to purchase headbands or nail polish. ▪ Individual #177 had a goal to count her change after buying something. This is an ideal goal for implementation in community settings. The training instructions for this objective, however, did not require that it be implemented in the community. The instructions read: "Training will occur in [Individual #177's home or outside of [Individual #177's] (sic) in a quiet area with minimal distractions." To make goals as functional as possible, efforts should be made to teach them in naturally occurring settings. Individual #177's team had done a good job of identifying a number of preferred activities, including community activities. Consideration should be given to integrating the implementation of this objective with one of those activities that is naturally reinforcing for Individual #177. For example, a number of inexpensive foods were listed as	

#	Provision	Assessment of Status	Compliance
		preferences, as were compact discs. Community activities related to these items could be incorporated into the teaching strategies for Individual #177's money management goal.	
	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;	PSPs generally had some individualized and measurable goals/objectives, treatment strategies and supports. However, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. As is discussed in other sections of this report, nursing plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that may have been referenced in the PSP. Specific individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of these essential plans. For example, in order to provide health care supports to individuals served, direct support professionals, as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. Some examples of the ways in which PSPs failed to define measurable objectives included: ▪ As noted above, Individual #291's 9/9/09 PSP identified him as being at high risk due to his weight. His weight was 158 pounds (90%) over his Desired Weight Range (DWR) of 139 to 174 pounds. His 9/9/09 PSP identified no measurable goals or objectives to assist him in losing weight. Subsequent "Staffing Reports," for example, on 2/8/10, indicated that: "The team agreed to monitor meal servings to ensure that [Individual #291] was receiving his appropriate calories; he receives a low calorie diet. The team is also encouraging more physical activity: [Individual #291] walks with staff, and other residents and [Individual #291] has helped organize a kickball game. [Individual #291] will also have a training objective to encourage him to make healthy choices when shopping for food items." These all appeared to be beneficial strategies. However, the only one that was measurable was the skill acquisition goal. No measurable parameters had been assigned, for example, to staff initiating walks with the individual, or encouraging other forms of physical activity. No specific responsibility was assigned for monitoring his caloric intake and documenting it. ▪ Although the nursing objectives in Individual #8's 12/9/09 PSP addressed potential for skin breakdown, and the need for the individual to lose 20 pounds, the responsible person for each of these objectives was listed as the nurse. For both of these objectives, direct support professionals play a key role in assisting the individual to remain healthy. However, no specific measurable objectives were included for the direct support professionals with regard to skin breakdown. On a positive note, there was a service objective for the staff to assist individual to walk around the campus loop on a daily basis. Although Individual #8 had a number of objectives designed to "increase her knowledge of	

#	Provision	Assessment of Status	Compliance
		keeping her body healthy," none of these related to the issues nursing had identified, specifically her weight and/or skin breakdown. In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the Facility is at the very initial stages of complying with this component of the SA.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted above, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. The lack of integration of services is illustrated in the following examples: ▪ As is discussed above with regard to Individual #291, his team did not identify in measurable terms the strategies that would be used to assist this individual who was 90% above his DWR to lose weight. Moreover, none of the documentation showed an integration of supports. For example, neither the PSP nor the "staffing reports" that documented subsequent team meetings showed an integration of psychological/behavioral services in the team's discussions about strategies to assist Individual #291 to lose weight. ▪ Many of the plans reviewed had a page(s) included entitled "Special Considerations." On these documents critical information was included regarding "components that should be incorporated into all interactions with" the individual. These are the types of components that should have been integrated into the action plans, and included as measurable objectives, with assigned responsibility for implementation, as well as documentation. For example: o For Individual #8, items that were included in the Special Considerations attachment, but should have been included in the service objective section of her plan, included but were not limited to: ensuring phone calls were on speaker phone, ensuring she did not leave campus except with designated people, ensuring sharp objects were not in her environment, monitoring for side effects of medication, and encouraging her to eat slowly. o Likewise, Individual # 177 had a number of "special considerations" that were not integrated into the action plans and service objectives. For example, she had a PNMP that required the head of her bed be elevated, and that she remain upright for one hour after meals. She also had medications for which side effects needed to be monitored, and a visitation plan that needed to be implemented. ▪ At times, there were inconsistencies with assessments, but these did not appear to be reconciled by the teams. For example, Individual #277's PSP indicated that she had had a seizure during the year, and anticonvulsant medication was	

#	Provision	Assessment of Status	Compliance
		started. Although her nursing care plan recognized she had a seizure disorder, this was not identified on the problem list requiring a nursing care plan. No objectives were included in her PSP to address this issue. It was not clear from the PSP that the team had even discussed it.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion, and the staff responsible. Methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	
	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	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. In nine plans reviewed (for Individual #94, Individual #233, Individual #93, Individual #242, Individual #277, Individual #401, Individual #291, Individual #177, and Individual#8), only one cooking goal, involving the use of the microwave was found. Although many of the homes on campus had kitchens, food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. For example, while the Monitoring Team was on campus, they witnessed a number of individuals walking about or riding their bikes independently, without much regard for typical pedestrian or biking rules or safety. Although it is positive that individuals have this level of independence, the different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the	For the goals and objectives included in PSPs, generally, the PSPs specified data to be collected and/or documentation to be maintained and specified a frequency for collection. Although often the frequency was vague, for example, "as needed," or at times was this column was left blank. In addition, it was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes to the process when there is little or no progress. The overarching concern was that many goals and objectives were not specified in individuals' PSPs. As a result, appropriate data was not being collected to assist teams in decision-making.	

#	Provision	Assessment of Status	Compliance
	data review.		
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.	Based on the review of PSPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between psychiatric and behavioral support; dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	
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.	This requirement will be reviewed during the next monitoring visit.	
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.	Based on interview with the Director of Quality Enhancement, at the time of the review, few monthly and/or quarterly reviews were being conducted by individuals' teams. As part of the onsite document request, the Monitoring Team requested monthly/quarterly reviews for a sample of individuals. Out of the nine individuals reviewed (Individual #94, Individual #233, Individual #93, Individual #242, Individual #277, Individual #401, Individual #291, Individual #177, and Individual#8), five had documented monthly staffing notes. However, none of these constituted a full review of the individuals' programs and supports. Generally, these were minutes from meetings that had been held to address a need to change a plan, discuss an on-campus move, or review a particular plan or support.	
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	In reviewing the various agendas and materials related to person directed planning, the training materials included voluminous information regarding the planning process, including many instruction sheets, and forms. Many of these materials appeared to be valuable. However, it was not clear how this information was presented to training participants, and if such presentation was meaningful, and resulted in the QMRPs and	

#	Provision	Assessment of Status	Compliance
	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.	other PST members attaining the skills and competencies necessary to develop adequate integrated plans for individuals at AUSSLC. More specifically, the agendas submitted did not correspond directly to the materials provided. Some additional concerns related to the content of some of the materials is discussed below with regard to Section S.3 of the SA. This is an area that will require further review during upcoming visits. In addition, with regard to the competency-based component of the training, the documents included a pre-test, and a "Basic Addendum and Goal Writing Post Test." Neither of these was sufficient to measure the competence of QMRPs with regard to the facilitation of the meeting, and/or the writing of the PSP document, or the competency of other team members with regard to the PSP process. Training appeared to have occurred in April 2009 for QMRPs, in May 2009 for "professional" staff, and for "Personal Support Teams" in October 2009. It was unclear from the materials provided if all staff had received training annually.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on a list, dated 4/8/10, that included for each individual at AUSSLC the date of his/her most recent PSP and previous PSP, five out of 389 individuals (1%) had not had a PSP meeting within the last year. For the four individuals who had been admitted to the Facility during the six months prior to the review, one individual's planning meeting was scheduled during the week of the review, which would have been within the 30 days of his admission; and for the remaining individuals, all three had had PSP meetings within 30 days of their admission. Information was not requested to determine if plans were available within 30 days of the meeting. This will be reviewed during the next onsite visit.	
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	AUSSLC was at the beginning stages of developing and implementing quality assurance/enhancement processes with regard to the development and implementation of PSPs. The Facility had developed a monitoring tool entitled the Personal Support Plan Meeting Monitoring Checklist. It appeared that this tool had been revised a few times in the months preceding the review, with the latest revision on 3/10/10. This tool was designed to review the PSP meeting, and included many appropriate indicators. It could be enhanced by adding some additional indicators, such as ones that would focus more	

#	Provision	Assessment of Status	Compliance
	the ISPs are developed and implemented consistent with the provisions of this section.	on the interdisciplinary team process; the integration of supports and services, for example, PNMPs, nursing care plans, etc.; the prioritization of goals and objectives; and the integration/implementation of goals and objectives into community settings, as appropriate. The Monitoring Team requested the completed monitoring forms for the three months prior to the onsite review. The Facility provided copies of six completed tools. One of these utilized the most recent format of the monitoring tool. The validity and/or reliability of some of the information on the tools were of concern. Based on the comments provided on the tools, indicators were not consistently scored the same way. For example, with regard to the indicator that addressed the appropriate Facility staff participating in the meeting, the form completed for Individual #94 indicated that vocational staff and the PT were at least 20 minutes late, and psychology, dietary, and the MRA representative all left early. This does not constitute full membership of the team, particularly to ensure an integrated approach to planning, but this indicator was marked "Yes." Likewise, for Individual #389, it was noted that the psychologist did not attend, but this indicator was scored as a "Yes." Similar discrepancies were found with other indicators, such as the indicator that addressed whether team members spoke directly to the individual. Finally, on some of the forms, there were indicators that were not scored at all. Criteria should be developed to ensure that the scoring for indicators is consistent, and validity checks, as well as inter-rater reliability studies should be completed to ensure the reliability, and validity of the monitoring data. It is positive that this tool had been developed, and improvements made to it over time. The Director of QE indicated that they had not yet begun to aggregate the data, but that this was the next step in the process. The QE Director also indicated that in late February 2010, they had begun to track late assessments, and the participation of interdisciplinary team members in PSPs. The Monitoring Team looks forward to reviewing the data generated from these efforts, as well as any resulting action plans during upcoming reviews. Another monitoring tool that should be developed would be one to measure the quality of the PSPs themselves. In addition, the numbers of reviews to be completed each month/quarter, as well as the sampling technique should be defined.	

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

1. Once the State's policy with regard to interdisciplinary teams and integrated planning is finalized, AUSSLC should adopt the State's policy and/or develop, as appropriate, its own policy on this topic.
2. The Facility should investigate the causes for some PSPs meetings not being held in a timely manner, and, as appropriate, should address the issues identified.
3. The following recommendations are offered with regard to training staff on the interdisciplinary approach and individualized planning process:

- Methodologies for determining QMRPs' as well as other team members' competence with regard to the development and implementation of PSPs should be developed and/or implemented. In order to measure a QMRP's competency in the development of PSPs, a two-step process should be considered. Specifically, tools should be developed to evaluate a QMRP's ability to facilitate the team meeting, and another to evaluate the QMRP's ability to develop a PSP that meets all of the related requirements.
- QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, including conflict resolution, particularly as is relates to the interdisciplinary team process.
- As teams are trained on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
- The training curricula currently used at AUSSLC should be reviewed to ensure that it adequately addresses relevant areas, including but not limited to identifying priority needs of individuals served; identifying all of the protections, services and supports an individual requires; developing measurable goals and objectives; and clearly defining expectations with regard to the implementation of and data collection related to action plans.

4. As indicated in other sections of this report, focused efforts should be made to improve the quality and timeliness of assessments that are used in the development of individuals' PSPs.
5. Barriers, if any, to the inclusion in PSPs and implementation of community-based skill acquisition programs, such as transportation, staffing, and funding, should be investigated and addressed.
6. Personal Focus Worksheets should be completed on every individual before their annual PST meeting. Staff should be trained on how to discover important information about a person's interests and wishes from observation rather than only from conversation, particularly when the individual does not communicate verbally.
7. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, and therapeutic support plans a part of the PSP, rather than stand-alone documents.
8. The Facility will need to be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking and realistic community safety skills, become a regular part of training programs for individuals served.
9. With regard to monitoring activities, the Facility should:
    a. Review and revise existing monitoring tools, as necessary, to ensure that there are indicators that address the various components of the SA, including but not limited to the interdisciplinary team process; the integration of supports and services, for example, PNMPs, nursing care plans, etc.; the prioritization of goals and objectives; and the integration/implementation of goals and objectives into community settings, as appropriate;
    b. Develop additional tools, as necessary, such as a tool to measure the quality of the PSP document itself;
    c. If not already done, set expectations with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, and the follow-up activities that are expected to occur;
    d. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.

SECTION 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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. It appears that the Facility is working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. Some of the most striking include the need for greater integration between dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. These are all discussed in further detail in the sections of this report that address these various disciplines.	
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	It appeared that the Facility was working on methodologies to ensure that recommendations from non-Facility clinicians were reviewed, considered, and documentation maintained justifying decisions. According to the Facility's Plan of Improvement, processes were being put in place for this beginning on 12/26/09, shortly before this review, with a target date for completion of 6/26/11. During upcoming monitoring visits, this will be reviewed.	

#	Provision	Assessment of Status	Compliance
	supports and services.		

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

1. Recommendations regarding integration of clinical services may be found in each of the respective sections of this report.
2. The Facility should continue to move forward with plans to ensure that appropriate clinicians review recommendations from non-Facility clinicians, and document whether or not such recommendations are accepted, and, if not, why not. As appropriate, recommendations should be forwarded to individuals' PSTs.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: According to the Facility's Plan of Improvement, the Facility was in the process of developing policies and procedures to implement these provisions of the Settlement Agreement. The target date for most of these activities was 6/26/11. As is illustrated throughout this report, different clinical disciplines were at different stages of ensuring that assessments and evaluations were completed as required or needed, treatment plans were developed and implemented, monitoring systems were in place to measure compliance with and the efficacy of treatment plans, and treatments and interventions were modified as needed.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who may benefit from communication systems; and individuals being considered for enteral nutrition.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and	This will be more fully assessed during the next monitoring visit.	

#	Provision	Assessment of Status	Compliance
	Related Health Problems.		
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.	As is referenced in the section above with regard to Section H.1 of the Settlement Agreement, without timely and thorough evaluations and assessment, the planning of treatments and interventions was hindered. For example, for individuals for whom communication needs had not been properly assessed, adequate treatments and interventions were not being developed, and implemented. Likewise, because nursing assessments did not result in the identification of a full range of nursing and other interventions to address individuals' diagnoses, nursing services were not appropriately integrated into PSPs, and proper treatment was not being provided.	
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.	As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, individuals' PSPs did not identify target symptoms or side effects to be tracked to assist in determining the efficacy of the treatment. Likewise nursing plans did not identify what clinical indicators were to be tracked, by whom, or when. Physical and nutritional management plans also did not identify the functional outcomes to be measured.	
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.	Again, as is illustrated, for example, in the nursing and physical and nutritional support sections of this report, there were not systems in place to effectively monitor the health status of individuals.	
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.	Until accurate clinical indicators are developed and monitored/measured, this will continue to be an indicator on which the Facility needs to work.	
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.	According to the Facility's Plan of Improvement, such policies were anticipated to be completed beginning at the end of December 2009, with a target date of 6/26/12. This will be further assessed during upcoming visits.	

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

1. Recommendations regarding the common elements of clinical care are included in other sections of this report.
2. The Facility should continue to develop and implement policies related to the common elements of clinical care.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS At Risk Individuals policy, dated 10/5/09; o DADS Nutritional Management Team policy, dated 12/17/09 o HST Revised Policy, dated 10/09; o Health Risk Assessment Tool-Nursing; o Braden Scale*;* o AUSSLC's Resident Current Health Risk Ratings list, undated; o AUSSLC's list of individuals who had emergency room visits and/or hospitalizations, between March 2009 and March 2010; o Hospitalizations from 3/09 through 3/10; o ER Admissions from 6/09 through 3/10; o Pneumonia Diagnosis from 8/08 through 8/09; o Choking-Heimlich Performed from 4/09 through 12/09; o HST Risk Levels/AUSSLC Health Status Team Meeting Notes for 2009 and 2010; o Health Risk Assessment Tools, dated 10/09; and o Nutritional Management Team (NMT) Review/Recommendations and Attendance Records from 3/09 through 3/10 ▪ **Interviews with**: o Rebecca Hall, RN, Chief Nurse Executive; o Kim Sweeney, RN, QE Nurse; o Carolyn Harris, RN, NOO; o Carla Jones, RN, Health Status Coordinator; o Karen Hardwick, Director Habilitation Therapies, and State Coordinator for Physical and Nutritional Management (PNM); and o Dr. Bibus, Medical Director ▪ **Observations of**: o Health Status Team meeting on 4/5/09; o Health Status Team meeting for Residence 783, on 4/6/10 o Infirmary; and o Various homes and day programs throughout campus
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The current risk assessment tools used by AUSSLC did not provide an adequate comprehensive risk assessment for any of the areas addressed, and did not result in the appropriate identification of clinical risk indicators or risk levels for the individuals reviewed.

	Standardized statewide tools with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals' risk levels are appropriately identified. The current system being used did not accurately identify individuals at risk, and did not ensure that proactive interventions were timely put in place to address the specific areas of risk. Once an appropriate risk identification system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and supports for at-risk individuals. Such assessments tools should also be used for reassessment in response to changes as measured by established at-risk criteria. The initial assessments and reassessments will need to occur according to the required timeframes set forth in the Settlement Agreement. The Health Status Team (HST) meeting has potential, however, in its current form it lacked appropriate criteria and structure to assist the team in accurately determining risk levels. The team discussion at these meetings should result in identification of an associated level of intensity of clinical supports to address the risks, as well as the implementation of proactive measures aimed at preventing risks.

#	Provision	Assessment of Status	Compliance
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.	At the time of this review, AUSSLC was not able to accurately identify individuals with clinical risks. The Facility was using the Health Risk Assessment Tool-Nursing as directed by the State to identify clinical risk indicators for individuals. However, this tool was simply a questionnaire that was scored either "yes" or "no" for questions in areas regarding Cardiac, Constipation, Dehydration, Diabetes, gastrointestinal (GI) concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. The questions contained on the tools had no weighted values and consequently, the tool did not provide an accurate indication of risk. The tool was not an adequate comprehensive risk assessment for any of the areas mentioned, and did not result in the appropriate identification of clinical risk indicators. Standardized statewide tools with established reliability and validity should be used in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified so that proactive interventions can be timely put in place to address these risks. For example, the Facility was using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. The tool clearly identifies levels of risk for skin issues, so that appropriate interventions can be implemented to treat the existing issue and prevent further worsening of the problem. Based on observations of the Facility's Health Status Team (HST) Meeting for Residence 783, during which representatives from all disciplines discussed and determined the risk rating (one to four, with one being the highest level of risk) for individuals, the lack of criteria used to assign a risk level rendered these risk determinations as arbitrary at best.	

#	Provision	Assessment of Status	Compliance
		For a number of individuals reviewed, the team struggled to assign risk levels without guidelines to assist in the process. In addition, aside from the Health Status Team meeting more frequently for individuals determined to be at the highest risk level, there appeared to be no other clinical benefits or interventions associated with being deemed at the highest risk level. As noted above, as documented on their Resident Current Health Risk lists, AUSSLC was using risk ratings that included a scoring of a one to four, with one being the highest level of risk. However, the current DADS policy addressing risk levels only contained risk levels from one to three, again with one being the highest risk. Although neither risk rating level system included adequate criteria on which to base a rating, there should be consistency in the assignment of risk levels. This is important to ensure consistency in: 1) the assignment of risk levels to individuals across Facilities; 2) setting and maintaining expectations with regard to follow-up activities depending on risk levels identified; 3) monitoring by the State's Central Office to ensure adequate follow-up for individuals identified as at risk; and 4) comparison of data on a statewide level of outcomes achieved for individuals identified as being at-risk. Also, at the HST meeting, there was no discussion or review of individuals assigned lower risk levels to ensure that proactive measures and interventions were in place to possibly prevent them from developing a higher risk status. Unfortunately, despite the amount of time the professionals spent in this meeting trying to determine a risk level number, clinical discussion regarding appropriate interventions to address current clinical issues and to improve outcomes did not occur in meaningful fashion. Although the Health Status Team meeting in its current structure did not adequately identify or ensure that risk areas were being appropriately addressed, the group had potential to fulfill its mission if a risk system was developed that included appropriate criteria and structure to assist the team in accurately determining risk levels. The appropriate assignment of such risk levels should result in an associated level of intensity of clinical supports being identified to address the risks, as well as the implementation of proactive measures aimed at preventing these and other possible risks. From review of AUSSLC's Resident Current Health Risk Ratings list and the list of individuals who have been admitted to the community hospital or seen at the community emergency room (ER), several individuals who have been hospitalized had not been identified by the HST as being at the appropriate level of risk. For example: ▪ Individual #39 was hospitalized four times for pneumonia/respiratory distress on 10/23/09, 11/14/09, 1/11/10, and 2/5/10, and for Status Epilepticus on 8/17/09, but was listed as a Risk Level "2" (high/ stable) on the Facility's	

#	Provision	Assessment of Status	Compliance
		Resident Current Health Risk Ratings list for risk of aspiration and medical issues. These hospitalizations were not indicative of stability regarding this individual's risk for aspiration or medical issues. ▪ Individual #89 was hospitalized on 3/12/10 for cardiac arrest, but was listed on the Resident Current Health Risk Ratings list as a Risk Level "3" (moderate) for medical risks. ▪ Individual #108 was seen in the emergency room on 8/25/09 for right hand pain from self-injurious behavior (SIB), on 11/9/09 for right hand pain after hitting a window, and on 1/28/10 for right hand pain after hitting a wall. He was assigned a Risk Level "3" (moderate) for risk of injury, and a Risk Level "4" (low) risk for behavior on the Facility's Resident Current Health Risk Ratings list. Clearly, the current risk identification system was not appropriately identifying individuals at risk, or providing an objective measure of the level of that risk. Because risks were not even being properly identified, they also were not being properly addressed. The DADS At Risk Individuals policy in Section V entitled Risk Levels/Ratings Assigned by the Health Status Team (HST), dated 10/5/09 identified three risk levels, including: High Risk-Level 1; Medium Risk-Level 2; or Low Risk-Level 3. This appeared to be the system that the HST at AUSSLC was using. The Nutritional Management Team (NMT) Review documentation from 3/17/09 to 3/17/10 included multiple risk levels: Level 1 Acute (A) or High (H); Level 2-Chronic (C) or Medium (M); or Level 3-Stable (S) or Low (L). A review of individuals on the Health Status Risk List, dated 10/2010 did not identify any individual at high risk for aspiration, although there were multiple individuals who had been admitted to the Emergency Department (ED) according to a list provided for the period from 3/09 to 03/10, and/or hospitalized for the period from 6/1/09 to 3/2/10, with a discharge diagnoses of pneumonia and/or aspiration pneumonia as documented below:	

Individual	HST Aspiration Risk Level	NMT Risk Level	# Hospitalizations with pneumonia diagnoses	# ED Visits with pneumonia diagnoses
Individual #252	Risk Level 2 (Medium)	-	3	0
Individual #262	Risk Level 3 (Low)	C (Chronic) (4/15/09) L (Low) (9/21/09)	1	1

#	Provision	Assessment of Status					Compliance
		Individual #375	Risk Level 3	-	1	1	
		Individual #426	Risk Level 2	S (Stable) (4/20/09)	3	4	
		Individual #396	Risk Level 2	C (3/24/09) A (Acute) (5/26/09) M (Medium) (8/24/09)	3	1	
		Individual #39	Risk Level 2	C (8/24/09) L (9/21/09)	7	3	
		Individual #336	Risk Level 2	S (5/20/09) L (11/18/09) M (12/16/09)	1	1	
		Individual #311	Risk Level 2	C (4/15/09) S (7/15/09) L (10/21/09)	1	0	
		Individual #22	No Risk Level	L (12/22/09)	2	1	
		Individual #322	Risk Level 2	H (High) (12/16/09) L (1/20/10)	1	0	
		Individual #199	Risk Level 2	S (3/24/09) M (9/21/09) H (12/22/09)	4	2	
		Individual #331	Risk Level 2	A (7/15/09) H (9/21/09)	3	3	
		Individual #216	No Risk Level	M (9/16/09) H (11/18/09) L (12/16/09)	1	2	
		Individual #380	Risk Level 2	-	1	0	
		Individual #413	Risk Level 2	S (6/17/09)	3	2	
		Individual #362	Risk Level 2	H (11/18/09)	1	2	
		Individual #286	Risk Level 3	S (3/24/09)	3	0	
		Individual #407	No Risk Level	C (6/17/09) A (7/15/09)	2	1	

#	Provision	Assessment of Status	Compliance

Individual #14	Risk Level 2	S (3/24/09)	2	1
Individual #227	Risk Level 2	C (4/15/09) L (2/17/10)	1	0
Individual #402	Risk Level 3	S (3/24/09) L (8/24/09) H (12/22/09)	5	0
Individual #28	Risk Level 2	-	1	1
Individual #27	Risk Level 2	-	1	0
Individual #212	Risk Level 2	A (3/24/09) L (12/22/09)	1	0
Individual #147	Risk Level 2	S (4/15/09)	2	3
Individual #188	Risk Level 2	-	1	2

It was not apparent why the HST and/or NMT did not identify individuals with multiple hospitalizations and ED visits with diagnoses of pneumonia and/or aspiration pneumonia as being at a high-risk level. It was unclear why no individual was identified at high risk of aspiration.

The Health Status Team and the Nutritional Management Team functioned independently of each other which did not support an integrated problem-solving approach to identifying individuals with the most complex physical and nutritional support needs, and providing effective supports to minimize their identified health concerns. The HST and NMT must agree on defined standardized risk categories and assessment processes to ensure individuals at highest risk are identified.

#	Provision	Assessment of Status	Compliance
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	As noted above, the Facility's risk screening tools were inadequate in identifying individuals' clinical risks indicators. Without an adequate system to identify individuals' risk indicators, the appropriate assessments had not been completed. Once an appropriate system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform initial interdisciplinary assessments of services and supports for these individuals, and re-assessments in response to changes as measured by established at-risk criteria, according to the required timeframes set in the SA.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	As stated previously, the Facility did not have the underlying screening and assessment processes in place that were necessary for implementation of this provision. The Facility acknowledged the deficits of the risk system in place, but reported that it had been mandated by the State to implement the system. At the time of this review, there had been no update or modification made to the Plan of Implementation addressing the risk system. From observation of the Health Status Team meeting, there was no indication that the Health Status Team had any effect on clinical outcomes for individuals. AUSSLC supported a number of individuals who were identified as having pica behavior. This can be life-threatening behavior in that individuals are at risk for choking, and/or ingesting substances or objects that could result in serious injury or death. At AUSSLC, many individuals who demonstrated this problem behavior had highly restrictive procedures in place, yet during tours of the site, the environment was found to be unsafe. For example, cigarette butts were noted in various locations throughout the campus. Either smoking should be restricted to a small number of areas or to one's personal vehicle, or it should be banned on the grounds of the Facility. If it is allowed in restricted areas, there must be sufficient secure receptacles to ensure the absence of this material on the grounds of the Facility.	

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

1. The State should consider identifying and implementing standardized tools to be used by all the Facilities in assessing and documenting clinical indicators of risk. These standardized tools should be selected based on their reliability and validity, as well as their ability to provide a weighted score, and meaningful clinical information to allow teams to identify objectively individuals' level of risk in the appropriate clinical areas.
2. In addition, there is a variety of information available from which to identify individuals who are potentially at risk, such as incident management data. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.
3. The Facility should develop and implement interdisciplinary assessments of services and supports for the individuals identified as at risk, and in response to changes as measured by established at-risk criteria, according to the required timeframes set forth in the Settlement Agreement.
4. As required by the SA, for each individual assessed, the Facility should establish and implement a plan within fourteen days of the plan's finalization, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk. More immediate action should be taken when the risk to the individual warrants. Such plans should be integrated into the

PSP, and should include the clinical indicators to be monitored and the frequency of monitoring.

5. The Health Status Team meeting format should be redesigned to ensure that appropriate criteria and structure are in place to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in the teams identifying an associated level of intensity of clinical supports to address the risks, as well as proactive measures aimed at preventing risks.
6. A policy should be developed and implemented that will ensure limited access to toxic materials (e.g., cigarette butts) by those individuals who display pica behavior. Either smoking should be restricted to a small number of areas or to one's personal vehicle, or it should be banned on the grounds of the Facility. If it is allowed in restricted areas, there must be sufficient secure receptacles to ensure the absence of this material on the grounds of the Facility.

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:	At the time this report was issued, information on the Facility's provision of psychiatric treatment was not available.

<table>
<tr><th>SECTION K: Psychological Care and Services</th><th></th></tr>
<tr><td>Each Facility shall provide psychological care and services 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:
o Austin State Supported Living Center Psychological and Behavioral Services Policy Manual, dated 1/27/10;
o Master list of individuals with behavior support plans dated 3/4/10;
o Behavior Support Plans for the following individuals: Individual #332, Individual #305, Individual #175, Individual #210, Individual #160, Individual #32, Individual #152, Individual #217, Individual #108, Individual #358, Individual #263, Individual #372, Individual #339, Individual #53, Individual #424, Individual #406, Individual #94, Individual #374, Individual #246, Individual #304, Individual #328, Individual #206, Individual #284, Individual #42, Individual #123, Individual #276, Individual #448, Individual #335, Individual #135, Individual #238, Individual # 409, Individual #326, Individual #182, Individual #364, Individual #378, Individual #299, Individual #167, Individual #350, Individual #75, Individual #212, Individual #389, Individual #2, Individual #124, Individual #170, Individual #344, Individual #360, Individual #341, Individual #95, Individual #195, Individual #219, Individual #86, Individual #56, Individual #98, and Individual #73;
o Data sheets for the following individuals: Individual #175, Individual #160, Individual #217, Individual #53, Individual #424, Individual #374, Individual #179, Individual #304, Individual #276, Individual #167, Individual #350, Individual #212, and Individual #195;
o Graphs depicting identified problem behavior for the following individuals: Individual #175, Individual #160, Individual #276, and Individual #350;
o AUSSLC Restraints, dated 3/17/10;
o Functional assessment of problem behavior for the following individuals: Individual #175, Individual #160, Individual #108, Individual #179, Individual #123, Individual #276, Individual #299, Individual #389, Individual #139, and Individual #98;
o Vita of Jose Levy, Director of Behavioral Services; and
o Positive Behavior Support Observation form
▪ Interviews with:
o Jose Levy, Director of Behavioral Services, and Bruce Weinheimer, DADS Coordinator of Behavioral Services, on 4/6/10;
o Kim Ingram, Director of Speech, Language, and Audiology Services and the Speech/Language staff, on 4/7/10;
o Sarah Knowles, Director of Active Treatment, on 4/8/10;
o Group of 13 Direct Support Professional, on 4/8/10; and
o Psychology Department Staff, on 4/8/10</td></tr>
</table>

- **Observations of**:
  - Home 501, Home 729, Home 730, Home 732, Home 772, Home 779, Home 781, Home 782, Home 783, Home 784, Home 785, Home 786, Home 787, Home 789, Home 791, Home 792, Home 793, Home 794, and Home 795;
  - Infirmary;
  - Workshop 503, Workshop 510, Workshop 532, Workshop 544, Workshop 732, and Workshop 775;
  - Aquadome;
  - Incident Management Meeting, on 4/5/10;
  - QMRP Meeting, on 4/5/10;
  - Residential Services Meeting, on 4/6/10;
  - Behavior Therapy/Peer Review Committee Meeting, on 4/6/10;
  - Timber Creek Unit Meeting, on 4/8/10;
  - Personal Support Planning Meeting for Individual #305, on 4/8/10; and
  - Human Rights Committee Meeting, on 4/8/10

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: At the time of the review, the Facility's Director of Behavioral Services, and one Psychologist I were Board Certified Behavior Analysts (BCBAs). The DADS Coordinator of Behavioral Services who had BCBA certification also provided additional support to AUSSLC, as well as all of the other SSLCs. Given that 276 individuals residing at the Facility had behavior support plans, this was an insufficient complement of psychology staff with demonstrated competence in Applied Behavior Analysis.

Information provided by AUSSLC's Director of Behavioral Services indicated that for only 41 individuals had some form of assessment of behavioral function been completed. This was only 15 percent of the individuals with identified behavior support plans. Without an informed understanding of the possible function of identified problem behaviors, plans designed to effect positive behavior change are likely to fail to effectively address the behavioral issues.

The behavior support plans that were in place provided a wealth of information about the individual. Most contained operational definitions of the target behaviors, a description of the hypothesized function of the same found under "Rationale for Current Intervention," and guidelines for staff to follow to prevent and address problem behaviors. It should be noted that in most cases, it was unclear how staff had identified the hypothesized function, because a formal Functional Behavior Assessment had not been completed. Areas in need of improvement included identifying functional equivalent replacement behaviors, and enhancing the reinforcement strategies designed to promote positive change.

It is essential that the data collection system that is used to monitor and evaluate individual progress be improved. As currently designed, this system lent itself to inaccuracies. Direct support professionals will

	need to be trained, and provided ongoing support to ensure that they are accurately measuring the rate, duration, and/or intensity of identified problem behaviors. The same will be necessary for all replacement behaviors. Equally important will be the design of a system that allows for ongoing measures of inter-observer agreement. At the time of the visit, monthly averages of targeted problem behaviors were displayed graphically. This did not allow psychology staff and other team members to make determinations if changes in behavior were due to revisions to a behavior support plan, changes in medication, illness, or any of the other variables that impact an individual's functioning. While competency-based training was the policy of the Facility, it was currently not in practice. It will be necessary for the Facility to design a program that allows for a combination of didactic training, as well as on-the-job training, so that staff can learn to implement behavior support plans in real time. Feedback can be provided while collecting measures of treatment integrity. Didactic training is important to establish a basic understanding of: a) identifying, defining, and measuring problem behavior; b) the possible functions of problem behavior; c) methods of assessment; and d) strategies designed to support positive behavior change. Competency-based training then allows the trainer to provide support and feedback, including constructive criticism, to the employee as he/she works with the individuals. This is not a system designed to catch errors or to be punitive, rather it is a system designed to ensure that the skills expected of staff are clearly delineated, often through task analysis, are explained to the staff prior to implementation, and then are trained in the setting in which the skills must be displayed. This ongoing support ensures that staff will be effectively trained to demonstrate the skills needed to competently carry out their job responsibilities in the work environment.

#	Provision	Assessment of Status	Compliance
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	At the time of the monitoring visit, AUSSLC employed two Board Certified Behavior Analysts, one of whom was the Director of Behavioral Services. Additionally, there was the added benefit that the state's Coordinator of Behavioral Services, a Board Certified Behavior Analyst, had an office onsite. As reported by the Director of Behavioral Services, the presence of the DADS Coordinator of Behavioral Services had been a real benefit to him and his staff. There were frequent opportunities for collegial discussion and feedback. The department also employed a total of 16 Associate Psychologists, including one Psychologist I who was BCBA certified, and two others who had nearly completed classes in Applied Behavior Analysis at the University of North Texas. When staff were interviewed, several other staff members expressed an interest in pursuing BCBA credentialing. Also noteworthy was the expressed interest of several psychology assistants in pursuing BCABA credentialing. The Director of Behavioral Services also indicated that he continued to recruit professionals who were board certified. DADS is to	

#	Provision	Assessment of Status	Compliance
	reasonable safety, security, and freedom from undue use of restraint.	be commended for the advertisement for BCBAs placed with the Association for Behavior Analysis International. As currently staffed, however, the number of board certified staff was insufficient to meet the needs of the 276 individuals who had identified Positive Behavior Support Plans.	
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.	Mr. Levy had served as the Director of Behavioral Services since 2009. He held a Master's degree in Health Psychology, and was a Board Certified Behavior Analyst with six years of experience working with individuals with developmental disabilities. During his interview, Mr. Levy reported that he was enrolled in a Ph.D. program. During the interview with Mr. Levy and later, with his staff, it was apparent that he was attempting to put in place certain measures that would improve both the development and implementation of Positive Behavior Support Plans for the individuals who reside at AUSSLC. He was tracking consents, reviewing plans to ensure that they were written in language that would be understood by most direct support professionals, and providing feedback to his staff regarding specific elements of the plans. The 20 members of the psychology staff who were interviewed consistently provided positive feedback regarding the support and supervision provided by both Mr. Levy and Dr. Weinheimer. When asked to provide feedback regarding possible improvements to the program, a number of recommendations were made. Although these do not relate to compliance with this provision, this information is provided here for the State and Facility's consideration: ▪ First and foremost, staff responded that direct support professionals needed to be supported better, both with improvements in salary and recognition for the work they perform. Further explanation was provided when one person stated that better supports for the direct support professionals would result in better supports being provided to the individuals served. ▪ As the discussion continued, staff reported that there were too many repetitive meetings with repetitive documentation. ▪ Staff also commented that there was very little evidence of appreciation of staff by the administration, with one person commenting further that this was a "very reactive Facility." ▪ When the staff were asked about specific supports within the psychology department, one staff member indicated that every psychology associate should have a psychology assistant assigned to him/her. ▪ With regard to the staff vests, the feedback included that the vests were insulting/degrading to the individuals served, they were dangerous as they were often pulled, and in the heat of summer, they were uncomfortable. ▪ A final request was to change from pagers to cell phones.	

#	Provision	Assessment of Status	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.	According to the Director of Behavioral Services, at the time of the review, AUSSLC had two tiers of internal peer review. The first review process involved his reading and commenting on all behavior support plans. While this is an admirable undertaking, it remains a daunting task given the high number of plans currently in place. The Behavior Therapy/Peer Review Committee provided the second tier of review. This group, which met weekly, consisted of the Director of Behavioral Services, and various members of the psychology department. This reviewer was able to observe a meeting of this committee. While the discussion was lively with participation by many of the attendees, there was no review of data to allow for objective analysis of plan/treatment efficacy. In fact, when the group was asked by the nurse to give feedback regarding the effects of a recent medication increase for Individual #75, the psychologist assigned to his home and responsible for his Positive Behavior Support Plan stated, "Common sense would tell me it's not working; I have no empirical data to tell me it's working or not." Observation of this meeting generally did not indicate that the group was able to critically review plans to identify technical issues with the plans that needed to be addressed. At the time of the visit, there was no external peer review system in place.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Guidelines for data collection were included in the Positive Behavior Support Plan and/or on the data sheet. When reviewing data collection sheets and progress reviews for these plans, it appeared that the reported data could be neither valid nor reliable. The following provide some examples of the problems with the current data collection systems: ▪ For many of the plans, for example for Individual #160, Individual #217, Individual #53, Individual #424, Individual #374, Individual #276, Individual #167, Individual #350, and Individual #195, data sheets were designed so that staff entered information at the end of their shift. These data sheets were divided into three sections: "AM," "PM," and "Nite." This suggested that data was recorded following an eight-hour shift requiring the compilation of observations of multiple staff. This system lent itself to inaccuracies, because staff were being asked to recall what occurred during the previous eight hours, often times for multiple individuals displaying multiple target behaviors. ▪ Other data sheets included instructions for staff to "… document each time that a behavior occurs during the 60 minute interval by placing a check mark or 'Y' in the box…" This would suggest that the frequency of the behavior would be documented. However, in every case there was only one notation indicating either the presence or absence of the behavior (for example, for Individual #175 and Individual #304). It appeared that in some cases, a recent change had been made to use this second type of data sheet (for example, for Individual #179 and Individual #212). ▪ In no case did the reviewer find data sheets on which staff recorded behaviors	

#	Provision	Assessment of Status	Compliance
		using hash marks. In every case, a whole number was recorded, suggesting that staff were relying on their memory to record incidents, and were doing so at one moment of their shift, and/or at one moment within the interval. ▪ For no individuals was there assessment of inter-observer agreement. The staff raised further concerns with the reported data. Both direct support professionals, and psychology staff reported that due to staffing shortages, data might not accurately reflect individual performance. Documentation in progress reports, including notations on graphs, suggested that data might be missing, incomplete, or unavailable (for example, for Individual #175, Individual #160, Individual #276, and Individual #350). Such poor recording systems prohibited an accurate analysis of treatment efficacy, yet decisions of great importance were being made based on these data. Of particular significance were decisions to introduce, discontinue, or adjust the dosage of various medications. In some cases, restrictions were being placed upon individuals based upon these data. For example: ▪ Individual #364 had had her visits with family curtailed due to a perceived worsening of her behavior following such visits. It was assumed that when she was in her family's care, she was not getting her medication, thus her behavior deteriorated, and therefore visits with her family had been restricted to campus. This decision appeared to have been made without the benefit of objective and accurate data. More specifically, the behavior support plan dated 2/9/10 contained the following statements: 1) Setting events, page 1: "…changes were made by her PST to change family visits to remain on campus only due to the fact that she returned late from her last furlough and there being questions regarding her receiving medications"; and 2) Page 3: "Many of her behaviors seem to take place when she returns from furlough. There is a history of her not taking medication while on furlough and this may be a contributing factor to many of her behaviors. She is also very non-compliant in taking her medications once she returns." Based on this documentation, it appeared she returned late after one furlough and she was now required to visit with her family on campus. This appeared to be overly restrictive, and raised the following questions: 1) Have the staff at the Facility worked with the family to ensure her timely return to the Facility? 2) Have the efforts been documented? 3) Have the staff investigated the "questions regarding her receiving medications?" and 4) Is there reliable proof that she is not getting her medication, and if so, have the staff at the Facility worked with the family to ensure they understand the importance of the medication? Further, the comment that "her behaviors <u>seem</u> to take place when she returns	

#	Provision	Assessment of Status	Compliance
		from furlough," (emphasis added) suggested that determinations were being made based upon staff opinion versus objective data.	
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 guidelines for the completion of Structural and Functional Assessment as outlined in the AUSSLC Psychological and Behavioral Services policy were comprehensive in their scope. However, at AUSSLC functional behavior assessments were identified for 41 of the 276 individuals with identified problem behavior (15%). Ten of these (24%) were completed in 2009, 22 (54%) were completed in 2008, and nine (22%) were completed in 2007. The Facility provided a sample of 10 assessments for review. These all provided extensive information about the individual, and demonstrated a range of strategies employed to gather information about the possible function of the identified problem behaviors. However, the problem remains that formal functional assessments had been completed for only 15 percent of the population identified with behavior support plans. This was in violation of the Facility's policy. The lack of an appropriately conducted functional assessment was certain to result in a less than adequately designed PBSP, which in turn often likely contributed to a diminished positive outcome for the individual. It is essential that a better understanding of the possible function of any problem behavior first be established, so that appropriate replacement behaviors and comprehensive contingencies can be determined.	
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.	As is discussed above with regard to Section K.4 of the SA, there were significant concerns regarding the reliability and validity of the data being collected. As a result, it is doubtful that assessments were based on accurate or complete data.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment	A total of 10 clinical records were reviewed onsite. Evidence of psychological assessments were found in every file, however, several were quite dated, having been completed in the 1990's (for example, for Individual #78, Individual #304, Individual #299, Individual #389, and Individual #195). Additionally a sample of five most recent psychological assessments was provided. The following provides the findings with regard to each of these five individuals: ▪ Individual #160 - Her psychological evaluation update was completed in 2002, less than one month after her admission to the Facility. It references an ICAP completed earlier in 2002, a Vineland Scale completed in 1997, and a Stanford-	

#	Provision	Assessment of Status	Compliance
	procedures.	Binet completed in 1985. Both the Vineland and an appropriate assessment of cognitive abilities were overdue at the time of the review. ▪ Individual #175 - Her psychological evaluation update was completed in 2008. Consideration should be given to completing a measure of adaptive behavior annually. ▪ Individual #276 - His psychological evaluation update was completed in 2009. The assessments completed are current. ▪ Individual #350 - Her evaluation was completed in 2008. Consideration should be given to completing a measure of adaptive behavior annually. ▪ Individual #212 - Her psychological evaluation update was completed in 1995. Reference is made to an evaluation completed in 1990 with a note that the findings remain current. Included was a reinforcer assessment completed in 1995. An updated assessment of adaptive behavior needed to be completed. In addition, if reinforcer/preference assessments are to be one component of the assessment process, these should be completed more often than once every 15 years.	
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.	A list of individuals scheduled for counseling was provided prior to the monitoring visit. It is unclear whether objectives for counseling were developed in such a way that objective measures of progress could be collected and analyzed to determine treatment efficacy. Further, there was at least one individual for whom counseling was indicated following the death of a family member. The following describes this individual's situation: ▪ The PSP for individual #95, dated 7/2/09, included the following: "Following his brother's death there was a big increase in (individual's) target behaviors especially self-injurious. There still may be some unresolved grief issues." Although he was referred to the chaplain, and there were guidelines for direct service professionals to help him through the grieving process, he was not scheduled to receive counseling at the time of the visit. However, under "Living Options Discussion Record," there was a note that the individual would need access to counseling to deal "… with the long term effects of the grief in losing his brother." The PSP clearly indicated the need for counseling, yet the individual was not receiving these services at the time of the visit. Although sensory integration strategies were not provided under the supervision of the psychology department, there were numerous examples of sensory strategies included in behavior support plans. Two concerns were raised. First, as with any approach to supporting positive behavior change, it is essential that objective measures be collected to determine treatment efficacy. Second, caution is advised as sensory integration has not been adequately researched to support its use as an evidence-based practice. A	

#	Provision	Assessment of Status	Compliance
		recent review by the National Autism Center (2009, p. 22-23) identified sensory integration as an unestablished treatment.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	A review of 54 Positive Behavior Support Plans was completed. The majority of these included rationales for the proposed intervention, including hypothesized function, operational definitions of the target behaviors, guidelines for antecedent management, and specific consequences following the target behaviors. It is important to note that there was no explanation for the method(s) used to determine the function of the behavior(s), because in most cases a formal Functional Behavior Assessment had not been completed. Only a few plans included a description of prior interventions, and these did not note outcome. A few had clear teaching guidelines, but this was not true for all, and none indicated who the author of the plan was. In some cases (for example, for Individual #175, Individual #108, Individual #53, Individual #406, Individual #123, Individual #448, Individual #238, Individual #124, Individual #170, Individual #360, and Individual #56), directions to staff, particularly in the prevention or antecedent management sections, were clearly written and represented a sensitivity and responsiveness to the preferences and dislikes of the individual. The Director of Behavioral Services indicated that he was trying to ensure that all plans were written using language that was non-technical and easily understood by the majority of the direct support professionals. There were several concerns related to the sample of PBSPs reviewed. First, there were several examples of replacement behaviors not being related to the hypothesized function of the targeted behaviors, or being inappropriate for the individual. Examples include: ▪ For Individual #372, the hypothesized function was to escape activities/environments and keep people away, but the replacement behavior was support to wear his helmet; ▪ For Individual #339, the perceived function of pica was automatic oral stimulation, but the replacement behavior was to play a musical instrument or hold a pica-safe item; and ▪ For Individual #364, the hypothesized function of problem behaviors was to escape, yet the replacement behavior was to teach her to respond to questions posed by the staff. ▪ For Individual #304, the replacement behavior was to initiate activities, one of which was throwing items across the room or kicking them under her chair. Later in the plan, throwing objects was identified as a problem behavior, the consequence of which was to tell the individual "No," then prompt her to pick up the thrown item. ▪ A similar concern was raised after reviewing the plan for Individual #219. While not listed in the replacement behavior section, staff were advised to give this	

#	Provision	Assessment of Status	Compliance

		individual old ties to tear. One of his target behaviors was tearing clothing. As a note in the margin indicated, this strategy was not appropriate, because the individual will likely not discriminate which clothing can be torn and which cannot.
		
		In other cases, the opportunities to learn or practice the replacement behavior were insufficient. Examples include:
		▪ Individual #175 was to practice problem solving 10 times per month. The teaching strategies that correspond with this behavioral objective provided staff with guidelines for helping her to problem solve. However, numbers of trials were not indicated.
		▪ Individual #217 was to talk with staff about his day one time per week. This was listed under teaching new behaviors. Additional notes were provided under prevention regarding how to respond if he was being teased, if he was agitated, or if he was using negative words. Additional advice included avoiding arguments and praising him for talking about what was bothering him. However, the only specific schedule for talking about his day is what is listed above.
		▪ Individual #276 had a behavioral objective to appropriately communicate his wants four times per month. Staff merely were advised to encourage him to identify what was bothering him, to resolve the problem, and to make positive choices. No further direction was provided about his communicating his wants.
		▪ Individual #135 and Individual #182 were to choose a sensory item once in the morning and once in the afternoon. The following provides more specifics about each:
		    o For Individual #135, the only other advice under teaching was to ensure that he does not engage in pica.
		    o For Individual #182, all other guidelines referred to encouraging him to carry appropriate materials/sensory items.
		▪ Individual #326 was to participate in a physical activity for 10 minutes once per shift. She was to be prompted to engage in this activity near 11:30 a.m., and 3:30 p.m. It was noted further in plan that she could be allowed to go outdoors when frequent monitoring could occur.
		▪ Individual #2 was to propel his wheelchair for at least 10 minutes twice per day. Documentation clearly indicated this was to be done once in the morning and once in the afternoon. If he signed walk at other times, he was to be provided a walk as possible, but if not possible, staff were to sign "later," and support his daily walk following replacement behavior training.
		▪ Individual #170 had a behavioral objective to ask others to leave her alone once per month. Staff were merely advised to remind her that she can go to her room if she wants to be alone.	

#	Provision	Assessment of Status	Compliance
		In general, there should be frequent opportunities throughout the day for individuals to learn and practice functional skills that will serve as effective and efficient replacement behaviors. While the communication dictionaries provide valuable information to the staff, the psychology and communication staff should collaborate on these. The following examples illustrate how behavioral strategies were not fully integrated with communication strategies: ▪ For Individual #73, the following advice was given in the Communication Dictionary: a) if he hits his head, find out what he wants and provide it; b) if he flips chairs, respect his choice and move things away; and c) if he throws things, respect his choice and either offer an alternative or leave him alone. Any of these responses have the potential to reinforce these behaviors. ▪ Another example involved Individual #378. The Communication Dictionary suggested to staff to let him try something different, or let him do something else if he pushes away or throws down an item. While gently pushing an item can be an appropriate form of protest, throwing is not. ▪ Similarly, the communication dictionary for Individual #2 advises staff to respect his choice and stop the activity if he continues to push, throw, or knock items off the table. Again, a gentle push is an appropriate form of protest, throwing and knocking items off tables are not. Other concerns regarding communication were raised when reviewing the plans for Individual #210 and Individual #350, both of whom are hearing impaired and whose primary means of communication is sign language. More specifically: ▪ In the case of Individual #210, the plan indicated that one setting event for problem behavior was "… difficulty communicating with others, yet the staff are not fluent signers." The behavior to increase was appropriately communicating his wants, yet again there was a note that "… the staff are not fluent signers." ▪ Similar statements were found in the plan for Individual #350. "When she is engaged in structured activities with an individual who can communicate effectively, she is less likely to engage in problem behavior." Yet, it was noted that "… the staff members in her current home do not know ASL [American Sign Language]." As recognized in these plans an individual's ability or lack thereof to communicate can have a profound effect on the individual's behavior. This stated lack of available resources to allow an individual to adequately communicate is sure to result in the failure of these plans. Other concerns were related to the contingencies described when identified problem behaviors did occur. In several cases, the contingency as described had the potential of	

#	Provision	Assessment of Status	Compliance
		reinforcing the behavior targeted for reduction. Examples include the following: ▪ Individual #332 was described as most likely to engage in aggression when the environment was noisy or chaotic, yet when he displayed this behavior, he should be asked to go to a quieter area. ▪ Individual #160, Individual #263, Individual #335, Individual #364, and Individual #344 had similar contingencies described in their plans. ▪ Contingent upon inappropriate sexual behavior, two choices for Individual #152 were either to go to his room for private time, or to take a shower. ▪ In other cases, following the target behavior, staff were instructed to tell the individual to stop the behavior, and then redirect him/her to a preferred activity. Examples include for Individual #305, Individual #195, and Individual #98. Additional concerns were raised due to the poor levels of engagement (i.e., appropriate use of available materials or behaviors appropriate to the activity) observed during the tour of the Facility. Several plans noted engagement as a critical component to reducing problem behavior. Specific statements found in plans included the following: ▪ "Try to keep (individual) busy with appropriate activities…," ▪ "… tends to increase stereotypies when there are no or few engaging activities…," ▪ "… tends to ruminate more often when he is not engaged in activities, training or treatment…," ▪ "Keep (individual) occupied, give him choices of things to do throughout the day," ▪ "Throughout the day, (individual) should be provided variety of leisure activities," and ▪ "During the day, keep (individual) busy with pleasant, interesting activities." These statements were found in the plans for Individual #210, Individual #123, Individual #182, Individual 375, Individual #389, and Individual #341, respectively. Other environmental factors such as the numbers of individuals living together in residential settings that offered little personal space raised concerns. The congregation of up to 22 individuals in one residence likely contributes to the problem behavior. This was particularly concerning given that the functions of many individuals' behaviors were hypothesized to be, for example, ways to escape noisy or chaotic environments, and keeping people away. A review of documents suggested that there was no ongoing assessment of an individual's preferences. While every plan included a list of presumed reinforcers, it appeared that staff generated this list, with occasional input from family members. Further, in many plans, it appeared that identified reinforcers were not employed to help	

#	Provision	Assessment of Status	Compliance
		strengthen appropriate behavior. Many plans advised staff to use praise to strengthen desired behavior, but praise was not identified as a strong reinforcer on the list of reinforcers. Token reinforcement was included in the plans for many individuals. However, tokens were to be delivered once at the end of a shift. This is a very thin schedule of reinforcement that will most likely have little impact on improving behavior. Psychology staff are encouraged to identify potential reinforcers through careful and frequent preference assessment, with delivery of reinforcement provided on a dense schedule.	
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.	At the time of the review, data was presented graphically using monthly averages and/or totals. This did not allow an individual's team to determine trends in behavior, or subtle changes and improvements in response to treatment. Although these same graphs noted medication dosages, it was difficult to determine changes in behavior following the introduction of medication, change in dosage, or discontinuation or medication due to the grouping of data in monthly averages or totals. Changes in targeted behavior can occur even when over-the-counter medication is introduced. Monthly reporting of the average or total occurrence of targeted behavior does not allow for a clear understanding of the effects of behavior support plans, medications, illness, or any of the other daily influences to which an individual is exposed. Additionally, the graphs included all behaviors targeted for reduction. This made for a very cluttered or busy graph, increasing the difficulty in completing an analysis of behavior change. Without ongoing review of daily changes in the target behavior, timely revisions to behavior support plans will not occur.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	The staff at AUSSLC are to be commended for the clarity with which specific sections of the PBSPs are written. When reviewing several of these documents, the reviewer found numerous examples of clear guidelines for preventative strategies and antecedent management in the section entitled: "Directions for Staff." However, the plans as they are currently written are too long for easy use on-the-job.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they	With 71% (276 of 389) of the individuals supported by AUSSLC requiring the implementation of behavior support plans, it is essential that staff receive competency-based training and ongoing support in the implementation of behavior support plans. As currently described, staff are "in-serviced" on all behavior support plans. Although the Center's policy stated that competency-based training was completed within 14 days of obtaining approvals and consents for a BSP, the Director of Behavioral Services, and DADS Coordinator of Behavioral Services acknowledged that at the time of the review, this was not occurring.	

#	Provision	Assessment of Status	Compliance
	are responsible and on the implementation of those plans.	Didactic training is important to establish a basic understanding of: a) identifying, defining, and measuring problem behavior; b) the possible functions of problem behavior; c) methods of assessment; and d) strategies designed to support positive behavior change. Competency-based training then allows the trainer to provide support and feedback, including constructive criticism, to the employee as he/she works with the individuals. This is not a system designed to catch errors or to be punitive, rather it is a system designed to ensure that the skills expected of staff are clearly delineated, often through task analysis, are explained to the staff prior to implementation, and then are trained in the setting in which the skills must be displayed. This ongoing support ensures that staff will be effectively trained to demonstrate the skills needed to competently carry out their job responsibilities in the work environment. Frequent measures of treatment integrity, using the Positive Behavior Support Observation tool, will allow psychology staff to provide regular feedback to the direct support professionals, and resolve any confusion or difficulty regarding the implementation of plans in a timely manner. Further review of the training materials and processes will be completed during the next onsite review.	
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.	At the time of the visit, the census at the Facility was 389 individuals. Although the psychology department employed 16 Associate Psychologists, only the Director of Behavioral Services, and one Psychologist I were BCBA certified, and met the requirements in Section K.1 of the SA. The ratio of BCBA certified psychologists to individuals was 2:389, or 1:195, which did not meet the requirement of 1:30. As noted above, a number of psychology staff were in the process of becoming BCBA certified. It was the reviewer's understanding that there were six psychology assistants with two vacancies at the time of the visit. These staff supported the 16 Associate Psychologists.	

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

1. Continued recruitment of BCBA staff is necessary and encouraged. The Facility may also want to consider developing an incentive program to encourage additional current psychology staff to pursue board certification. Consideration should be given to developing a similar system to provide training to staff with undergraduate degrees who could work towards certification as assistant behavior analysts.
2. It will then be necessary to create a system for ensuring that all ABA trained staff maintain their certification. Further assistance could be provided to certified individuals by scheduling on-site opportunities for continuing education, and/or by supporting attendance at regional and national conferences or workshops.
3. Consideration should be given to the development of annual work performance evaluations for all staff. This will provide a standard and formal opportunity to give positive feedback along with constructive suggestions for improved performance.

4. Changes should be made to the Behavior Support Committee meeting to ensure that it results in functional outcomes that will benefit the individuals served. The author of the Behavior Support Plan should be prepared to present data, discuss the success or failure of the plan, and suggest/request changes to the plan, if necessary. Input from QMRP, and other PST members may be provided to the committee in alternative fashion through review of PST minutes, signatures attached to the BSP, etc. The Committee should obtain input from direct support professionals responsible for the implementation of the plan. This also may occur in a format other than their attendance at the meeting. Minutes should be recorded with tasks assigned with expected due dates.
5. To facilitate the development of external peer review, consideration should be given to partnering with a nearby SSLC. Psychology staff from Austin SSLC and the other Facility could travel to each location monthly to provide external peer review. If travel proved difficult, meetings could be held at each Facility on alternating months. Each group could spend time presenting individual cases while getting feedback from their colleagues at the other Facility. This might be a good first step in fulfilling this requirement of the Settlement Agreement. In the future, the Facility is encouraged to consider regularly scheduled visits from professionals in the fields of Applied Behavior Analysis and developmental disabilities to provide additional objective feedback and advice.
6. It is essential that the Facility improve its data collection system to ensure that collected measures are reliable and valid. Reliance on systems that encourage staff to enter information at the end of their shifts should be eliminated. Measures should reflect the rate, duration, and/or intensity of problem behavior and its corresponding replacement behavior. Staff must understand the operational definitions of all targeted behaviors, must be able to identify the presence and absence of the same, and must collect measures that provide an accurate reflection of the frequency and severity of the problem.
7. Inter-observer agreement should be assessed regularly, but no less than once each month.
8. Functional behavior assessments should be completed as soon as possible for each individual at AUSSLC who has a BSP. Once this has been completed and the results incorporated into the BSPs, functional assessments should be completed annually for every individual who has not made progress under the current behavior support plan. In addition, when an individual's circumstances change or an individual is subject to repeated restraints, the functional assessment should be updated. This is a critical area that requires immediate attention. The guidelines outlined in the Structural and Functional Assessment Report are an excellent resource. It will be essential when completing these assessments to ensure the participation of direct support professionals who are most familiar with the individual.
9. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice. This is particularly critical for those suggested strategies that are not evidence-based.
10. As previously noted, the current format of the Behavior Support Plan provides a great deal of relevant information. Behavior support plans should be reviewed with a critical look to ensure that: a brief history of prior interventions and their related outcomes are added to the BSP or Functional Assessment; the identified replacement behaviors are clearly tied to the hypothesized function of the problem behavior(s); clearer teaching guidelines for strengthening/teaching replacement behaviors are included; the type of reinforcement used is individualized; the schedules of reinforcement are adequate to result in behavioral change; the specific consequences that are delivered contingent upon the target behavior are developed in consideration of hypothesized function(s) of problem behavior(s); clear data collection measures that reflect pertinent information about the target behavior(s) are included; and there is identification of the person or persons responsible for oversight of the plan. Additionally, assessment of an individual's preferences should be ongoing.
11. As BSPs are developed, and as part of the peer review process, careful consideration should be given to ensuring that responses to behaviors do not result in strengthening the behavior, by for example, reinforcing the individual by providing them with what has been identified to be the function of the behavior. This will require strong emphasis on replacement behaviors and antecedent strategies. For example, instead of waiting to remove a person engaging in SIB from a loud environment, when the function of the behavior has been identified as escaping from such environments, the BSP should focus on removing the individual before the problem behavior occurs, and helping him/her develop a communicative response that signals a desire to change environments.
12. It is recommended that psychology staff develop an abbreviated version of an individual's behavior support plan that can serve as a quick

reference for all staff.

13. The staff person responsible for developing the BSP should be identified by name.
14. The resources necessary for the full implementation of behavior support plans need to be made available. This includes, but is not limited to adequate staffing resources, including staff with fluency in individuals' primary method of communication, for example, American Sign Language.
15. The Facility should develop a plan to reduce the numbers of individuals residing together in living units. The congregation of up to 22 individuals in one residence likely contributes to problem behavior.
16. Each identified problem behavior should be graphed separately, with graphs depicting daily occurrence of the same. Phase changes lines should be included to note changes in intervention, medication (including dosage), health status, or environmental change. There should be a system in place to ensure regular review of all graphs, and revisions to the behavior support plans, as necessary. All staff working with the individual should have the opportunity to participate in this regularly scheduled review.
17. Training on individual behavior support plans should occur across all shifts as these plans are developed and revised. The policy that requires competency-based training for all staff implementing behavior support plans should be put into practice as soon as possible. Time should be arranged for uninterrupted initial training on all plans, with follow up conducted on-the-job.
18. Measures of treatment integrity should be collected on a regular basis with samples taken on a variety of plans across shifts.
19. As is recommended with regard to Section D of the SA, direct support professional staffing needs to be stabilized to ensure that adequate numbers of well-trained staff are available to consistently and effectively implement behavior support plans for the over 70 percent of the individuals at the Facility who need them.
20. Consideration should be given to creating a more flexible schedule for psychology staff. For example, staff assigned to homes in which school-aged individuals reside should consider altering their work schedules so that they are available during the hours that the individual is in the home. Others may want to consider varying their hours from day-to-day or week-to-week to allow interaction with a greater number of staff across more hours of the day.

SECTION L: Medical Care	
	At the time this report was issued, only limited information on the Facility's provision of medical treatment was available.

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 QE Nursing tools and data; o AUSSLC Nursing policies and procedures; o AUSSLC's Infection Control Policies; o Infection Control weekly infection reports; o AUSSLC's Trends In Infection Control Highlights reports; o AUSSLC's Infection Control curriculum for new employee orientation; o Infection Control Safety Compliance audits for January 2010; o AUSSLC Hand Washing audits; o Nursing Meeting minutes dated 1/7/10, 1/14/10, 1/21/10, 1/28/10, 2/4/10, 2/11/10, 2/18/10, and 3/4/10; o Nursing Plan of Implementation meeting minutes dated 10/22/09; o Infection Control Committee Meeting minutes dated 6/30/09, 10/20/09, and 2/5/10; o QE Medication Administration Observations data; o AUSSLC's Medication Observation monitoring tool; o AUSSLC's Nursing Table of Organization; o Emergency Response Assessment form; o Medical Emergency Drill form for the 6200 system; o AUSSLC's nursing staffing data; and o The medical records for the following individuals: Individual #237, Individual #452, Individual #262, Individual #275, Individual #22, Individual #410, Individual #54, Individual #28, Individual #286, and Individual #175, Individual #402, Individual #166, Individual #291, Individual #210, Individual #276, Individual #8, Individual #182, Individual #17, Individual #39, Individual #100, Individual #426, Individual #362, Individual #331, Individual #188, Individual #77, Individual #42, Individual #73, Individual #280, Individual #439, Individual #416, Individual #287, Individual #235, Individual #195, Individual #92, Individual #183, Individual #175, Individual #343, Individual #53, Individual #233, and Individual #111, Individual #268, Individual #45, Individual #81, Individual #122, Individual #302, Individual #244, Individual #53, Individual #395, Individual #248, Individual #46, Individual #111, Individual #405, Individual #7, Individual #429, Individual #399, Individual #274, Individual #322, and Individual #423 ▪ **Interviews with**: o Rebecca Hall, RN, CNE; o Carolyn Harris, RN, Nurse Operations Officer o Kim Sweeney, RN, QE Nurse; and o Kay Cowan, RN, MSN, FNP, BC, Infection Control Nurse IV ▪ **Observations of**: o Medication Administration in Castner Building; and

	○ Demonstration of the emergency equipment in the Infirmary
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: AUSSLC had 124 positions allotted for Nursing, and at the time of the review, had 25 vacancies. Of the 25 vacancies, 15 were for Registered Nurses (RNs) and 10 were for Licensed Vocational Nurses (LVNs). In order to meet minimum staffing ratios, the Facility used the services of six agencies. The Facility had been providing an abbreviated orientation for the agency nurses, and had formally and informally identified problematic issues related to the use of agencies. The lack of consistent nursing staff needs to be addressed to facilitate the provision of adequate clinical care, and positive outcomes for the individuals being served at the Facility. Also, the Facility needs to re-evaluate its current orientation process for agency nurses to ensure the individuals at AUSSLC are provided competent and appropriate nursing services. AUSSLC needs to develop a functional Infection Control Department, and develop policies, procedures, and protocols in accordance with standards of practice as outlined in the SA and HCGs. In addition, the Facility needs to develop and implement a number of Nursing and Infection Control monitoring instruments that will accurately reflect the quality of nursing care being provided, and to ensure timely identification of problematic trends and implementation of timely plans of correction. These data generated by the Nursing and Infection Control monitoring tools need to be integrated into the Facility's Quality Management and Risk Management systems. There were a number of significant problematic issues found regarding complete and adequate nursing assessments related to symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to the off-site medical center, as well as upon return to the Facility. The Nursing Care Plans at AUSSLC did not include appropriate and measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions. The medication administration system at AUSSLC needs to be critically reviewed and revised to ensure that nurses are following standards of practice when administering medications. The Medication Administration Observations should be conducted quarterly for all nurses who administer medications. At the time of the review, AUSSLC was not conducting medical emergency drills. The Facility needs to develop and implement a comprehensive system addressing emergency response.

#	Provision	Assessment of Status	Compliance
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.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sections that address various areas of compliance as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and code blues drills. 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 SA. <u>Staffing</u> Regarding staffing, AUSSLC's RN and LVN staffing data at the time of the review showed that they had a number of nursing position vacancies at the Facility. The department had a total of 124 nursing positions with 25 vacancies; 15 for RNs and 10 for LVNs. In order to meet minimum nursing staffing ratios, the Facility used the services of six agencies. The Chief Nurse Executive reported that although the Facility had a high use of agency nurses, the orientation training for an Agency Nurse was significantly abbreviated compared to the orientation expectations for a state-hired nurse. A packet that included information such as an introduction to the Facility, and nursing forms was sent to the agency nurse prior to working at AUSSLC. They were also required to take training for Prevention and Management of Aggressive Behavior (PMAB), and Abuse and Neglect. They were then assigned to a staff nurse at the Castner Building for one day of mentoring, and were observed administering medications. This is not an adequate orientation for nurses who are expected to provide supports to individuals with complex medical and behavioral needs. From interviews with the Chief Nurse Executive, the Nurse Operations Officer, and the QE Nurse, problematic clinical issues such as medication errors/variances had been identified both formally and informally in relation to the use of agency nurses. Having consistent nursing staff was identified as the ultimate goal. However, until that is achieved, the Facility will continue to need to rely on agency nurses. As a result, the Facility needs to re-evaluate its current process for orientation of agency nurses to ensure the individuals at AUSSLC are provided competent and appropriate nursing services. The Facility had LVN students from Austin Community College come to the Facility for a short clinical rotation. However, recruitment from this group had been minimal. The Chief Nurse Executive reported that there was a possibility that Nurse Practitioner students from University of Texas may be doing a clinical rotation at the Facility. However, there had been no formal decision, and this was still in the early stages of discussions.	

#	Provision	Assessment of Status	Compliance
		The Chief Nurse Executive reported that the Facility had struggled to fill its existing nursing positions, and had not been successful in its efforts to recruit nurses. Barriers to recruiting and retaining nursing staff were reported to be the salaries offered, and competition from other health care agencies. The lack of consistent nursing staff needs to be addressed to facilitate the provision of adequate clinical care, and positive outcomes to the individuals being served by the Facility. At the time of the review, AUSSLC had four units, including 28 homes and one 14-bed infirmary. The Infirmary and Castner Estates unit provided 24-hour nursing care. For the units that did not have 24-hour nursing coverage, the Facility used a Campus Nurse that made regular rounds, and covered the rest of the Facility during the night shift. From review of AUSSLC's nursing staffing assignments, at the time of the review, the Facility had 70 positions for RNs, and 54 positions for LVNs. The Chief Nurse Executive directly supervised the Hospital Nurse Liaison, Nurse Educator, the Infection Control Coordinator, the Nurse Operations Officer, the psychiatric nurses, and the Administrative Assistant. From review of AUSSLC's staffing levels, the minimum staffing requirements were based on a fixed number of nursing staff (RNs and LVNs) per specific Unit, but could be modified based on census, acuity, and staff workload related to individual or staff activities. Although the Facility's staffing data did not indicate that they had fallen below minimum staffing levels for nursing, the Facility was not using any tool to assess and track its acuity. Additional issues to consider regarding modification to staffing and acuity include the following: 1. The education and experience of the nurses; 2. The number of nurses in orientation; 3. The number of temporary/agency staff assigned to the Unit; 4. The particular shift, required activities, and duties; 5. The physical layout of the Unit; 6. Facility resources; 7. Available technology used on the Unit such as computers; 8. Unit volatility that includes admissions, transfers and discharges; 9. The number of high risk individuals on a Unit; and 10. A method to assess Unit acuity. <u>Quality Enhancement (QE) Efforts</u> At the time of this review, the Nursing Department had few monitoring systems in place to assess nursing care and clinical outcomes. However, AUSSLC had a Quality Enhancement (QE) nurse that conducted and coordinated regular audits on various items such as an 180-day order review, direct support professional training for new physician orders, acute care plans, acute health problems, pro re nata (PRN) or "as	

#	Provision	Assessment of Status	Compliance
		needed" medications, injuries, bowel records, equipment for sleep apnea, diet orders, gastrostomy tube (g-tube) feedings, and hypothermia. Although QE was conducting a number of audits, the tools did not include any items addressing the quality of the provision of nursing supports, such as nursing treatment plans or nursing assessments. In addition, the sample sizes audited were very small, and various Case Managers conducted the audits, but inter-rater reliability had not been tested. The items on the auditing tools generally only addressed the completion of a task, such as the presence or absence of specific documentation, rather than addressing the quality of the supports provided. As a result, the data generated provided little to no information regarding the quality of clinical practices. For example, the items on the Head-To-Toe Assessment for Acute Health Problems auditing tool included the following questions: ▪ Did the nurse complete a head-to-toe assessment? ▪ Did the nurse assessment include a full set of vital signs? ▪ Did the nurse document directions given or orders received in the MD orders? ▪ Did the nurse communicate with the practitioner in the progress record? These are important questions. However, there were no items addressing the quality of the assessments and notes audited. In addition, there were some items on the QE tools that included a number of elements to be audited rather than just one element. The data would not be able to be interpreted, because it would be impossible to determine which elements of the item were in compliance and which were not. Consequently, the compliance scores generated from the current tools did not consistently accurately reflect the quality of the nursing care. Although there is much potential in the auditing processes of the QE Nurse, AUSSLC's existing data regarding compliance could not accurately be interpreted since it did not include the total the population being reviewed (N), and the sample of that population audited (n) to yield a percent sample size. This information is essential to accurately interpret the relevance of the compliance scores generated. Usually, compliance scores for samples under 20% cannot be applied to the total population. Thus, AUSSLC's QE data cannot be accurately interpreted, analyzed, or evaluated to determine if it is reflective of the practices being measured. Based on interviews with the QE Nurse during the review, she was aware of the lack of quality items contained in the current QE monitoring tools, and the unreliability of the data generated. Even with the issues with the monitoring tools and processes, there were some problematic issues being identified, such as the lack of complete sets of vital signs included in nursing assessments, and the lack of medication observations conducted. However, at the time of the review, the QE data was receiving little attention	

#	Provision	Assessment of Status	Compliance
		from the Nursing Department. Basically, no plans of correction were found addressing the problematic issues noted from the QE data. At the time of the review, the Facility had no system in place for ensuring that the disciplines being provided QE data were addressing problematic trends identified. A review of AUSSLC's Nursing Meeting minutes demonstrated that there was little mention of problematic issues identified through the QE audits. Likewise, there was no discipline-specific documentation found that included the identification of the problematic issues, a summary of an analysis of such issues, descriptions and/or dates of actions implemented to correct the issues, and/or subsequent monitoring data indicating whether the interventions implemented were effective. Disciplines meeting minutes could be modified to include these specific elements so that this information is in one succinct document. This will be particularly important as the QE Departments from the various Facilities, in conjunction with the State and disciplines develop and implement additional monitoring tools, and generate additional clinical data in alignment with the SA. Based on the information reviewed and summarized above, AUSSLC needs to develop and implement a number of nursing monitoring tools that will accurately reflect the quality of nursing care being provided. This is essential in order for the Facility to quickly identify problematic trends, and implement timely plans of correction. To facilitate this process, the State and the Facility should consider using the already established tools provided by the Monitoring Teams addressing compliance with the SA and Healthcare Guidelines. In addition, the data generated from the monitoring tools should be regularly reviewed and addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. In developing these monitoring systems to meet compliance with the SA, the Nursing Department needs to evaluate its current allocation of positions since it currently has only one QE Nurse assigned for auditing. <u>Nursing Assessments</u> A review of individuals who experienced acute symptoms was one of the methods by which the Monitoring Team assessed nursing care. By looking at how the Facility addressed some of the most significant nursing issues, strengths as well as weaknesses in the system can be identified. A review of 12 individuals' medical records who were transferred to a community hospital (Individual #237, Individual #452, Individual #262, Individual #275, Individual #22, Individual #410, Individual #54, Individual #28, Individual #286, Individual #175, Individual #402, and Individual #166) found that there were significant problems in the documentation regarding the nurses' assessment in the following areas: ▪ The lack of documentation regarding the status and appropriate assessment of	

#	Provision	Assessment of Status	Compliance
		the individual at the time of the onset of the symptoms; ▪ Significant delays in documentation after the individual was identified as experiencing a change in status; ▪ Lack of documentation indicating what type of temperature was taken (i.e., oral, rectal, tympanic); ▪ The lack of documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; ▪ No documentation indicating that a transfer packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility; ▪ Lack of updating the Nursing Care Plan to reflect changes in status and new interventions; ▪ The lack of adequate descriptions of the site of injuries or bruises; ▪ The lack of lung sounds assessed and documented for respiratory issues; ▪ The lack of neurological checks and mental status documented for individuals with a significant change in mental status; ▪ Illegible progress notes; ▪ The lack of assessment of bowel sounds, and abdomen for individuals with constipation; ▪ The lack of documentation that status changes had been reported to team members; ▪ The failure to timely notify physicians regarding the individual's change of status; ▪ The lack of assessments regarding pain; ▪ The lack of follow-up when pro re nata medications (PRNs – as needed) were given; ▪ The lack of specific values documented in the progress notes for vital signs; and ▪ The lack of full sets of vital signs documented in the records for acute changes in status. As an example of some of the problems noted: ▪ In the case of Individual #286, the nurse's note indicated that there were increases in the individual's temperature and the pulse over a short period of time. The type of temperature obtained was not consistently documented so that accurate comparisons could be made in assessing the individual's status. There was nearly an eight-hour gap in the notes after the individual was noted to have a change in status. This indicated that the individual potentially had not	

#	Provision	Assessment of Status	Compliance
		been assessed after an episode of an elevated temperature and pulse was identified. The next nurses' note reflected that the individual's temperature had significantly risen to 102 degrees Fahrenheit. In addition, there was no systems assessment documented that included lung sounds for this individual who was at risk for aspiration. There was no note that indicated that the physician was consistently notified of the elevated temperature and pulse. Also, there was no mental status of the individual documented throughout the acute episode. There was no nursing assessment prior to the individual leaving the Facility, no time or mode of transportation, or indication that anyone from the Facility accompanied the individual to the hospital. In addition, the assessment of the individual upon return to the Facility from the hospital was inadequate, because it did not include a head-to-toe assessment. There were a number of significant problematic issues found in the 12 records reviewed regarding complete, adequate and appropriate nursing assessments of symptoms for acute changes in status. As noted above, there were some cases where there was no documentation indicating that an individual was even being sent to the hospital, and most cases had inadequate assessments before and upon return to the Facility. Reviews of two individuals' cases were done on-site with Facility nursing staff who at the reviewer's request, provided feedback regarding the documentation found in the medical records. There were a few nurses that provided impressive comprehensive and critical feedback during the on-site review and these talents should be cultivated when the Facility begins to monitor issues regarding acute changes in status. AUSSLC had a filled position for a Hospital Liaison Nurse who visited and documented the individuals' status while they were in the hospital. This is a significantly beneficial clinical position to allow the Facility to remain informed when individuals are admitted to the community hospital, and to provide necessary information to the acute care facility. The documentation of the Hospital Liaison was maintained in the individuals' medical records to ensure all team members had access to the clinical information to ensure continuity of care. In addition, from a policy perspective, based upon a review of AUSSLC Nursing Policies, Procedures and Protocols, there was no policy/procedure found addressing Acute Change in Status. The Facility needs to develop and implement a policy and procedure addressing this critical issue. At the time of this review, the Facility had no adequate system in place for monitoring nursing care and documentation for individuals who experienced acute changes in health status to ensure appropriate nursing practices were being implemented. This area should be viewed as a priority when developing and implementing a monitoring system	

#	Provision	Assessment of Status	Compliance
		to ensure that adequate nursing practices are being conducted for those in this high risk category. <u>Availability of Pertinent Medical Records</u> During the review, it was noted that a number of documents were not in the medical records and had to be located, because they had not been filed in a timely manner. This was a consistent problematic issue throughout the review process while on-site. The Medical Director, Chief Nurse Executive, and the QE Nurse verified that there were on-going problems with record keeping due to the lack of adequate staff available to file documents in the records. For example, a number of chest x-rays were not found in the records for individuals who had positive PPDs. The Facility needs to ensure that documents are timely filed in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Nursing Peer Review</u> Based on a Nursing Peer Review document submitted by the Facility for 3/22/10, Nursing Peer Reviews had been operationalized as an investigative process of review for suspected, inappropriate practice. As defined by the American Nurses Association (ANA) in 1988, peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. In alignment with the ANA's philosophy of peer review, the Facility should consider completing case reviews of individuals who have had to be transferred to the hospital and/or ER as a clinically relevant area. A statewide policy should be developed and implemented addressing regular nursing peer reviews. Such reviews should focus on the identification of strengths and weaknesses of the Facility's nursing practices, include critical analyses of nursing practices, and identify problematic trends. When problematic trends are identified, plans of correction should be generated, and clinical outcomes should be measured to determine if improvements are realized as a result of the corrective actions. <u>Infection Control</u> Infection Control (IC) is an area in which it is essential that proper nursing supports are in place at the individual-level, and that there are proper systems in place to prevent the spread of infections on a facility-wide basis. The failure to appropriately monitor and address infectious disease places individuals, staff, and all visitors at significant risk. Infectious diseases affect the short-term, as well as the long-term, and even life-long	

#	Provision	Assessment of Status	Compliance
		health of individuals who contract them. At the time of the review, AUSSLC did not have adequate infection control procedures in place at either the individual or systematic level. With regard to IC at AUSSLC, at the time of the review, the Facility did not have an adequately functioning Infection Control Department. The Facility had one Family Nurse Practitioner as the IC Nurse who had some clinical background in dealing with infection control diseases in a rural setting. The Infection Control Nurse had been in the position since 2007. There were no other clerical or clinical employees in the department. However, a 20-hour position was being secured to assist with the employee health program. Review of the Facility's IC program revealed that there was no database maintained in the areas regarding the surveillance of Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); Human Immunodeficiency Virus (HIV); immunizations; vaccines; or antibiotic use. At the time of the review, no comprehensive and accurate lists existed to track individuals with infection control issues. Consequently, AUSSLC had no reliable data addressing infection control issues. In fact, during the review, the Facility had to aggregate information from the homes to produce some individuals' names that had experienced a chronic or acute infectious process within the past year. The Facility needs to develop and implement a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data. In addition, the Facility had few Infection Control policies, and those that did exist did not adequately address basic IC practices and/or the operations of the IC department. Based on the interview with the IC Nurse, there were a number of informal systems that were in place that needed to be formalized into policies and procedures to ensure consistency. The Facility needs to ensure that adequate IC policies and procedures are developed and implemented in alignment with the SA and Healthcare Guidelines addressing Infection Control requirements. A statewide Infection Control Manual would be very useful to the Facilities. Also, there was no system in place that ensured that the residential units were accurately and promptly reporting required issues to the IC Department. Without ensuring that the IC data are reliable and timely reported, the Facility cannot accurately and timely identify where training on appropriate IC practices are needed, or identify IC trends and implement appropriate corrective actions. The overall documentation of the activities of the IC Department was contained in IC Committee Meeting minutes. Although the IC Committee minutes reflected discussions	

#	Provision	Assessment of Status	Compliance
		regarding issues such as hand washing, environmental checklists, H1N1 and Hepatitis B vaccines, there was no documentation of comprehensive analyses regarding problematic issues or clinical outcomes related to infection control. Although the IC Nurse was compiling data regarding weekly infection reports, there was no analysis found addressing any trends in the data, inquires into problematic trends, corrective actions addressing any problematic trends, or monitoring of outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units. Consequently, the department's data only represented raw numbers, rather than clinical outcome indicators that should be used by the Facility to monitor and improve its infection control practices. Based on a review of the Infection Control Committee Meeting minutes, there was little to no information contained in these minutes to demonstrate that the Facility was addressing issues related to Infection Control practices rather than merely presenting tasks that were to be completed. Modifying the format of the minutes so they contain pertinent information regarding issues discussed; corrective actions; dates, timeframes and assigned responsibility of action steps; expected and actual outcomes; and how the implementation efforts will be monitored to ensure the desired clinical outcome is achieved would guide the Committees in addressing necessary IC issues, and significantly improve the infection control documentation. At the time of this review, the Facility was conducting environmental audits using the AUSSLC Infection Control Safety Compliance Checklist. It was not clear how often these audits were conducted. Based on a review of the completed audits and this reviewer's observations while on-site, the audits did not accurately reflect the lack of cleanliness observed at the Facility. In addition, when problematic issues were identified, there was no indication that any type of follow-up or resolution was initiated. Also, there were no reports found that addressed or analyzed the data from the environmental audits. At the time of the review, there was no monitoring system in place that addressed issues regarding appropriate treatment practices for infection control issues. For example, there was no monitoring system in place to ensure that individuals with Hepatitis C were screened for immunizations for Hepatitis A and B, and, if needed, had received them, or that individuals with MRSA had received the appropriate antibiotic, and that contact precautions were appropriately followed on the units and in day programs. In addition, no tracking was found for individuals who refused treatments such as immunizations or PPDs indicating that their treatment teams were addressing the refusals and implementing interventions. In addition, based on interview with the QE Nurse and IC Nurse, the Facility did not include any infection control data as a part of key indicator data for Quality	

#	Provision	Assessment of Status	Compliance
		Management/Risk Management. As the Facility continues to develop these systems, Infection Control information should be integrated into this system, as well as integrated into the other disciplines' reviews regarding practices and clinical outcomes. For example, mealtime monitoring would be another avenue to collect and review appropriate infection control practices. Based on a review of the IC documentation and data, there was a significant lack of a connection between clinical issues at the residential unit level and the activities of the Infection Control Department. During an interview with the IC Nurse, she reported that there was no review of the Nursing Care Plans for individuals with infectious diseases by either Infection Control or Nursing to ensure that they were clinically appropriate, and/or that the interventions were actually being implemented. As is discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 18 individuals' records that were reviewed who had either a chronic or acute infectious disease, none had a Nursing Treatment Plan that actually identified or addressed the infectious disease. In a review of ten records, the annual documentation by the physicians regarding a screening for any active signs or symptoms of Tuberculosis for individuals who are Purified Protein Derivative (PPD) positive were found to be inconsistently documented. Two individuals' records, Individual #248 and Individual #423, did not include any documentation of a screening, and the remaining eight either noted no problems in the respiratory section of the annual physical, or a clearer documented screening in the narrative section of the annual physical. In addition, a number of chest x-rays were noted to have been completed from the physicians' notes, and assessments, but the actual chest x-rays themselves were frequently not found in the records. Proper hand washing as well as the implementation of other Standard Precautions are key elements of infection control. A review of the Facility's Infection Control new employee orientation materials demonstrated that hand-washing and Standard Precautions were included in the curriculum. However, some of the materials reviewed used the term "Universal Precautions," which are now referred to as "Standard Precautions." There appeared to be competency-based training regarding only hand washing included as part of the curriculum. The training lacked elements such as the clean-up of biohazards, as well as the types of infectious diseases, their symptoms, and prevention methods. In addition, from the lack of Nursing Treatment Plans found addressing infectious diseases, additional and on-going competency-based training regarding Infection Control issues is warranted for the Nursing staff. Although hand washing was included as an item on the Facility's current Hand Washing monitoring tool, there were no data indicating that the staff conducting the monitoring	

#	Provision	Assessment of Status	Compliance
		was competent in the procedure, and there was no summary or analysis of the data found indicating if staff were using the proper techniques. At the time of the review, there was no data found that verified that all vaccines and immunizations were administered in a timely manner, and according to Centers for Disease Control (CDC) guidelines. Since many of the individuals have been at the Facility for a number of years, the original lab work was not usually found in the records making it difficult, if not impossible, to determine if individuals received the appropriate administration of vaccines. Although the IC Nurse had past clinical experience and background in infectious diseases, additional expertise and staffing will be needed to build and structure an adequately functioning Infection Control Department, and implement tracking systems in alignment with the Health Care Guidelines and the Settlement Agreement. In addition, the development and implementation of statewide Infection Control policies and monitoring tools would facilitate this process. <u>Code Blue Drills</u> From review of available documentation, AUSSLC had not been conducting emergency medical drills. The Facility had been using a "6200 system" that was implemented in response to a past deficiency noted by a regulatory agency. Based on explanations of this system by the QE Nurse and Chief Nurse Executive, a code-like system was required to be implemented for both major and minor issues. Using this type of system for all incidents dilutes the need for urgent actions that are required for true emergencies. The Facility had recognized this issue and was in the process of modifying the system. However, at the time of the review, the Facility did not have a policy or procedure outlining actions to be taken during a medical emergency, nor was there any type of committee review for medical emergencies. In addition, the Facility did not collect or trend any data related to the current 6200 system. The Facility needs to develop and implement a comprehensive system addressing emergency response. During the review, significant problematic issues were found with regard to staff's knowledge of the Facility's emergency equipment in the Infirmary. When asked to demonstrate the use of the emergency equipment, three of three nurses (100%) were unfamiliar with how to turn on the oxygen. One of the oxygen tanks for the Infirmary was inoperable because it did not have a regulator attached to it. This was in spite of the fact that documentation on the emergency checklist indicated that the equipment was being regularly checked. In addition, the nurses did not know how to check the suction machines to ensure that they were operational. One nurse also did not know where the automatic external defibrillator (AED) was kept on the unit. Supplies that were to be taken for "6200s" were not regularly checked to ensure they were available. The Facility	

#	Provision	Assessment of Status	Compliance
		needs to implement a system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. It is imperative that all licensed staff receive competency-based training regarding emergency procedures and equipment use. Observations of these skills should be conducted at least quarterly and during drills. Once the Facility develops an appropriate emergency response system, it is essential that the use of the emergency equipment is incorporated into the emergency training and drills. This is necessary to ensure that when an emergency arises, the nurse will be familiar with the operation of the emergency equipment. In the midst of an emergency, nurses should already have a working knowledge of the equipment, and should know exactly what supplies are needed, and where these supplies are kept. This will avoid delays in treatment during an actual emergency. Physicians also need to participate in the Emergency Drills. It is essential that the physicians practice their role in a medical emergency so that they are familiar with the Facility's emergency systems, and with the staff's knowledge of emergency procedures.	
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.	Twenty-eight individuals' records were reviewed, including: Individual #291, Individual #210, Individual #276, Individual #8, Individual #182, Individual #17, Individual #39, Individual #100, Individual #426, Individual #362, Individual #331, Individual #188, Individual #77, Individual #42, Individual #73, Individual #280, Individual #439, Individual #416, Individual #287, Individual #235, Individual #195, Individual #92, Individual #183, Individual #175, Individual #343, Individual #53, Individual #233, and Individual #111. All had quarterly nursing assessments completed in a timely manner. However, the quality of these quarterly assessments required significant improvement. The nursing assessment form used checkmarks for most of the sections, and nursing staff frequently did not add any additional pertinent information to these sections. The Nursing Summary narrative section for all of the 28 quarterly assessments reviewed contained mainly raw data without any analysis of whether the individuals were doing better or worse than the previous quarter. For example: ▪ Individuals who had lab work during the quarter only had the current values noted on the assessment without mention of a comparison to the previous lab values. ▪ A list of the nursing diagnoses were included on the quarterlies, however, there were no summaries indicating if there had been progress or lack of progress regarding the goals and objectives for each of the nursing diagnoses. Overall, the nursing quarterly and annual assessments need to include an analysis of progress made during the quarter rather than just listing raw data such as lab values and appointment dates.	

#	Provision	Assessment of Status	Compliance
		In addition, as mentioned above, the Quarterly Nursing Assessments reviewed did not indicate progress or lack thereof regarding individuals' measurable objectives, and service and/or supports that should have been, but generally were not included in individuals' Nursing Care Plans. As discussed in further detail below, the Nursing Treatment Plans at AUSSLC generally did not include appropriate measurable objectives. As the Nursing Department works to improve these, it will be essential for the nursing quarterly assessments to include a discussion of the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies, supports and services.	
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.	Review of 28 individuals' records (Individual #291, Individual #210, Individual #276, Individual #8, Individual #182, Individual #17, Individual #39, Individual #100, Individual #426, Individual #362, Individual #331, Individual #188, Individual #77, Individual #42, Individual #73, Individual #280, Individual #439, Individual #416, Individual #287, Individual #235, Individual #195, Individual #92, Individual #183, Individual #175, Individual #343, Individual #53, Individual #233, and Individual #111) found that all of the Nursing Treatment Plans (100%) were of very poor quality, and provided little to no direction regarding meeting the needs of the individuals experiencing a variety of health issues. The interventions listed on the treatment plans for issues such as skin integrity, included items such as "administer medication as ordered," and "notify physician when skin problems occur." These interventions are services that have to be provided to all individuals. The lack of individual-specific interventions based on individualized needs in the Nursing Treatment Plans render them meaningless in providing staff direction for caring for individuals, and being able to measure individuals' progress toward their health/behavioral goals. Although some objectives/goals contained in the Nursing Treatment Plans were noted to be measurable, behavioral and/or observable, most were not or were not clinically appropriate for the specific health issue. Although most interventions were reactive in nature, documentation of the implementation of the interventions listed in the Nursing Treatment Plans was rarely found in the progress notes. None of the nursing interventions reviewed 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, there were generally no proactive interventions included in the 28 Nursing Treatment Plans reviewed. Nursing Treatment Plans that included a problem noting that an individual was at risk for a specific issue such as aspiration included interventions that only addressed reactive care rather than preventative care. For example:	

#	Provision	Assessment of Status	Compliance
		▪ The Nursing Treatment Plan for Individual #92 indicated that the objective was for the individual to have no episodes of urinary tract infections (UTI). The interventions included: the nursing staff would administer fluids as ordered without specification of the amount of fluids, would monitor and record temperature, and record full set of vital signs if UTI confirmed, administer antibiotics as ordered, and assess urine for signs of increased infection. There was little included in the Treatment Plan indicating how nursing would assist in preventing occurrences of UTIs. Also, there was no indication how often staff were to document interventions (e.g., daily, weekly), who would review the documentation and how often, what constituted an adequate amount of fluids, and/or how adequate fluid intake was to be tracked and reviewed. ▪ In the case of Individual #343, the objective in the Nursing Treatment Plan stated the individual would have an improved level of health by having an ideal body weight by 6/23/09. Aside from the fact that the objective was out-of-date, no specific information was provided such as how much weight loss was safe and appropriate for this individual, and what the desired weight range was that the team had identified. The Treatment Plan included no actual interventions, such as getting the individual engaged in some type of physical activity, to assist the individual in reaching the desired goal. An additional sample of individuals' records was reviewed to determine if individuals with chronic and acute infectious diseases had appropriate care plans to address their needs. Specifically, a review was completed of 18 Nursing Treatment Plans for individuals diagnosed with a variety of infectious diseases including: Individual #268, Individual #45, Individual #81, Individual #122, Individual #302, Individual #244, Individual #53, Individual #395, Individual #248, Individual #46, Individual #111, Individual #405, Individual #7, Individual #429, Individual #399, Individual #274, Individual #322, and Individual #423. Of the 18 individuals, none had Nursing Treatment Plans addressing these issues. The Nursing Treatment Plans did not address any of the essential elements for a contagious illness, including the need for precautions to be used when taking care of the individual, teaching the individual and staff to prevent the spread and transmission of the infection, and/or the signs and symptoms to regularly assess and document. Based on this review, there was no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control procedures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented. At the time of this review, AUSSLC did not have an adequate monitoring instrument addressing the quality and implementation of Nursing Treatment Plans. From the review, the Nursing Treatment Plans did not provide an adequate and appropriate guide regarding the specific needs of the individuals. In addition, there was no evidence that	

#	Provision	Assessment of Status	Compliance
		even the inadequate nursing interventions listed in the Nursing Treatment Plans were actually being implemented. There needs to be a monitoring system in place ensuring that appropriate Nursing Treatment Plans are in place, and that the nursing interventions are being implemented.	
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.	From review of AUSSLC's Nursing policies, procedures, and protocols, there appeared to be a number of missing or inadequate components. For example, there were no protocols found addressing issues such as diabetes, cardiac conditions, changes in mental status, and metabolic syndrome for individuals prescribed certain psychotropic medications. In addition, the nursing protocols that were provided by the Facility lacked specific criteria for what should be included in progress note documentation, and/or other specifics such as timeframes for initiating and completing assessments, and specific parameters as to when to notify the physician of certain critical information. The Nursing Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice, as defined by the requirements of the SA and Health Care Guidelines. Once that is accomplished, the department then needs to develop and implement associated monitoring instruments with established inter-rater reliability at 85% or above to ensure that these practices are being adhered to consistently.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	As noted in the section of this report that addresses Section I of the SA, the Facility was using the Health Risk Assessment Tool as the tool for the identification of clinical risk indicators for individuals. As mentioned previously, this tool was simply scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. The tool was not an adequate risk assessment for any of the areas mentioned, and its implementation did not result in the appropriate identification of clinical risk indicators. The Facility was however, using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. Standardized risk assessments with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, the teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.	
M6	Commencing within six months of	The Facility's medication error/variance system is discussed in detail below with regard	

#	Provision	Assessment of Status	Compliance
	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.	to Section N.8 of the SA. From interviews with nursing staff and review of AUSSLC's Medication Error Committee minutes, there appeared to have been little supervision provided for licensed nurses in the administration, monitoring, and recording of the administration of medications. The Facility recently implemented a new tool to monitor medication administration that appeared to be comprehensive. However, the current procedure at AUSSLC for the medication observations was that nurses were only observed administering medication annually or when an error occurred, which is too infrequent to ensure that appropriate medication administration practices are being consistently followed, especially in a facility that uses a number of agency nurses. Nurses should be observed administering medication at least on a quarterly basis. The Facility will need to develop and implement a tracking system to ensure that each nurse is observed at least quarterly, including agency nurses. During one observation for medication administration, the medication nurse was observed standing in a corner until 8 a.m. waiting to administer the 7 a.m. medications. When asked about this situation, the nurse reported that he did not want to upset the direct support professionals by asking them to escort the individuals to receive their medications, because he had to work with them all day. It was not until a staff member conducting the observations with this reviewer intervened that the individuals began receiving their 7 a.m. medications. In addition, the medication nurse did not recognize that the lateness of the medication administration constituted a medication variance. During observations of medication administration for individuals who received their mediations via tube, the nurses overall did well except for the following issues: ▪ Privacy was not consistently provided to individuals during medication administration; ▪ Information about the medications was not usually provided to the individual prior to medication administration; and ▪ The nurses did not ensure the individual was in the proper position prior to medication administration. At the time of the review, the current medication system lacked any type of reliability, and the lack of oversight appeared to have led to significant deviations of accepted standards of practice, as defined in the SA. AUSSLC needs to critically review its entire medication system, and develop and implement systems that will ensure adherence to appropriate medication administration practices.	

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

1. It is essential that efforts in recruiting and maintaining a stable nursing staff continue to be implemented, and expanded. This will require an

analysis of the issues negatively impacting the Facility's ability to hire and retrain a stable nursing workforce, and the development of a plan to address the issues identified.

2. The Facility needs to re-evaluate its current process for providing orientation training to the agency nurses to ensure the individuals at AUSSLC are provided competent and appropriate nursing services.
3. A monitoring system should be developed and implemented to ensure:
   - Completion, quality and timeliness of Nursing Assessments;
   - Nursing Treatment Plans are individual-specific and meet professional standards of care;
   - Interventions listed in Nursing Treatment Plans are proactive, are being timely and appropriately implemented, and are modified in response to the individuals' progress;
   - Individuals who experience changes of status are reviewed, including reviews of individuals who were sent to community hospitals and Emergency Rooms; and
   - All nurses who administer medications are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors. Such review should occur at least quarterly to be consistent with generally accepted professional standards, as defined in the SA.
4. Inter-rater reliability for all monitoring tools should be established at 85 percent or better.
5. The current allocation of nursing positions should be evaluated to meet requirements for developing departmental monitoring activities.
6. The Facility needs to development and implement a policy and procedure on addressing acute change in status.
7. Regular Nursing peer review should be conducted in alignment with the American Nurses Association's philosophy, rather than as an investigative process.
8. Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
9. The Facility needs to develop and implement a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data.
10. The Facility needs to develop and implement IC policies and procedures that result in an appropriately functioning Infection Control Department.
11. Consideration should be given to securing the services of an expert in the area of Infection Control to provide consultation to the State and the Facilities.
12. The need for additional staff for the Infection Control Department at AUSSLC should be evaluated.
13. Statewide IC monitoring instruments should be developed and implemented to ensure that individuals with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other individuals who live in or utilize the same buildings, as well as staff, and visitors are appropriately protected from transmission of infections.
14. Systems should be developed and implemented to ensure reliability of IC data.
15. The structure of the IC minutes should be revised to include a systematic review of data trends for individuals and employees. Discussions at IC meetings should include analyses of data, inquiries into potentially problematic issues, and for any issues identified, a plan of action that includes the name of the person responsible for follow-up and the date when it will be implemented, and updates on the achievement of desired outcomes.
16. The Infection Control Department should collaborate with other nursing staff regarding the development and implementation of individualized–specific, appropriate Nursing Treatment Plans for IC issues.
17. The Infection Control Department should ensure that unit staff members receive appropriate on-going competency-based IC training.
18. Infection Control Environmental audits should accurately reflect the environmental conditions, and corrective actions should be taken and documented.
19. IC data should be integrated into the Facility's Quality Management system.
20. The Facility needs to develop and implement a system addressing Medical Emergencies and Drills that includes policies and procedures that

include, but are not limited to: a) emergency medical drills that are conducted at least quarterly, on every unit, and every shift, and include the use of emergency equipment; b) standards requiring physician participation in emergency drills at least once per quarter; c) critical committee review of drills and actual emergencies; and d) plans of correction developed and implemented to address problematic issues.

21. Competency-based training should be implemented regarding emergency procedures that include the use of emergency equipment.
22. Ongoing competency-based training should be provided to all licensed staff regarding the appropriate procedures for checking emergency equipment.
23. A monitoring system should be developed and implemented requiring nurses to demonstrate the use of the emergency equipment when checking it to ensure that it is in good working condition.
24. The Nursing Assessment forms and processes should be revised to ensure that a comprehensive nursing assessment is conducted. The current form consists of a checklist that does not set the expectation for a comprehensive analysis of information. As noted above, the current format for nursing assessments results in only raw data being reported, but not analyzed.
25. Nurses and any other staff responsible should be required to complete competency-based training on:
    - Nursing Assessments;
    - Writing and monitoring Nursing Treatment Plans; and
    - The proper administration and documentation of medication.
26. Nursing Treatment Plans should be revised to include specific goals/objectives that are objective and measurable, as well as interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are to be reviewed, and when they should be modified.
27. The role of nursing in the interdisciplinary treatment team process should be expanded to ensure that treatment plans are derived from an integration of the individual disciplines' assessments, and that goals and interventions are consistent with clinical assessments.
28. The Nursing Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice, as defined by the SA and Health Care Guidelines.
29. As is recommended with regard to Section I of the SA, standardized risk assessments with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.
30. AUSSLC needs to critically review its entire medication system, and develop and implement systems that will ensure adherence to appropriate medication administration practices.

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 AUSSLC's Pharmacy policies, including: Pharmacy Policy on Physician Notification for Interactions, Allergies and Side Effects; Adverse Drug Reaction (ADR) Monitoring; Management of Controlled Substances on Residential Units; and Medication Error Policy Addendum; o AUSSLC's Internal Plan of Improvement for Daily Medication Counts; o Medication Error Committee Meeting minutes, dated 7/27/09, 8/24/09, 9/28/09, 11/18/09, 12/14/09, 1/29/10, and 2/10; o The following Drug Utilization Reviews (DUEs): November 2009 for Levothyroxine; February 2010 for Clopidogrel, and Clozapine; o Adverse Drug Monitoring Report for deep vein thrombosis (DVT); o Pharmacy and Therapeutics Committee Meeting minutes, dated 11/12/09, and 2/25/10; o Psychiatric Polypharmacy Committee Meeting minutes, dated 11/13/09, 12/14/09, 1/14/10, 2/11/10, and 3/11/10; o Psychoactive Polypharmacy Reports for 12/09, 1/10, 2/10, and 3/10; o Nursing Policies, including: Monitoring of Side Effect Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS); o Medication Administration Observation data from 3/09 through 4/8/10; o Quarterly Drug Regimen Review forms for the following individuals; Individual #36, Individual #359, Individual #70 , Individual #112, Individual #242, Individual #148, Individual #11, Individual #193, Individual #356, Individual #215, Individual #196, Individual #34, Individual #171, Individual #265, Individual #117, Individual #310, Individual #260, Individual #323, Individual #347, Individual #363, Individual #268, Individual #334, Individual #22, Individual #44, Individual #113, Individual #264, Individual #64, Individual #319, Individual #372, Individual #180, Individual #412, Individual #141, Individual #52, Individual #458, Individual #67, Individual #272, Individual #275, Individual #88, Individual #241, Individual #282, Individual #183, Individual #278, Individual #194, and Individual #29; o Medical records for the following individuals: Individual #301, Individual #446, Individual #82, Individual #443, Individual #273, Individual #133, Individual #288, Individual #249, Individual #321, Individual #318, Individual #312, Individual #199, and Individual #456; and o QE Plans of Implementation for Medication Issues ▪ **Interviews with**: o Jamie Patch, R.Ph., Pharmacy Director; o Rebecca Hall, RN, CNE; o Carolyn Harris, RN, NOO; o Kim Sweeney, RN, QA Nurse; and

	○ Julie Moy, MD, State Medical Director
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Whenever an individual was prescribed a new medication at AUSSLC, a system was in place to check for potential issues with the existing medication regimen. Although the pharmacy maintained all physicians' orders for two years, a formal written procedure describing the system needed to be developed and implemented to ensure that there was supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needed to be documented. At the time of the review, the Facility had a recent vacancy for a clinical pharmacist. Consequently, they were behind regarding the completion of the quarterly Drug Regimen Reviews for six homes. Once this position is filled, the Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner, or that clinical justification is documented for recommendations that are not implemented. At the time of the review, AUSSLC was in the process of implementing a system to monitor the use of "Stat" (i.e., emergency medication), and chemical restraints in alignment with the SA. Such a system should ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment. The Facility had conducted drug utilization evaluations (DUEs) in November 2009 for Levothyroxine; and in February 2010 for Clopidogrel, and Clozapine. Although conclusions and recommendation were generated for each DUE conducted, there was no indication if these had been appropriately implemented. In order to bring the DUE processes to appropriate conclusion, the Facility should document any plans of correction with dates implemented, or clinical justifications for not implementing changes. The State's Medical Director had been working on this requirement with all the SSLCs, and was continuing to develop the DUE process in alignment with the SA and Health Care Guidelines. The Facility appeared to have a significant problem regarding the underreporting of medication errors. The Facility's own QE data indicated that significant issues existed regarding the medication administration, and error/variance systems. Nursing staff at the Facility did not consistently agree on what constituted a medication error that needed to be reported. Since medication error reporting was not yet reliable, increasing medication observations and implementation of a spot check system should be initiated. The spot check system should include a review of the Medication Administration Records (MARs), and the narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately, and that both the on-coming and off-going nurse has signed the narcotics log.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	A review of the AUSSLC pharmacy policies that were provided found that the Facility had very few policies/procedures in place addressing Pharmacy Services and its procedures. There appeared to be two new policies in alignment with the Settlement Agreement and Health Care Guidelines, including the Pharmacy Policy on Physician Notification for Interactions, Allergies and Side Effects, and Adverse Drug Reaction (ADR) Monitoring Policy and Procedure. However, there were no dates of implementation included on these. An inspection conducted by the Texas State Board of Pharmacy on 8/25/95 indicated that the pharmacy was advised to update its policies and procedures to reflect the procedures used in the pharmacy. Since the subsequent inspection on 7/31/07 did not cite this issue, it was not clear to the reviewer if the Facility had additional pharmacy policies that were not provided for the review. For consistency of practice, there should be a statewide Pharmacy Manual developed and implemented at all Facilities in alignment with pharmacy standards of practice, as described in the SA/HCG. In addition, a monitoring system needs to be developed and implemented to ensure that these policies are consistently being implemented. An interview with the Pharmacy Director indicated that when a physician wrote a new order for a medication for an individual, the pharmacist received the new order, and entered it into the WORx software system that completed an automatic review of the new medication. This review assessed the newly prescribed medication regarding the appropriate dosing, listed allergies, and potential interactions with the individual's current medication regimen. If a problem was identified, the prescription was held, and the physician was notified informally by phone or in-person. The pharmacist then made a note on the Intervention Section of the WORx program, and a note might be made on the physician's order to document the problematic issue. The pharmacy then maintained the physicians' order for two years. Although the Facility had a system in place addressing this requirement, portions of the system were informal without consistent supporting documentation. In addition, the policy addressing this issue, entitled Pharmacy Policy on Physician Notification for Interactions, Allergies and Side Effects, did not state specifically where this process should be documented. A system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication might have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented. In alignment with the HCG, there also needs to be a policy describing the process to be used should there be a disagreement between physician/practitioner and pharmacist that would warrant involvement of the Medical Director.	

#	Provision	Assessment of Status	Compliance
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 review of the Quarterly Drug Regimen Reviews was completed for 44 individuals, including: ; Individual #36, Individual #359, Individual #70 , Individual #112, Individual #242, Individual #148, Individual #11, Individual #193, Individual #356, Individual #215, Individual #196, Individual #34, Individual #171, Individual #265, Individual #117, Individual #310, Individual #260, Individual #323, Individual #347, Individual #363, Individual #268, Individual #334, Individual #22, Individual #44, Individual #113, Individual #264, Individual #64, Individual #319, Individual #372, Individual #180, Individual #412, Individual #141, Individual #52, Individual #458, Individual #67, Individual #272, Individual #275, Individual #88, Individual #241, Individual #282, Individual #183, Individual #278, Individual #194, and Individual #29. This review identified the following issues: ▪ There was no place on the Drug Regimen Review forms that included documentation that a recommendation was actually implemented by the physician or practitioner, or the clinical justification for a physician not following a recommendation. The form only required that the physician or practitioner place a checkmark by a statement indicating that they agree or disagree with the pharmacist's recommendation. From example, 26 of the 44 DRRs (60%) reviewed indicated that the physician or practitioner agreed with a recommendation made by the pharmacist. However, only six of these 26 (23%) contained documentation from either the physician/practitioner or pharmacist indicating that the recommendation was actually implemented. A modification to the current DRR form could possibly address this issue. Examples of pharmacy recommendations not addressed on the DRRs included: o Individual #141: Suggested to increase calcium carbonate to 600 milligrams (mg) at 7 a.m. and 5 p.m. o Individual #52: Suggested to increase calcium intake to 1,200 mg daily in divided dosages; o Individual #485: Suggested to increase calcium carbonate to 600 mg twice daily, and consider discontinuing calcitonin nasal spray and begin alendronate, if indicated; o Individual #87: Suggested to increase calcium carbonate to 600 mg at 7 a.m. and 5 p.m., and add Vitamin D, if indicated; o Individual #272: Suggested to increase calcium carbonate to 600 mg at 7 a.m. and 5 p.m., and add Vitamin D, if indicated; o Individual #275: Suggested to increase calcium carbonate to 600 mg at 7 a.m. and 5 p.m., and add Vitamin D, if indicated; and o Individual # 29: Suggest reviewing current psychiatric diagnosis of Oppositional Defiant Disorder. ▪ Due to the recent vacant clinical pharmacy position, the DRRs for six homes have not been timely conducted. The Facility was aware of this issue and was	

#	Provision	Assessment of Status	Compliance
		in process of updating these DRRs. ▪ The pharmacist inconsistently commented on the completion of the MOSES and DISCUS, as required for individuals on psychotropic medications. Overall, the DRRs by the pharmacist were appropriate and comprehensive. In addition, for individuals prescribed psychotropic medications, the DRRs were routed to both the individuals' primary care physician and the psychiatrist for review of pharmacy recommendations. This is an excellent practice and should be adopted by all facilities to ensure collaboration and safe medication practices. In summary, the Facility needs to develop a system to ensure that the DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner. In addition, there did not appear to be any timeframes by which the physician/practitioner needed to review the completed DRR, and/or when the DRR needed to be placed in the record. A statewide policy addressing DRRs would ensure consistency among the Facilities.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	A review of AUSSLC's Pharmacy Policies that were provided found that there were no policies that specifically addressed the elements of this requirement. Based on a review of the Pharmacy and Therapeutics Committee Meeting (P&T) minutes, the Committee was in the process of outlining the procedure for reviewing chemical restraints. The minutes indicated that the psychologists were to fill out an evaluation form entitled the Administration of Chemical Restraint Consultation after each use of stat medications and/or chemical restraints, and forward it to the Psychiatrist and clinical pharmacist to evaluate the appropriateness of the use of medication. Thus far, only two Administration of Chemical Restraint Consultation forms (one each for Individual #75, and Individual #202) had been submitted. However, AUSSLC's data contained a list of 22 individuals who had received a chemical restraint since 1/2010. In addition, the two forms reviewed were not thoroughly completed to enable a review to ensure that the medications were used in a clinically justifiable manner, and not as a substitute for long-term treatment. Clearly, this system was in the initial stages of implementation. The Facility had implemented a Psychiatric Polypharmacy Committee in November 2009. The Committee had met monthly since that time. This committee had generated Psychoactive Polypharmacy Reports regarding individuals' clinical case reviews. These reports provided monthly updates regarding the use of polypharmacy. The committee meeting minutes and the Psychoactive Polypharmacy Reports indicated that the Facility had implemented a process by which to clinically review and monitor the use of polypharmacy, and that this process had begun to have a positive outcome for individuals.	

#	Provision	Assessment of Status	Compliance
		The Psychiatric Polypharmacy Committee minutes and the Psychoactive Polypharmacy Reports indicated that based on clinical reviews, it had been decided that 21 individuals who had been prescribed polypharmacy did not need it. The total number of individuals receiving psychiatric polypharmacy dropped from 66 individuals in November 2009 to 45 in March 2010. However, there was no indication from the P&T Committee or the Psychiatric Polypharmacy Committee meeting minutes or reports if monitoring was being conducted regarding the use of benzodiazepines, and anticholinergics to ensure clinical justification, and attention to associated risks. If these areas are being reviewed, the minutes and reports need to reflect the related information. If they are not yet being reviewed, the system used to review and monitor polypharmacy could include these elements with documentation of the use of benzodiazepines and anticholinergics included in the Psychiatric Polypharmacy Committee minutes and Psychoactive Polypharmacy Reports.	
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.	This is addressed above with regard to Sections N.1 and N.2 of the Settlement Agreement.	
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.	The MOSES is for monitoring side effects of psychotropics, and the DISCUS is for monitoring Tardive Dyskinesia. They are two tools for two different issues. AUSSLC was using both to monitor for the appropriate clinical issue. The HCGs require: "Tardive dyskinesia screening to include DISCUS immediately prior to initiating therapy as a baseline and every three months during treatment and for six (6) months following discontinuation of a neuroleptic medication. The MOSES will also be completed every six (6) months." At the time of the review, AUSSLC had current policies in place addressing this requirement. The minutes of the P&T Committee for February 2010 indicated that there were new MOSES/DISCUS forms, and that the psychiatric nurses were completing all of the MOSES/DISCUS monitoring for individuals seen in Psychiatric Clinic. For individuals not seen in the clinic, the individuals' RN Case Manager would be completing the monitoring for side effects. As noted above, the DRRs reviewed did not include a	

#	Provision	Assessment of Status	Compliance
		statement if a MOSES and/or DISCUS were needed or timely completed. The Facility's QE Nurse was monitoring this requirement. A review of 13 individuals (Individual #301, Individual #446, Individual #82, Individual #443, Individual #273, Individual #133, Individual #288, Individual #249, Individual #321, Individual #318, Individual #312, Individual #199, and Individual #456) found that all had a current MOSES. Out of nine that required a DISCUS, one (Individual #249) did not have a current DISCUS. In addition, only one individual, Individual #446) had a Nursing Treatment Plan that partially addressed self-injurious behavior and aggression, but did not address any goals and objectives for an individual on psychotropic medication such as the need to conduct MOSES and/or DISCUS monitoring. These issues need to be included in the Nursing Care Plans.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	At the time of the review, AUSSLC had a recent policy addressing Adverse Drug Reactions (ADR) in place. The minutes of the Pharmacy and Therapeutics Committee indicated that there had been one individual that had developed a left lower leg deep venous thrombosis, possibly secondary to Raloxifene. Medications were discontinued, and the individual was being treated for the DVT. However, the written report regarding this incident did not include if the ADR was deemed reportable to the Food and Drug Administration, and/or if any further action was warranted. The Facility needs to develop and implement a monitoring system in the event that there is an ADR, to ensure that all the required documentation is completed. A statewide policy, in alignment with standards of practice, as defined by the SA, and Healthcare Guidelines should be considered to address this requirement.	
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	The Facility had conducted the following Drug Utilization Reviews (DUEs): November 2009 for Levothyroxine; and February 2010 for Clopidogrel, and Clozapine. Compliance data was generated for each DUE conducted. Although conclusions and recommendation were generated for each DUE conducted, there was no indication if these had been appropriately implemented. In order to bring the DUE processes to appropriate conclusion, the Facility should document any plans of correction with dates implemented, or clinical justifications for not implementing changes. The State's Medical Director had been working on this requirement with all the SSLCs, and was continuing to develop the DUE process in alignment with the SA and Health Care Guidelines.	

#	Provision	Assessment of Status	Compliance
	care with regard to this provision in a separate monitoring plan.		
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.	Information regarding medication errors/variances also is included above with regard to Section M.6 of the SA. Based on review of the Medication Error Committee Meeting minutes, Medication Administration Observation data, and interviews with the Chief Nurse Executive, QE Nurse, and unit medication nurses, AUSSLC had significant problematic issues regarding the integrity of the medication administration system and error reporting system. At the time of the review, the system at the Facility was a medication error system, rather than a medication variance system. From review of the Facility's medication error data from July 2009 through January 2010, and the minutes of the Medication Error Committee, there appeared to be a significant problem with the under-reporting of medication errors based on the census, and the number of medications given on a daily basis. A review of ten of the Facility's Medication Error Reports found that there were significant trends in having an excess of medications or not enough medications in the individuals' medication cart bins, indicating that medications were either not administered or administered incorrectly. This issue was also noted in the Medication Error Committee minutes. Moreover, the minutes stated that the nurses were not consistently completing a Medication Error Report when this situation occurred. Consequently, the Facility's medication error data was unreliable. Based on information contained in the Medication Error Committee Meeting minutes, a number of the errors actually identified were attributed to agency nurses. The Facility's practice at the time of the review was to conduct medication observations annually and when a medication error had occurred. However, annually observation was not adequate, especially since the Facility had significant nursing staffing issues, and used a number of nurses from various nursing agencies who administered medications. The Facility needs to increase its medication observations from annually to quarterly for all nurses who administer medications. From conversations with nurses' who administer medications, there was significant confusion regarding what constituted a medication error/variance, and the procedure to be used when Medication Administration Records (MARs) were found blank. In addition, a review of the Facility's Medication Administration Observation data indicated that issues were found regarding medications that were pre-poured, failure to check the placement of a tube prior to the administration of medication by the tube, signing the MARs before medications were administered, not signing the MARs at the time medications were administered, lack of individuals' photographs on the MARs for proper identification, medications given late, medications not administered as ordered, and	

#	Provision	Assessment of Status	Compliance
		medication carts that would not lock. All of these issues deviate from appropriate standards of practice, as defined by the SA, and render the Facility's medication administration system unreliable. During the review, a number of nurses were asked if missing initials on the MARs constituted a medication error/variance, and the answers varied considerably. Some thought the blanks were medication errors, some thought they had a certain timeframe to initial the MAR for it not to be an error/variance, and some stated that they did not deal with this as part of their responsibilities. Only a few of the nurses asked stated that they were responsible for completing a Medication Error Report if they had found a blank space on the MAR. Most stated it was the Supervisors' job to deal with any issues related to medication errors. The Facility needs to develop and implement a system to ensure that MARs are regularly checked to determine that medications were given as prescribed. When issues such as missing initials on the MARs are identified, a review needs to be completed to determine whether the individual actually received the medication, and a Medication Error/Variance Report needs to be submitted since the MAR blank constitutes a variance from the appropriate procedure. Since the medication error reporting system was not yet reliable at AUSSLC, increasing medication observations and implementing a spot check system should be initiated that include a review of the MARS and narcotics logs during each shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately, and that both the on-coming and off-going nurses have signed the narcotics log indicating that the narcotic count was conducted by both nurses. AUSSLC's current policy only indicated that "two nurses" were to count the narcotics. The policy needs to be revised to include the on-coming and off-going nurses. In addition, the State should consider moving from a medication error system to a medication variance system. A medication variance system focuses on all aspects of the medication delivery system, and places an emphasis on identifying potential areas that could lead to errors. Once such areas are identified, the focus would be on implementing proactive measures to prevent such errors from occurring. In reviewing the minutes from the Medication Error Committee, there was no documented comprehensive narrative analysis, and/or discussion of the barriers in the medication administration process or system. The documented discussion represented merely a review of the numbers of medication errors for some of the months, but not for others, without any analysis of problematic trends, or suspected underlying causes for	

#	Provision	Assessment of Status	Compliance
		such trends. In addition, were no plans of correction generated to address problems found during medication observations conducted by Facility staff. A number of Plans of Implementation were developed and implemented by the QE Nurse addressing, for example, the following problematic issues: ▪ An individual who may not have been receiving Lactulose as prescribed; ▪ Nursing staff not following the procedure for completing an overage/excess form, and returning medications to the pharmacy when a discrepancy was noted during daily medication counts; ▪ Nursing staff not following physicians' orders, or medication administration policy and procedure when administering Calcitonin Nasal Spray; ▪ Nurses violating the security of controlled substances by leaving medication cabinet keys in plain sight in medication rooms; and ▪ Nursing staff not dating medication bottles when they were opened, and making it impossible to monitor for expired medications. None of these plans of implementation were found mentioned in the Medication Error Committee minutes, P&T Committee minutes, or in the Nurses' Meeting minutes. Consequently, there was no indication if any of the interventions included in the Plans of Implementation were implemented and/or resulted in any positive outcomes. There needs to be collaboration between nursing, pharmacy, and QE in addressing AUSSLC's medication error/variance system. From observations, interviews, and review of documentation, actions taken thus far by the Facility to address medication errors/variances have made little impact on the system.	

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

1. The Pharmacy Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing pharmacy services. The Pharmacy Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of practice, as defined by the SA and Health Care Guidelines.
2. A system should be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication might have adverse effects in combination with the existing medication regimen, as well as the physician's response to this notification. If the physician makes the decision not to follow the recommendations made by the pharmacist, an entry must be made in the progress notes clinically justifying such a decision.
3. The pharmacy needs to develop a system to ensure that the quarterly DRRs are timely completed, that there is documentation addressing the acceptance or refusal of the pharmacists' recommendations, and that there is specific supporting documentation that the recommendation was implemented by the physician or practitioner. A modification to the existing DRR form could address the issue regarding documentation that demonstrates the implementation of the accepted recommendation by the pharmacist.
4. Consideration should be given to the development and implementation of statewide policies on DRRs, and Adverse Drug Reactions.

5. A system should be developed and implemented to ensure that the prescribing medical practitioners and the pharmacist collaborate: a) 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; b) in monitoring the use of benzodiazepines, and anticholinergics to ensure clinical justifications and attention to associated risks; and c) in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications. The current system AUSSLC has in place for review of polypharmacy could be expanded to include the other elements of this requirement.
6. The Facility, specifically nursing, should develop and implement a monitoring system to ensure that MOSES and DISCUS are timely conducted, and that for individuals who require this, that there is a Nursing Care Plan addressing these needs.
7. The Facility should ensure that there is timely identification, appropriate reporting, and remedial action regarding all significant or unexpected adverse drug reactions.
8. State Office and the Facility should continue the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care, as defined by the SA and Health Care Guidelines. Any plans of correction developed in response to these reviews should be included in the discussion and meeting minutes of the Committee.
9. The Facility should ensure that policies regarding medication errors/variances identify all failures to properly sign the Medication Administration Record and/or the Narcotics Logs as errors/variances, and that appropriate follow-up occurs to prevent recurrence. The Facility should move from a medication error system to a medication variance system in alignment with the requirement of the SA.
10. The Facility should implement increased medication administration observations to quarterly.
11. The Facility should implement documented spot checks to ensure the MARs and Narcotic Count Logs are documented appropriately.
12. Nurses should conduct counts of narcotics and document such counts in the Narcotic Log at the beginning/end of each shift, as well as when the keys are passed to another nurse for breaks, and when the keys are returned to the originally assigned nurse. The Facility's policy needs to be revised to include these specific elements.
13. The Facility should conduct an analysis and implement a plan of correction with nursing to address the underreporting of medication errors/variances.
14. Training should be provided to all nursing staff regarding the reporting of medications errors.
15. The Medication Error Committee should conduct regular analyses regarding medication errors to identify trends, identify the potential causes, and implement plans of correction aimed at the prevention of such errors. At the time of the review, a number of trends appeared to already exist. Thorough analyses of these trends should be conducted as soon as possible, and plans developed and implemented to address them.
16. The Pharmacy, Nursing, and QE Departments need to collaborate regarding issues related to medication administration and errors/variances.

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 Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) assessments, Nutrition assessments, Consultations [e.g., gastrointestinal (GI), modified barium swallow studies (MBS), orthotics), Dental Section, PSP, BSP, Physical and Nutritional Management Plan (PNMP), Special Considerations, Annual Physical, Annual Nursing assessment, NMT individual-specific documentation, HST Risk Level assessments, therapy consultations, therapy observation in individual record, and therapy case/progress notes for the following: Individual #305, Individual #42, Individual #74, Individual #213, Individual #139, Individual #396, Individual #251, Individual #92, Individual #378, Individual #393, Individual #212, Individual #222, Individual #223, Individual #423, Individual #342, Individual #426, Individual #97, Individual #231, Individual #28, Individual #252, Individual #286, Individual #22, Individual #402, Individual #380, Individual #39, Individual #199, and Individual #430; o DADS Nutritional Management Team policy, dated 12/17/09; o DADS Physical Nutritional Management policy, dated 12/17/09; o Dining Plans for Individual #48, Individual #290, Individual #301, Individual #394, Individual #311, Individual #101, Individual #17, Individual #270, Individual #157, Individual #28, Individual #161, Individual #309, and Individual #365 living in Home #787; o PNMP Checklist Instructions, dated 1/07; o PNMP Coordinator Training Competencies, not dated; o PNMP Coordinator Training Schedule, dated 5/10; o Orientation and Pre-Service Training Schedule, dated 2/10; o Lifting/Transfer Mechanics, not dated; o PNMP Guidelines, not dated; o New Employee Orientation (NEO)Observation Day Checklist/Test, not dated; o List of Facility Specific Training Curricula and Materials, not dated; o Schedule/Guidelines for On-going Staff Training, dated 3/10; o Curricula/Training Materials (CPR, Basic Life Support, Defensive Driving, Lifting/Transferring, Abuse/Neglect), various dates; o Staffing Budget, dated 3/10; o Shift Coordinator-Coverage Log, dated 3/10; o Hospitalizations from 3/09 through 3/10; o ER Admissions from 6/09 through 3/10;

	- Pneumonia Diagnosis from 8/08 through 8/09; - Choking-Heimlich Performed from 4/09 through 12/09; - List of Therapy Staff and Nutritional Management (NM) Team, dated 3/10; - Curricula Vitae (CVs) for Physical and Nutritional Management Team (PNMT) Members; - Continuing Education-Speech/Hearing, dated 2/10; - Attendance for PNMT Meetings-PNMP Clinics, for 2009 and 2010; - NMT Review/Recommendations and Attendance Records for 3/09 through3/10; - HST Risk Levels/AUSSLC Health Status Team Meeting Notes for 2009 and 2010; - DADS HST Revised Policy, dated 10/09; - Health Risk Assessment Tools, dated 10/09; - PNMPs, not dated; - OT Evaluation Update, dated 3/10; - OT/PT Evaluation Updates by Residence/Address for various dates (files listed by address); - Assessment blank forms, dated 2009; - PSPs for Individuals on Physical Nutritional Management (PNM) Assessment List, various dates; - Meal Observation Tools (blank forms), not dated; - Monitoring Schedule/Forms/Tools from 12/09 through 2/10; - NMT Report (blank), not dated; - Dining Plan Template, not dated; - List of Individuals on Modified Diets, dated 3/10; - List of Individuals with Diet Texture Changes (downgraded), from 3/09 through 2/10; - List of Individuals with Body Mass Index (BMI) greater than 30, dated 3/10; - List of Individuals with BMI under 20, dated 3/10; - List of Individuals with Unplanned Weight Loss from 7/09 through 2/10; - NEO and Refresher Training (check-offs and written test) blank from, not dated; and - Number of Staff Trained, from 1/09 through 3/10 **Interviews with**: - Sara Reves, BS, OTR, Lead Occupational Therapist; - Mace Welch, Lead Physical Therapist; - Occupational Therapists, Physical Therapists and Speech Language Pathologists; - Karen Hardwick, Director of Habilitation Therapies and State Coordinator for Physical Nutritional Management (PNM); and - Group of 13 Direct Support Professionals, on 4/8/09 **Observations of**: - Meals in homes 787, 732 (Dove and Eagle), 793, 779F (Falcon), 779R (Roadrunner), 779H (Hummingbird), and 729; - Homes 792, 791, 793, 779F (Falcon), and 779R (Roadrunner); - Workshops 527, 544, 796, and 775; - Pool; - Physical Medicine Clinic with Dr. Joe Urquidez, Physical Medicine and Neurotoxin

	Institute, on 4/6/10; and o Grand Rounds, on 4/7/10
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The philosophy of coordinated physical and nutritional supports service delivery is to establish a foundation to support health and wellness without compromising independence and personal choice, which enables individuals to be actively and functionally engaged at home, work and during leisure time. Habilitation Therapies staff were working to build a foundation for a physical and nutritional support delivery system, but these supports were not being consistently implemented due to overriding staffing issues at AUSSLC. Overriding staffing shortages and concerns must be addressed swiftly to enable AUSSLC to build a solid foundation to support the individuals living at AUSSLC, and consistently implement physical and nutritional support services. The Nutritional Management Team (NMT) membership was not stable from meeting to meeting. The Facility needs to review the membership of the NMT to identify a consistent group of clinicians and staff, and ensure these individuals have demonstrated competency in working with individuals with the most complex physical and nutritional management needs. In addition, a review of the NMT membership as of 3/8/10 showed that a physical therapist was not a member of the NMT. NMT members will need ongoing continuing education to support their roles and responsibilities of providing supports to individuals with the most complex physical and nutritional supports needs. A number of individuals who had changes in status, or were seen in the Emergency Department (ED) or hospitalized for diagnoses of, for example, aspiration pneumonia or placement of a feeding tube were not reviewed by the NMT. There should be a documented NMT referral process for individuals who were admitted to the emergency department and/or hospital. This referral process should be developed by the NMT, with medical staff collaboration. It should require referral to the NMT of individuals with identified risk factors from the Nutritional Management High Risk Screening Tool, as well as individuals experiencing other health risk indicators including, but not limited to, fecal impactions, decubitus ulcers, fractures, mobility-related falls, diagnoses of pneumonia, etc. It did not appear that habilitation therapies staff who were members of the NMT regularly participated in the internal mortality reviews. Designated members of the NMT should participate in internal mortality reviews. This experience would provide a significant learning opportunity to assist them to identify future individual-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels. Comprehensive assessments were not completed for individuals with complex physical and nutritional support needs. The NMT should provide integrated, comprehensive assessments for those individuals with

	the most complex physical and nutritional support needs. Such assessments should lead to the development of support strategies to minimize or remediate health concerns. There should be written, measurable, functional outcomes to be achieved. Appropriate follow-up activities should be identified to ensure efficacy of these strategies, and/or allow for revision of strategies that are determined not to be effective. These strategies should also include individual-specific monitoring for individuals at highest risk. Mealtime errors observed by the Monitoring Team placed individuals at risk during mealtimes. There was a need to analyze dining plans within each home to determine the appropriate staffing ratio to ensure implementation of dining plan strategies. During mealtime observations, the Monitoring Team noted the presence of pulled/relief staff assigned to dining rooms without knowledge and/or person-specific training on mealtime protocols, which had the potential to place individuals at risk of harm. Mealtime oversight was needed during mealtimes to support staff and individuals in providing a safe mealtime environment. In addition, poor alignment and support impacted individual's efficiency in production at workshops; compromised their independence at mealtimes, and had the potential to place individuals at harm with identified health concerns. Observations by the Monitoring Team at mealtimes, in homes, and day programs/workshops documented multiple individuals in their seating systems not positioned correctly to provide optimal alignment and support. Staff did not reposition individuals who were in poor alignment. Strategies identified on PNMPs (diet texture, fluid consistency, position and alignment, and adaptive equipment) were not integrated into medication administration record(s) and/or Nursing Care Plans. There needed to be collaboration between Nursing and Habilitation Therapies to ensure that individual PNMP content was integrated appropriately into these documents. The content for new employee orientation in the area of physical and nutritional supports needs to be reviewed with regard to the current time allotment and course content. Efforts need to be made to ensure there is sufficient time to provide competency-based training so that staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely. Facility monitors should receive competency-based training, and complete a performance check-off to achieve accurate scoring and ensure inter-rater reliability. Compliance thresholds for PNMP monitoring should be established. Scores falling below the threshold would require the development of an action plan to address identified individual or systemic concerns. Such action plans might, for example, require staff re-training for individual-specific PNMPs, or on the foundational skills of PNM. The Facility did not have a policy to address choking incidents. A choking policy/procedure should be developed to include criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to AUSSLC Risk Management and Quality Improvement.

#	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 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,	The philosophy of coordinated physical and nutritional supports service delivery is to establish a foundation to support health and wellness without compromising independence and personal choice, which enables individuals to be actively and functionally engaged at home, work and during leisure time. At AUSSLC, Habilitation Therapies staff were working to build a foundation for a physical and nutritional support delivery system, but these supports were not being consistently implemented due to overriding staffing issues at AUSSLC, including significant staff turnover, mandatory overtime, and the utilization of pulled/relief staff. Direct support professionals provide the foundation of the service delivery system at AUSSLC, but as is discussed elsewhere in this report, a number of factors led to instability in direct support professional staffing. Staff who were not properly trained and/or exhausted were likely to make mistakes in the implementation of essential plans such as mealtime protocols and PNMPs. This placed the individuals living at AUSSLC at risk of harm. As is also noted elsewhere in this report, even basic care was not being provided consistently as illustrated by multiple individuals who were observed to have poor personal hygiene (dirty hair, dirty clothing, etc.). Overriding staffing shortages and concerns must be addressed swiftly to enable AUSSLC to build a solid foundation to support the individuals living at AUSSLC, and consistently implement physical and nutritional support services. Due to multiple requirements included in this provision of the SA, each requirement is discussed in detail below: PNM team consists of qualified SLP, OT, PT, Registered Dietitian, and, as needed, ancillary members [e.g., Medical Doctor (MD), Physician Assistant (PA), and Registered Nurse Practitioner (RNP)]. DADS Nutritional Management Team policy (#013) identified the composition of the NMT as Physician; Occupational Therapist; Speech Language Pathologist; Registered Nurse; Dietitian and other disciplines as indicated by need, including but not limited to Physical Therapy, Certified Occupational Therapy Assistant (COTA); Licensed Vocational Nurse; Psychologist; Qualified Mental Retardation Professional; home staff and others. The policy also documented the specific roles of team members as primary care provider, occupational therapist, speech language pathologist, registered nurse, registered dietitian, and qualified mental retardation professional, but did not identify the role of a physical therapist. As of 3/8/10, the AUSSLC Nutritional Management Team totaled 38 members. The members were reported to include: 22 Registered Nurses, four Medical Doctors, one Nurse Practitioner, six Occupational Therapists, one Certified Occupational Therapy Assistant, one Qualified Mental Retardation Professional, one Speech Language Pathologist, and two Registered Dieticians. A physical therapist was not a member of the NMT.	

#	Provision	Assessment of Status	Compliance
	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.	These NMT members were not consistently present from meeting to meeting. The Facility needs to review the membership of the NMT to identify a consistent group of clinicians and staff, and ensure these individuals have demonstrated competency in working with individuals with the most complex physical and nutritional management needs. <u>There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs.</u> Continuing education documentation was submitted for a Speech Pathologist who was an NMT member. Documentation of continuing education sessions or activities were not submitted for other NMT members. NMT members will need ongoing continuing education to support their roles and responsibilities of providing supports to individuals with the most complex physical and nutritional supports needs. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> Nutritional Management Team attendance sheets and/or minutes were submitted for the following dates:	

NMT Meeting Date	Attendance Sheet	Meeting Minutes
3/18/09	Y	N
3/24/09	Y	Y
4/15/09	Y	Y
4/20/09	Y	Y
5/20/09	Y	Y
5/26/09	Y	Y
6/17/09	Y	Y
7/15/09	N	Y
7/20/09	N	Y
8/16/09	N	Y
8/19/09	Y	Y
8/24/09	Y	Y
9/16/09	Y	N
9/21/09	Y	Y
10/21/09	Y	Y
10/27/09	Y	Y
11/18/09	Y	Y
12/16/09	Y	Y
12/22/09	Y	Y

#	Provision	Assessment of Status	Compliance

1/20/10	Y	Y
1/26/10	Y	Y
2/17/09	Y	Y
2/23/10	Y	N
3/17/10	N	Y
Total: 24		

There were a total of 24 NMT Review meetings. The NMT met twice a month with the exception of March 2009 (one meeting), June 2009 (one meeting), August 2009 (3 meetings), November 2009 (one meeting), and March 2010 (1 meeting). The NMT Review and Recommendations minutes for the following dates: 8/19/09, 11/18/09, and 1/26/10 omitted the field with the individual's names. NMT Review and Recommendations minutes dated 6/17/09 did not consistently identify individual's names. The NMT attendance sheets documented that all NMT members did not attend every meeting. A master NMT member list for each meeting was used to document attendance. For example, a physician, six nurses, two occupational therapists, one certified occupational therapy aide, one speech language pathologist, one dietitian, and an additional individual whose discipline was not identified attended the NMT Meeting on 3/18/09.

An individual-specific Nutritional Management Team Report was completed for individuals reviewed which documented:

- Name;
- Date of Birth;
- Admission number;
- Residence;
- Videos;
- GI status;
- Esophagogaastroduodenoscopy (EGD) date;
- Annual NMT Review;
- NM Problems;
- Estimated Desired Weight Range;
- Review date(s);
- Reason for review; and
- Discussion/recommendations.

Although the NMT met regularly, individuals identified who had a change in status were not consistently reviewed by the NMT. These individuals did not receive a comprehensive assessment to identify recommendations with measurable, functional outcomes leading to the development of strategies to minimize or remediate identified

#	Provision	Assessment of Status	Compliance
		health concerns. These strategies should be monitored on a frequent basis to ensure efficacy of these strategies, and/or revision if they are not effective. The following individuals experienced a change in status, but were not reviewed by the NMT and/or were assigned risk levels that were not congruent with the *Nutritional Management High Risk Screening Tool*: ▪ Individual #286 was hospitalized two times in 2010 and one time in 2009, including: o From 1/21/10 to 2/7/10, with a discharge diagnosis of recurrent aspiration pneumonia and MRSA; o From 1/5/10 to 1/13/10, with a discharge diagnosis of GI bleed resolved, Atelectasis secondary to mucous plug, status/post (s/p) bronchoscopy; and o From 12/14/09 to 12/22/09, with a discharge diagnosis of aspiration pneumonia resolved and respiratory distress resolved. The NMT did not review Individual #286 after hospitalizations with documented diagnoses of aspiration pneumonia. The Nutritional Management High Risk Screening Tool, not dated, identified a diagnosis of aspiration pneumonia as Level 1-Acute, and the individual(s) were to be reviewed at the next scheduled NMT meeting. His PSP, dated 1/27/09, Risk Tracking Record identified PNMP/Special Considerations for aspiration/choking and dehydration. Individual #286 was reviewed by the NMT on 03/24/09 with the identified risk level as stable. Based on documentation provided, the NMT did not review him after his hospitalizations in December 2009 or January 2010. ▪ Individual #28 was hospitalized from 2/21/10 to 3/1/10 with discharge diagnoses of pneumonia, likely aspiration, and new onset of seizures. The NMT did not review Individual #28 post hospitalization. ▪ Individual #39 was hospitalized seven times, including on 6/16/09, 7/9/09, 8/17/09, 10/15/09, 11/14/09, 1/1/10, and 2/15/10 with diagnoses of aspiration pneumonia, respiratory distress, status epilepticus, and brochospasms improved. The NMT Review and Recommendations minutes, dated 6/17/09 documented reviews in 2/08, 9/08 and 2/09. Her assigned risk level was Level 2-Chronic. The NMT did not review Individual #39 after her numerous hospitalizations, including ones that resulted in a diagnosis of aspiration pneumonia. ▪ Individual #402 was hospitalized five times, including on 6/9/09, 6/20/09, 7/15/09, 12/1/09, and 12/14/09 with diagnoses of aspiration pneumonia, respiratory distress and MRSA. The NMT Review and Recommendations documented a review in 03/09. His risk level was Level 3-Stable. The NMT did not review Individual #402 after multiple hospitalizations with diagnoses of aspiration pneumonia. ▪ According to the AUSSLC Hospital Admission list from March 2009 through	

#	Provision	Assessment of Status	Compliance
		March 2010, the following individuals were hospitalized with a diagnosis of aspiration pneumonia, but were not reviewed by the NMT post hospitalization: Individual #252, Individual #227, Individual #413, Individual #426, Individual #199, Individual #212, Individual #188, Individual #362, Individual #407, Individual #262, Individual #14, and Individual #27. ▪ Individual #322 was hospitalized with a diagnosis of aspiration pneumonia on 11/06/09. NMT Review and Recommendations minutes, dated 12/16/09 indicated that an OT Consultation on 11/13/09 documented a decline that had been identified over the year in oral processing and swallowing, as well as recent suspected aspiration pneumonia. It was recommended that the physician consider continuing the current diet order for pureed texture with liquids. NMT recommendations stated: "No one able to report on Individual #322. He will be seen on 01/10." The NMT Review and Recommendations minutes, dated 1/20/10 indicated that the team was to continue measures in place, and that Individual #322 was to be followed up by HST. His Risk Level was identified as low. ▪ Individual #362 was hospitalized on 10/11/09, with discharge diagnosis of pneumonia, right lower lobe likely aspiration. The Nutritional Management Team Review and Recommendations minutes, dated 11/18/09 recommended follow-up on weight and follow-up in one month. The NMT Review minutes from 12/16/09 stated: "no one able to report on Individual #362. Will be seen in 01/10." NMT Review recommendations from 01/20/10 were that the MD had agreed to change his diet to regular calorie, and he was to be referred to the GI clinic. Further review was to occur in 2/10, or after GI clinic. Individual #362 was not reviewed during NMT on 2/17/10. ▪ According to the AUSSLC Hospital Admission list from March 2009 to March 2010, the following individuals received feeding tubes, but were not reviewed by the NMT prior to and/or post placement of the tube: Individual #345 (G/J tube placed 6/20 to 6/24/09), and Individual #22 (G-tube placed 1/12/10 to 1/25/10). ▪ Individual #396 received a gastrostomy tube (Hospitalization 7/4/09 to 8/3/09). The NMT review on 8/24/09 documented "report that she is getting G-tube this month (06/09)." The NMT recommendation was to follow up on her weight. ▪ AUSSLC ED Admissions (March 2009 through March 2010) documented the following individuals with emesis/vomiting: Individual #68, Individual #452, Individual #231, Individual #453, Individual #200, Individual #46, Individual #404, Individual #157, Individual #334, Individual #345, and Individual #357. The NMT did not review these individuals, which was not consistent with the criteria on the Nutritional Management High Risk Screening Tool.	

#	Provision	Assessment of Status	Compliance
		There should be a documented NMT referral process for individuals who were admitted to the emergency department and/or hospital. This referral process should be developed by the NMT, with medical staff collaboration. It should require referral to the NMT of individuals with identified risk factors from the Nutritional Management High Risk Screening Tool, as well as individuals experiencing other health risk indicators including, but not limited to, fecal impactions, decubitus ulcers, fractures, mobility-related falls, diagnoses of pneumonia, etc. It did not appear that habilitation therapies staff who were members of the NMT regularly participated in the internal mortality reviews. Designated members of the NMT should participate in internal mortality reviews. This experience would provide a significant learning opportunity to assist them to identify future individual-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels. <u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs).</u> A review of individual PNMPs, Special Considerations and PSPs documented inconsistencies and omissions from document to document as evidenced below: ▪ A current Personal Support Plan was not submitted for Individual #286. The plan submitted was dated 1/27/09. His outdated PSP indicated: "continue PNMP to ensure skin integrity and use of positioning to prevent respiratory problems from reflux. Report discrepancies or changes in functioning to Habilitation Therapies for consideration of plan revision." His PNMP did not discuss his risk of aspiration (as stated in his PSP), although he had been hospitalized for pneumonia in 2006, 2008, 2009 and 2010. His PSP had a service objective for constipation although his dining plan did not discuss the importance of fluid intake. His Special Considerations, dated 1/27/09, and PNMP, revised 1/27/10, presented conflicting information. For example, Special Considerations documented "keep head of bed elevated," but the PNMP stated: "head of bed may be lowered (not flat) for check and change." The PSP OT/PT section stated that Individual #286 should have a wedge to elevate his head further during bathing. This recommendation was not incorporated in his PNMP or Special Considerations, and no justification was provided for the PST not accepting this recommendation. The absence of the instruction to elevate his head with a wedge during bathing, and conflicting instructions within the PNMP and Special Considerations would be confusing for direct support professionals. This was even more concerning due to the significant staff turnover, and the use of pulled/relief staff. Without adequate and clear instructions for staff, the possibility for staff error was heightened, which would place Individual #286 at risk of harm.	

#	Provision	Assessment of Status	Compliance
		Identification, assessment, interventions, monitoring, training as outlined in sections O-2 through O-8 as described below. As stated above, the NMT did not consistently identify individuals who were hospitalized with a discharge diagnosis of aspiration pneumonia, and/or had received a gastrostomy and/or a gastrostomy/jejunostomy tube. The NMT did not complete a comprehensive assessment to identify recommendations with measurable, functional outcomes leading to the development of strategies to minimize or remediate identified health concerns.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	A process is in place that identifies individuals with PNM concerns (HCG VI.C.2 and 3). The process includes levels of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels (HCG VII.C.1; VI.B.1). The DADS Nutritional Management Team policy in Section III, entitled Basics of the Nutritional Management Process (policy #013, implementation date of 1/31/10) individuals at risk for nutritional management issues included those who: ▪ Have neurological/musculoskeletal conditions such as spasticity, dystonia, hemiplegia, Parkinson's disease, stroke, etc.; ▪ Have gastroesophageal reflux or other GI Conditions; ▪ Have a history of choking or aspiration; ▪ Have a history of frequent upper respiratory infections; ▪ Have anemia of unknown origin; ▪ Have orthopedic abnormalities; ▪ Have disorders of posture or muscle tone; ▪ Are lethargic because of medication, seizure disorder, illness, or other reasons; ▪ Have lost weight or are chronically above or below their estimate desirable weight range; ▪ Exhibit a delayed oral developmental level; ▪ Have oral/dental anomalies; ▪ Have conditions which cause extreme dryness of the mouth or excessive oral secretions; ▪ Have a history of risky mealtime behaviors such as eating too rapidly, eating textures other than prescribed; and ▪ Others. A number of the risk factors identified in the policy were not represented in the Nutritional Management High Risk Screening Tool. The risk factors listed in the Nutritional Management High Risk Screening Tool were: ▪ History of choking; ▪ History of reflux/vomiting; ▪ Down Syndrome;	

#	Provision	Assessment of Status	Compliance
		▪ History of GI problems; ▪ Dependently fed; ▪ Respiratory illness requiring treatment; ▪ Enteral feeding; ▪ Low weight/weight loss; ▪ Anemia of unknown origin; and ▪ Altered diet texture. The Discovery/Referral Phase of the DADS policy indicated that individuals would be screened for risk factors and assigned a risk level corresponding to the following matrix: ▪ 1-High Risk; ▪ 2-Medium Risk; and ▪ 3-Low Risk. However, the Nutritional Management High Risk Screening Tool*,* not dated, identified risk levels using different language: ▪ Level 1-Acute to be reviewed at next scheduled NMT meeting; ▪ Level 2-Chronic to be reviewed in 30 days to one year; and ▪ Level 3-Stable. Neither the NMT policy nor the high risk screening tool defined the criteria for these risk levels, or identified health risk indicators, such as decubitius ulcers, fecal impactions, recurrent hospitalizations, fractures, mobility-related falls, etc. It was unclear why particular risk levels were assigned to individuals with complex physical and nutritional support needs as discussed above with regard to Sections I.1 and O.1 of the SA. <u>Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.</u> As stated above with regard to Section O.1 of the SA, individuals at an increased risk level were not provided with comprehensive assessments. PNMPs did not consistently address strategies for medication administration and oral care. <u>All comprehensive assessments:</u> ▪ <u>Are conducted by the PNM Team;</u> ▪ <u>Identify the causes of such problems; and</u> ▪ <u>Contain proper analysis of findings and measurable, functional outcomes.</u> As stated above with regard to Section O.1 of the SA, comprehensive assessments were not completed for individuals with complex physical and nutritional support needs. The NMT should provide a comprehensive assessment for those individuals with the most complex physical and nutritional support needs that leads to the development of support	

#	Provision	Assessment of Status	Compliance
		strategies to minimize or remediate health concerns. There should be written, measurable, functional outcomes with designation of appropriate follow-up to ensure efficacy of these strategies, and or revision of strategies that are not effective. These strategies should also include individual-specific monitoring for individuals at highest risk. Assessment results are integrated into the design of the appropriate PNM support plans as outlined in HCG VI and VIII (see specific review tools) and SA O-3 through 0-8. Once the Facility is completing comprehensive assessments, this indicator will be further reviewed. Updates are provided as needed or at a minimum annually for all individuals with identified PNM supports. This indicator will be further reviewed during the next on-site visit.	
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.	All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). Per an undated document entitled "Have PNM Needs (no date)," 365 individuals were identified as having physical and nutritional management (PNM) needs, and 24 individuals were identified as not have physical and nutritional management needs. Ninety-four percent of the census at the time of the review living at AUSSLC had identified PNM needs. PNMPs for these individuals were not submitted as requested in the document request. DADS Physical Nutritional Management policy (#012) in Section III on Physical Nutrition Management Plan (PNMP) Critical Elements indicated, amongst other things, that: ▪ All individuals who require Physical Nutritional Management services shall be furnished with a PNMP or Mealtime and positioning/Dining Plan; ▪ All individuals who cannot feed themselves, are at risk for choking or aspiration and who require positioning associated with swallowing, shall be identified and provided with plans and supports sufficient to meet their needs; ▪ PNMP shall identify specific positioning regimes as appropriate, including positioning for enteral eating, prevention of aspiration pneumonia, and complications of gastro esophageal reflux disease (GERD); and ▪ PNMP shall state any precautions that should be observed because of underlying medical conditions or risks. Although this policy included many of the necessary elements for PNMPs, the list of PNMP critical elements did not incorporate strategies for bathing/showering, oral hygiene and/or medication administration. These activities have the potential to provoke swallowing difficulties with individuals with identified health concerns (i.e., aspiration pneumonia).	

#	Provision	Assessment of Status	Compliance
		As appropriate, PNMP consists of interventions /recommendations regarding: Positioning/alignment; Oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; Food/Fluid texture; Adaptive equipment; Transfers; Bathing; Personal care; In-bed positioning/alignment; General positioning (i.e., wheelchair, alternate positioning); Communication; and Behavioral concerns related to intake. The standard PNMP format submitted contained the following categories: focus, assistive equipment, communication, mobility, transfer, mobility positioning, skin care, bathing, and dining instructions. The PNMPs reviewed did not provide instructions for oral intake strategies for oral care and medication administration. For example: ▪ Individual #286's PSP, dated 1/27/09 documented "poor oral hygiene, fair teeth, slight periodontal inflammation, soft tissue exam within normal limit." His PNMP did not address strategies for oral hygiene to minimize his risk of aspiration and reflux. People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. PNMPs for individuals who were enterally nourished did not provide instructions for oral intake strategies for oral care. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. Physical Nutritional Management Program (PNMP) policy (#012) in Section III on Physical Nutritional Management Plan (PNMP) Critical Elements stated: ▪ The PNMP shall be written to meet identified needs and based on input from Habilitation Therapies, medical/nursing staff, Health Status Team, Nutritional Management Team, PNMP Team/Clinic, home staff, the PST, and other as appropriate. ▪ The PNMP shall be addressed at the annual planning meeting and as often as needed, approved by the Personal Support Team, and included as part of the Personal Support Plan. This indicator will receive further review during the next on-site review. PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results. As stated above with regard to Section O.1 of the SA, the NMT did not review individuals consistently after a change in status, and therefore, did not update the PNMP. In other cases, the NMT made recommendations for changes to PNMPs, but follow-up to determine if the recommendations had been incorporated into the PNMP, and were being implemented by staff was not documented. There is congruency between Strategies/Interventions/ Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. This indicator	

#	Provision	Assessment of Status	Compliance
		will receive further review during the next on-site review.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan. Mealtimes were observed in the following homes: 787, 732 (Eagle and Dove), 793, 779F, 779R, 779H, and 729. The following 57 individuals were observed during meals: Individual #161, Individual #301, Individual #311, Individual #365, Individual #28, Individual #394, Individual #157, Individual #270, Individual #309, Individual #290, Individual #408, Individual #79, Individual #147, Individual #115, Individual #452, Individual #223, Individual #416, Individual #453, Individual #280, Individual #372, Individual #193, Individual #215, Individual #312, Individual #2, Individual #90, Individual #64, Individual #356, Individual #319, Individual #143, Individual #264, Individual #78, Individual #262, Individual #448, Individual #37, Individual #266, Individual #206, Individual #86, Individual #364, Individual #153, Individual #160, Individual #326, Individual #379, Individual #94, Individual #308, Individual #229, Individual #201, Individual #80, Individual #222, Individual #191, Individual #299, Individual #390, Individual #439, Individual #3, Individual #45, Individual #213, Individual #182, and Individual #339. The following mealtime errors were observed: ▪ Individuals in poor alignment and support in wheelchair and/or regular dining chair; ▪ Staff did not reposition individuals before or during the meal to achieve better alignment and support; ▪ Individuals without footrests on wheelchairs; ▪ Individuals in wheelchairs without shoes; ▪ Staff standing over individuals during meals to assist; ▪ Staff seated on the wrong side of an individual who needed physical prompts to slow down (i.e., individual was right handed and staff was seated on the left); ▪ Wheelchairs not locked during the meal; ▪ Multiple individuals coughing during the meal; ▪ Staff not cueing individuals to slow pace for food and/or fluids; ▪ Individuals with significant loss of food and fluid; ▪ Staff presented too large a bite of food; ▪ Staff presented too large an amount of fluid; ▪ Staff presented incorrect fluid consistency; ▪ Staff not using prescribed adaptive equipment (e.g., dycem mats not used); ▪ "Pulled" staff in dining room without knowledge of individual and/or dining plan; ▪ Staff ratio not sufficient to implement dining plans' presentation techniques, and/or to provide adequate supervision;	

#	Provision	Assessment of Status	Compliance
		▪ Individuals seated in dining room and waiting an extended amount of time for food (in excess of 30 minutes); ▪ Staff did not follow dining plan presentation techniques (e.g., not offering fluids throughout meals or cueing individuals to take a drink between bites of food); ▪ Minimal staff engagement with individuals during meals; and ▪ Cross contamination by staff not washing hands, or using hand sanitizer between assisting different individuals. These mealtime errors placed individuals at risk during mealtime. There was a need to analyze dining plans within each home to determine the appropriate staffing ratio to ensure dining plans were implemented as prescribed. Mealtime oversight was needed during mealtimes to support staff and individuals to provide a safe mealtime environment. <u>Individuals are in proper alignment and position.</u> Observations of individuals at mealtimes, in their homes, and in day programs/workshops identified multiple individuals who were not positioned correctly in their seating systems. For example, their pelvic positioning devices were not snug, and did not secure their pelvis to provide optimal alignment and support. Staff did not reposition individuals who were in poor alignment and support. Poor alignment and support impacted individuals' efficiency in production at workshops; compromised their independence at mealtimes, and had the potential to place individuals with identified health concerns at risk for harm. The importance of ensuring individuals are in appropriate alignment and support throughout the 24-hour day needs to be a priority for staff. This needs to be reinforced during new employee orientation, as well as heightened attention given to it during PNMP and meal monitoring. <u>Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and or increased risk of aspiration.</u> Strategies identified on PNMPs (diet texture, fluid consistency, position and alignment, and adaptive equipment) were not integrated into Medication Administration Record(s), and/or Nursing Care Plans. There needed to be collaboration between Nursing and Habilitation Therapies to ensure that individual PNMP content was integrated into these documents. <u>Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.</u> This indicator will receive further review during the next on-site review.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> According to the Orientation and Pre-Service Training Schedule, revised 3/10, the following training related to physical and	

#	Provision	Assessment of Status	Compliance
	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.	nutritional supports was being provided: ▪ Orientation and Mobility, one hour duration; ▪ Lifting Techniques/Workplace Injuries, 15 minute duration; ▪ Dietitian/Food Textures, one hour duration; ▪ Therapeutic Handling & Positioning, three hour duration; ▪ Deaf Awareness, 45 minute duration; ▪ Communication with People Who Live Here, one and a half hour duration; ▪ Sign Language, one and three-quarter hour duration; and ▪ PNMPs and OT documentation; Assistive Equipment-Hosiery, hearing aids, eating equipment and documentation; resident diet information-Thick-it, lemon ice, documentation (matching what was observed to diet); carrying on PNMPs information to workshops, one and a quarter hour duration. The following curriculum handouts were presented: ▪ Lifting/Transferring of Consumers (stand/pivot transfer, mechanical lift, and two or more person manual lift); ▪ PNMP Physical Management Plan; ▪ The Why's of PNMP (wheelchairs, positioning, walkers, gait belts, orthotics, compression hosiery and protective gear); ▪ The Why's of Assistive Feeding and Specialized Equipment (giving fluids, lemon ice, thickened liquids, adaptive equipment); ▪ PNMP Guidelines; ▪ PNMP Documentation; ▪ General Instructions for Meals; ▪ Modified Food Textures; ▪ Thickened Liquids; ▪ Consumer Nutrition: Meeting the Client's Needs (power point presentation); ▪ Words Most Often Seen on Diet Cards; ▪ Austin State School Diets; ▪ Modified Food Textures; ▪ Whole Finger Foods; ▪ Gluten Free Diet; and ▪ Approved Snack List. Mealtime observations did not support that staff had consistently acquired the foundational knowledge and skills to allow them to follow dining plans and support safety at mealtimes. Foundational competency-based training for mealtimes should encompass mealtime position and alignment, presentation techniques to enhance nutritional intake and hydration, aspiration and choking precautions, strategies to minimize the risk of aspiration and choking, presentation of the Facility choking policy, and techniques to promote optimal levels of independence and skill acquisition during	

#	Provision	Assessment of Status	Compliance
		mealtimes. This training should also address the importance of implementing appropriate person-specific dining plan strategies that should be followed during oral hygiene and medication administration. The content for new employee orientation in the area of physical and nutritional supports needed to be reviewed to re-assess the current time allotment and course content. Sufficient time should be allotted for provide competency-based training to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely. Job descriptions for direct support professionals should incorporate these training requirements, as well as performance evaluations. PNMP Coordinators were new positions within Habilitation Therapies. These positions were designed to provide support to OTs, COTAs, PTs, PTAs, and SLPs by providing training and coaching/mentoring to direct support professionals, as well as monitoring. The undated document entitled PNMP Coordinators Job Performance Competencies identified a competency performance check-off for PNMP Coordinators in the following areas: ▪ Dining room observation and reporting problems to responsible department; ▪ Ability to read diet cards, understand dining plan precautions and instructions; ▪ Understanding of diet textures and use of Thicken Up and lemon ice; ▪ Mixing Thicken up; ▪ Recognize and describe purpose of dining equipment; ▪ Relate instructions on PNMP to focus statements; ▪ Purpose of assistive equipment; ▪ PNMP observations and reporting problems to Habilitation Therapies; ▪ Positioning (in bed, GERD, aspiration precautions, pressure relief and wheelchair); ▪ Equipment application (splints, palm protectors, orthotics, hosiery); ▪ Lifting, transferring and repositioning; and ▪ Monitor and use ARJO equipment, bath benches, wheelchairs, and walkers. PNMP Coordinator Training Competencies indicated that PNMP Coordinators must demonstrate competency prior to providing staff training in the following areas: ▪ Diet cards and dining plans; ▪ Diet textures; ▪ Liquid thickener; ▪ Purpose of dining equipment and demonstrate purpose; ▪ Purpose of lemon ice; ▪ PNMP and related focus to instructions;	

#	Provision	Assessment of Status	Compliance
		▪ Positioning; ▪ Equipment application; ▪ Use of ARJO equipment, bath benches, wheelchairs and walkers; ▪ Mechanical lifts; ▪ Transfers (stand/pivot and 2-person manual); and ▪ Reposition residents in wheelchairs, bed and per their dining plan. An undated PNMP Coordinator Training Schedule provided the following PNMP training schedule: ▪ April 30: Food Service Training in the Kitchen; ▪ May 5: Wheelchair Positioning Training I; ▪ May 7: Food Service Training in the Kitchen; ▪ May 12: Wheelchair Positioning Training II; ▪ May 19: Bed Positioning I; and ▪ May 26: Bed Positioning II. As stated above, there was a competency check-off for job skills, as well as training competencies to ensure PNMP Coordinators demonstrated the requisite knowledge and skills to be effective trainers and monitors. These skill competency check-offs did not incorporate indicators for communication related competencies, such as the use of alternative or augmentative communication (AAC) devices. There should be an ongoing validation process with regard to monitoring for PNMP Coordinators by professional staff (OT, COTA, PT, PTA, and SLP) to achieve accurate scoring, and a high level of inter-rater reliability. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> Skills Check Off for Body Mechanics, Therapeutic Handling and Positioning, dated 2/25/10 identified a performance check-off for body mechanics, including communication, area preparation, posture, squatting, and lifting technique for the following transfers: mechanical lift, two-person, and stand pivot. Therapeutic positioning staff demonstration skills included communication, area preparation, posture, positioning of individual, hand placement, and draw sheet. The final component of the skills check off was wheelchair management for brakes, arm/footrests, seat belt, etc. An undated documented entitled New Employee Orientation Day Checklist specified information provided to new employee(s) by a PNMP Coordinator with regard to location of PNMP, Dining and Diet Cards. Sections on bathing, toileting, mealtime, tooth brushing, and individual's personal appearance identified tasks to be completed by staff with a section for successful completion, and date completed. There was a written test entitled Test Your Knowledge: PNMPs, undated.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><u>All foundational trainings are updated annually.</u> The Competency Training and Development January 2010 Calendar listed Lifting and Transfer refresher classes. An assessment checklist for the Transfer/Lifting Refresher Class required staff to complete a stand/pivot transfer, two-person manual reposition and mechanical lift. Staff had to prepare the environment for lifting, position the person, and complete the transfer. There were no refresher classes identified for mealtimes.

<u>Staff are provided person-specific training of the PNMP by the appropriate trained personnel.</u> DADS Physical Nutritional Management policy (#012) in Section II on Staff Training indicated that:
▪ Staff will be trained when changes are made to PNMPs;
▪ Unit supervisory staff will ensure that substitute direct contact staff receives training on PNMPs of assigned individuals prior to working with them;
▪ Documentation of training will include signature of both parties to acknowledge training occurred; and
▪ Direct contact staff will be retrained whenever supervisor or other staff identifies a need.

As illustrated above with regard to the mealtime observations conducted, it did not appear that staff had the necessary competencies to implement dining plans. It was unclear if unit supervisory staff had received person-specific competency-based training for PNMPs to provide appropriate training to direct support professionals.

<u>PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.</u> During mealtime observations, pulled/relief staff were assigned to dining rooms without knowledge and/or person-specific training, which has the potential to place individuals at risk of harm.

<u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> Refer above to the indicator "Staff are provided person-specific training of the PNMP by the appropriate trained personnel."</td><td></td></tr>
<tr><td>O6</td><td>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</td><td><u>A System is in place that monitors staff implementation of the PNMPs.</u>
DADS Physical Nutritional Management Program (PNMP) in Section VII on Monitoring policy (#012) indicated:
▪ PNMPs should be monitored as scheduled, and as needed by Residential supervisors, Team, Nursing, Specialized Therapy and other professional staff to assess effectiveness of plans, to ensure ongoing implementation, and to make changes as necessary;
▪ PNMPs should be monitored by supervisors for implementation and to report</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	implementing such plans.	any problems and training needs; ▪ PNMPs should be monitored by professional staff for proper application of equipment and techniques, to ensure effectiveness of Plans and proper implementation, and to correct problems; ▪ Equipment used in physical management program will be monitored daily by direct contact staff for cleanliness, wear, and needed repair; and ▪ All equipment will be monitored as scheduled and evaluated at least annually and as needed by Habilitation Therapy staff for continued appropriateness and fit. The Handbook Habilitation Therapies Physical Nutritional Management, revised 2009, in Section IV on Physical Nutritional Management Program indicated that PNMP signature sheets should be submitted to the program monitor at the end of each month to ensure program effectiveness in regard to health issues and objectives. The Habilitation Therapy Meal Observation and Training Roster, undated, identified the following areas with the stated indicators to be utilized for staff training and monitoring: ▪ Positioning (head, wheelchair, dining chair, enteral feeding); ▪ Texture (food and fluid); ▪ Equipment; ▪ Dining Plans (out/in use, instructions followed, lemon ice served, liquids served with meal, correct texture, seconds offered); ▪ Instructions posted/on table (texture, thick-it, lemon ice); ▪ Reported to nursing (excessive coughing and/or vomiting); and ▪ Supervisory staff present. The Habilitation Therapies PNMP Observation and Training Roster, undated, included the following areas with related indicators to be monitored under each area: ▪ Positioning (wheelchair, footrests, bed, head, alignment, enteral feeding); ▪ PNMP (out/in use, pictures accurate, plans followed, documentation completed); ▪ Equipment (used correctly, good repair, clean); ▪ Transfers (correct transfer used, stays used, brakes locked); and ▪ Supervisory staff monitoring. PNMP Monitoring Logs and Meal Monitoring Log were submitted for three months which documented the following:	

#	Provision	Assessment of Status	Compliance
		PNMP Monitoring	

PNMP Monitoring

Month	# of Monitoring(s)	Homes	Homes Monitored More Than Once
December 2009	11	8	3
January 2010	10	9	1
February 2010	10	10	0

Meal Monitoring

Month	# of Monitoring(s)	Homes	Homes Monitored More Than Once
December 2009	21	14	6
January 2010	19	16	3
February 2010	4	4	0

PNMP Monitoring was completed by OTs, PTs, and PTAs. Meal Monitoring was completed by OTs, COTAs, PTs, and PTAs. Documentation was not submitted to describe the development and implementation of the monitoring schedule.

Monitoring Form Logs for December 2009, January and February 2010 were submitted for Castner, Timber Creek, Wood Hollow, Sunrise, LSC, Settlement Agreement Coordinator (SAC), Vocational, QE, Habilitation Therapies, and Food Service. These logs identified staff responsible for monitoring. Identified staff were to send emails related to the status of monitoring assistive equipment once a month (QMRP's), and three times a month (Home Supervisor). Meals were to be monitored once a week by the QMRP, Home Supervisor, Unit Program Coordinators, Psychology, Vocational, LAC (acronyms list did not identify what this meant), SAC, Unit Director, Social Worker, Nurses, Quality Enhancement, and Habilitation Therapies.

The Mealtime/Snack Observation Checklist Form, dated 1/22/09 was submitted and identified 22 monitoring indicators. Forty-five Mealtime/Snack Observation Checklist forms were submitted for February 2010 for 18 homes: 727 (six forms); 729 (one form); 730 (one form); 732E (four forms); 732M (five forms); 779F (one form), 779H (two forms); 779R (three forms), 782 (three forms); 783 (two forms); 784 (two forms); 786 (three forms); 787 (one form); 788 (two forms); 789 (three forms); 791 (three forms) 793 (two forms) and 795 (one form). The following homes did not submit Mealtime/Snack Observation Checklist forms: 501, 772A, 772B, 796, 797, 781, 785, 792, 795, 732D. Per the Monitoring Form Log meals, were to be monitored once per week for QMRP, Home Supervisor, Unit Program Coordinators, Psychology, Vocational, LAC, SAC, Unit Director, Nurses, Quality Enhancement, and Habilitation Therapies. The number of forms per home submitted did not document compliance with the Monitoring Form Log

#	Provision	Assessment of Status	Compliance
		requirements. In addition, the same indicators were checked "no" in the following areas multiple times, but there was no documentation of intervention and/or correction: ▪ Clothing protectors were not appropriate; ▪ Dining plan was not out and in use, instructions not followed, photos and equipment did not match, and assistive equipment not in good condition and not used; ▪ Individual was not well positioned in wheelchair, position at table and/or their head was not positioned correctly; ▪ Individual did not like what was being served and choices were not offered; ▪ Family style dining was not made available to individuals who were capable of participating; ▪ Staff did not ensure individual carried out their grooming activities; ▪ Individuals were not given second portions; ▪ Staff were not sitting at the tables with individuals, and assisting those who needed assistance at eye level; ▪ Staff did not ensure individuals washed their hands prior to eating their meal and/or snack; and ▪ Mealtime/snack was not served in a timely manner. Some of these indicators were not sufficiently discrete to identify the specific area of non-compliance. For example, indicator number six stated "Was the dining plan: A. Out and in use? B. Are the instructions being followed? C. Do Photos and Equipment match? D. Was the assistive equipment in good condition and was it in use?" If this indicator was checked "no" the assumption would have to be made that staff were not following any of the components of the indicator, but this may not be accurate. There were multiple indicators on the form that presented this problem. As a result, the analysis of these forms would not provide reliable data to identify individual-specific and systemic issues. However, it is concerning that despite the problems with the form, that issues that were identified repeatedly occurred with no apparent resolution. One hundred fifty-six Habilitation Therapies Meal Observation and Training Roster forms were submitted for the following homes: 501 (19 forms); 727I (nine forms); 729 (one form); 730 (two forms); 732D (nine forms); 732E (12 forms); 732M (13 forms); 772A (two forms); 772B (one form); 779F (one form); 779H (six forms); 779R (eight forms); 781 (six forms); 782 (seven forms); 783 (10 forms); 784 (11 forms); 785 (11 forms); 786 (three forms); 787 (six forms); and 796 (19 forms). Forms were not submitted for the following homes: 797, 788, 789, 791, 792, 793, 794, 795, and 727C.	

#	Provision	Assessment of Status	Compliance
		The Habilitation Therapies Meal Observation and Training Roster identified three scores: Yes (1), Partial (2), and No (3). There was not a scoring legend to provide staff instructions for scoring "partial." There were no scoring instructions to guide staff. The following were examples of multiple indicators checked "no," and staff had documented issues of non-compliance at the bottom of the monitoring forms without resolution: ▪ Equipment missing; ▪ No napkins offered; ▪ Only one staff in workshop; ▪ No dining cards out; ▪ No water was offered; ▪ Kitchen was very dirty, food on the floor and dirty dishes left out; ▪ Staff refused to sign; ▪ Liquids not served with meal; ▪ Individuals not positioned correctly; ▪ Incorrect texture presented; and ▪ Meal was late. The Habilitation Therapies PNMP Observation and Training Roster forms were submitted for December 2009, January, February, March, and April 2010. The sixty forms for February 2010 were reviewed for the following homes: 727I (one form); 729 (seven forms); 730 (three forms); 732M (one form); 779R (two forms); 781 (four forms); 782 (five forms); 785 (eight forms); 786 (one form); 787 (two forms); 789 (one form); 791 (two forms); 792 (three forms); 793 (eight forms); 794 (four forms); and 795 (eight forms). Multiple monitoring sheets documented that PNMPs, positioning, and transfers were not observed, which should be an integral component of PNMP monitoring. A physical support monitoring system should ensure continued staff competency in knowledge and skills acquired in foundational training, as well as individual-specific PNMPs. This monitoring should be systematic and routine with consistent use of performance indicators to enable system-wide analysis of monitoring results. Individuals who are at most risk for aspiration, skin breakdown and fractures should be prioritized for more frequent monitoring. For example, individuals who were identified by the NMT as Acute – Risk Level 1 would be candidates for increased monitoring. Facility monitors should receive competency-based training, and complete a performance check-off to achieve accurate scoring and ensure inter-rater reliability. Compliance thresholds for PNMP monitoring should be established. Scores falling below the threshold would require the development of an action plan to address identified individual or systemic concerns. Such action plans might, for example, require staff re-training for individual-specific PNMPs, or on the foundational skills of PNM.	

#	Provision	Assessment of Status	Compliance
		In addition to the monitoring forms discussed above, there were some individual monitoring forms. The Facility should review these multiple forms to determine if they continue to be useful and provide a consistent, integrated approach to monitoring. For example: ▪ There was an individual-specific meal monitoring form, undated, that was completed for individuals the NMT and/or HST had identified as being at high risk for low weight. The form documented diet, diet texture, snacks, and instructions. There were 30 days to check off for breakfast, 10 a.m. snack, lunch, 3 p.m. snack, and supper. The bottom section had space for comments/problems. ▪ There also was an individual-specific Lifting-Transfer Monitoring Form, undated, with the following fields: date, time of day, name of individual observed, home/program area, monitor's name, signature of staff monitored, and eight indicators to be monitored. If a staff person was unable to answer a question and/or perform a skill, the monitor was to write a brief description of what was done to correct the error. ▪ The Individual Meal/Snack Observation form, revised 11/25/09, included the following fields: home, date, observation time, identification of meal/snack observed (i.e., breakfast, snack), time meal/snack served, name of monitor, title, reason for meal/snack observation and 14 monitoring indicators. The completed form was to be returned to the QA nurse. If any indicator was answered no, then an intervention had to be documented. On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs. A review of submitted monitoring sheets documented monthly monitoring, but it was not consistent from home to home. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. The policy did not provide clear direction for the implementation of the monitoring process, criteria for and identification of PNMP monitors, definition of the PNMP monitoring tool with description of each performance indicator, definition of the competency-based training process for PNMP monitors to support confidence in monitoring results, definition of staff re-training thresholds, explanation of validation and inter-rater reliability process for PNMP monitors, definition of the analysis process of PNMP monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration of the PNMP monitoring system into the Facility Risk Management and Quality Improvement systems. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Habitation Therapies PNMP Observation and	

#	Provision	Assessment of Status	Compliance
		Training Roster did not address monitoring for oral care or medication administration. The implementation of these daily activities has the potential to place an individual with identified health risk indicators (i.e., aspiration pneumonia) at risk. <u>All members of the PNM team conduct monitoring.</u> As stated above in Section 0.1 and O.2, the NMT members did not implement individual-specific monitoring. <u>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.</u> This indicator will receive further review at the next onsite visit. <u>The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda.</u> This indicator will receive further review at the next onsite visit. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> In order to review the Facility's response to individual's need for immediate intervention, responses to choking incidents were reviewed. During future reviews, other indicators will be reviewed as well. The Nutritional Management High Risk Screening Tool documented any choking incident as Acute – Risk Level 1, and the individual was to be reviewed at the next scheduled NMT meeting. Five individuals had choking incidents that involved using an abdominal thrust (Cases Involving Heimlich Maneuver-no date). It was unclear why the NMT did not review individuals who experienced a choking incident, did not review these individuals at the next scheduled meeting, and/or did not complete a comprehensive assessment, as illustrated below: ▪ Individual #97's choking incident occurred on 6/14/09. Interventions documented were that the doctor was notified, the individual was transported to the ER, a chest X-ray was completed, the individual was admitted to the infirmary, the individual's diet was reviewed, an increased supervision level was put in place for meals, a video fluoroscopy was ordered, and in-service training was provided to staff to monitor his pace of eating. He should have been reviewed by the NMT at the next scheduled meeting on 6/17/09, but he was not. Individual #97 was reviewed by the NMT on 7/15/09 for a follow-up to a video fluoroscopy. Recommendations were PRN (when necessary) for review by the NMT, and to be followed up by the HST. His HST Risk Level for Choking was 2, and the NMT Risk Level was Level 3-Stable. The NMT did not complete a comprehensive evaluation for Individual #97. ▪ Individual #423's choking incident occurred on 4/23/09. Interventions completed were the individual: was assessed at the home by RN, provided close supervision during meals and snacks, had an OT evaluation, and had a diet change from ground to pureed. He was reviewed at the next scheduled NMT	

#	Provision	Assessment of Status	Compliance
		meeting on 5/20/09. Recommendations were to continue measures already in place, and follow-up by the HST. His HST Risk Level was 2 – Medium, and his NMT Risk Level was Level 3-Stable. The NMT did not complete a comprehensive evaluation for Individual #423. ▪ Individual #223's choking incident occurred on 6/30/09. Documented interventions were that the individual was transported to infirmary, OT/PT were to reassess diet texture, the shift coordinator was to complete extra rounds, a videoesophagram was ordered, and the individual was to continue on a ground diet texture, and discontinue rice. The next scheduled NMT meeting was on 7/15/09. Individual #223 was not reviewed by the NMT until 07/20/09. Recommendations were to follow-up after the GI Clinic for GI recommendations. Individual #223's NMT Risk Level was Level 1 - Acute, and HST Risk Level was 2 - Medium. She was reviewed by the NMT on 8/24/09, with recommendations to follow-up on EGD, and to continue measures already in place. Her NMT Risk Level changed to Level 2-Medium. The NMT did not complete a comprehensive assessment for Individual #223. ▪ Individual #333's choking incident occurred on 10/12/09. Interventions documented were that the RN assessed the individual at home, the doctor assessed the individual at the infirmary, food stealing was added to the Support Plan, and the shift coordinator increased rounds. No HST Risk Level was assigned for choking. This individual was not reviewed by the NMT after the choking incident. ▪ Individual #342's choking incident occurred on 12/26/09. Interventions documented were that the individual was assessed by infirmary RN, and assessed by doctor, a psychological assessment was requested, and the shift coordinator increased rounds. Individual #342 was not reviewed by the NMT based on the NMT Review and Recommendations that were submitted. No HST Risk Level was assigned for choking. The Facility did not have a policy/procedures for choking incidents. A choking policy/procedure should be developed, including criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to the AUSSLC Risk Management and Quality Improvement processes. This policy/procedure should be incorporated into new employee orientation and annual refresher training as well as conducting intermittent drills with staff to ensure staff awareness of the choking policy/procedure.	

#	Provision	Assessment of Status	Compliance
		Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. The policies entitled Nutritional Management Team and Physical Nutritional Management Program did not define which individual monitoring indicators based on an identified level of risk would be corrected within a specified time period to minimize harm to an individual. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. A formal monitoring reporting process to support appropriate follow-up for identified areas of non-compliance was not defined in the policies entitled Nutritional Management Team and/or Physical Nutritional Management Program. Process includes intermittent internal validation checks to ensure accuracy. A validation and re-validation process of PNMP monitors was not presented in the policies entitled Nutritional Management Team and/or Physical Nutritional Management Program.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. As discussed in further detail above with regard to Sections O.1 and O.2 of the SA, the NMT met frequently, but there were concerns related to the process used to identify individuals at risk. The assignment of risk levels was not congruent with the Nutritional Management Screening Tool. Individuals with high-risk health risk indicators (i.e., aspiration pneumonia, obesity) were assigned risk levels of Chronic - Level 2, and/or Stable - Level 3. The NMT will need to identify entrance criteria (standardized process for identifying individuals at risk) for referral to the NMT, as well as exit criteria (achievement of functional outcomes) to discharge an individual from the NMT. The extensive universe of individuals reviewed by the NMT within the Chronic - Level 2 and Stable - Level 3 categories did not allow time for the NMT to focus on individuals with the most complex physical and nutritional support needs. The NMT should provide the following supports to individuals at high risk: comprehensive assessments resulting in measurable, functional outcomes; development and implementation of interventions based on outcomes; individual-specific monitoring of interventions to ensure efficacy; and modification of interventions if they are not successful. Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted. This indicator will receive further review at the next onsite review. The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated	

#	Provision	Assessment of Status	Compliance
		as needed. On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. This is discussed with regard to Section 0.6 of the SA related to monitoring above. Members of the PNM team complete monitoring system. This is discussed with regard to Sections 0.1 and O.2 of the SA. The PNM teams did not consistently complete individual-specific monitoring as documented in NMT Review and Recommendations, dated 3/24/09 to 3/17/10. Immediate interventions are provided when the individual is determined to be at an increased risk of harm. As stated above, staff non-compliance documented through observation; monitoring of dining plans and PNMPs; significant staff turnover; staff exhaustion from working mandatory double shifts and the use of pulled/relied staff have the potential to place individuals at increased risk of harm.	
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.	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status (HCG VI.C.3.c.1.d), and the need for continued enteral nutrition is integrated into the PSP: PSPs were reviewed for the following individuals receiving enteral nutrition: Individual #286, Individual #431, Individual #331 , Individual #178, Individual #321, Individual #31, and Individual #366, Individual #396, Individual #434, Individual #62, Individual #44, and Individual #22. None of their PSPs (0%) addressed the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, and/or strategies that had been developed to transition an individual to oral intake, if appropriate. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. A review of NMT individual recommendations from 3/17/09 to 2/17/10 did not document a plan for an individual who was enterally nourished to return to oral feeding and/or receive pleasure feedings. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). The Nutritional Management Team policy, dated 12/17/09, did not specifically address the frequency and depth of evaluations related to enteral nutrition to be completed by the following disciplines: nursing, physician, Speech/language pathologist and occupational therapist. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. This indicator will receive further review during the next on-site visit.	

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

1. As is recommended with regard to Section D of the SA, direct support professional staffing needs to be stabilized to ensure that adequately numbers of well-trained staff are available to implement consistently and effectively physical and nutritional support services.
2. The PNMT membership should include the expertise of a physical therapist.
3. The Facility needs to review the membership of the NMT to identify a consistent group of clinicians and staff, and ensure these individuals have demonstrated competency in working with individuals with the most complex physical and nutritional management needs.
4. Ongoing opportunities should be provided for continuing education for PNMT members to support their responsibilities in working with individuals with complex physical and nutritional support needs.
5. There should be a documented NMT referral process for individuals who were admitted to the emergency department and/or hospital. This referral process should be developed by the NMT, with medical staff collaboration. It should require referral to the NMT of individuals with identified risk factors from the Nutritional Management High Risk Screening Tool, as well as individuals experiencing other health risk indicators including, but not limited to, fecal impactions, decubitus ulcers, fractures, mobility-related falls, diagnoses of pneumonia, etc.
6. Designated members of the NMT should participate in internal mortality reviews. This experience would provide a significant learning opportunity to assist them to identify future individual-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels.
7. PNMP need to be fully integrated into individuals' PSPs. When changes occur to PNMPs, individuals' teams need to meet to discuss the proposed changes, and PSPs need to be amended, as appropriate.
8. The State and/or AUSSLC should establish guidelines to define further the categories of high, moderate and low levels of risk for physical and nutritional health risk indicators. The two systems within the State and Facility's policies for the establishment of risk levels should be reconciled. The guidelines also should establish thresholds to trigger initial and further evaluation, and the intervals of review based on the degree of an individual's identified level of risk. These guidelines should define the entrance criteria for review by the PNMT to ensure the individualized physical and nutritional support needs of a person are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the PNMT for each individual. In developing these guidelines, the PNMT should review the Health Care Guidelines, Section VI, on Nutritional Management Planning, which provides criteria for risk categories. Additional health risk indicators such as decubitus ulcers, obesity, fecal impactions, recurrent hospitalizations, fractures, mobility-related falls should be considered as high-risk categories for review by the PNMT.
9. The NMT should focus on providing supports to individuals at highest risk and with the most complex needs by completing a comprehensive assessment for each with recommendations leading to the development of measurable, functional outcomes. Strategies will need to be developed and implemented for each individual to minimize and/or remediate identified health concerns. Individual-specific monitoring also needs to be implemented for those individuals at highest risk.
10. In addition to the components of the current PNMPs at AUSSLC, PNMPs should incorporate strategies for individuals for medication administration, and oral hygiene, as well as any other activities that present potential risks such as water activities. More than one PNMP may need to be in place for an individual. For example, it might be appropriate for a PNMP to be designed and implemented just for nursing staff who are responsible for the administration of medication.
11. There is a need for Facility administration, in collaboration with Habilitation Therapies, to analyze dining plans within each home to determine the appropriate staffing ratio to ensure dining plans are implemented.
12. Mealtime oversight is needed to support individuals and staff, and provide a safe mealtime environment.
13. Collaboration between Nursing and Habilitation Therapies is needed to ensure that individual PNMP content is integrated into medication administration records (MARs), as well as nursing/health care plans.
14. The content for new employee orientation in the area of physical and nutritional supports needs to be reviewed to reassess the time allotment, as well as course content to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans

safely.

15. The importance of ensuring individuals are in appropriate alignment and support throughout the 24-hour day needs to be a priority for staff. This needs to be reinforced during new employee orientation, as well as heightened attention given to it during PNMP and meal monitoring.
16. Facility administration, in collaboration with Habilitation Therapies, should establish procedures that would not allow pulled/relief or agency staff who had not demonstrated competence in the implementation of the individualized mealtime protocols for individuals at high risk during mealtimes to provide mealtime assistance to such individuals. In addition, adequate support should be provided to pulled/relief/agency staff who may be assigned to dining rooms without knowledge and/or individual-specific training to ensure individuals are safe during mealtimes.
17. Facility monitoring policies should provide clear direction for the implementation of the monitoring process, criteria for and identification of PNMP and Mealtime monitors, definition of the PNMP/Mealtime monitoring tool with description of each performance indicator, definition of the competency-based training process for monitors to support confidence in monitoring results and inter-rater reliability, definition of staff re-training thresholds, explanation of validation process for monitors, definition of the analysis process of monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration the PNMP monitoring system into Facility Risk Management and Quality Improvement systems.
18. The Facility should review the multiple individual monitoring forms to determine if they continue to be useful and provide a consistent, integrated approach to monitoring.
19. Due to the inconsistent review by the NMT of choking incidents, a choking policy/procedure should be developed to include criterion for referrals to a mealtime incident response team based on operational definitions for choking, partial airway obstruction and aspiration/dysphagia risk. These procedures should define team membership, functional roles and responsibilities, action response timeframes, documentation requirements, follow-up and review guidelines, and ensure operational linkage to AUSSLC Risk Management and Quality Improvement systems. This policy/procedure should be incorporated into new employee orientation and annual refresher training. Intermittent drills also should be conducted with staff to ensure staff awareness of the choking policy/procedure.
20. Documented interdisciplinary, comprehensive assessments need to be completed for each individual receiving enteral nutrition on an annual basis. These assessments need to involve at least the following disciplines: nursing, physician, Speech/language pathologist, and occupational therapist. The interdisciplinary discussion regarding the results of the assessments, and the team's recommendations need to be clearly documented in the PSP of each individual receiving enteral nutrition.

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 OT/PT/SLP assessments, Nutrition assessment, Consultations (GI, MBS, orthotics), Dental Section, PSP, BSP, PNMP, Special Considerations, Annual Physical, Annual Nursing assessment, NMT individual-specific documentation, HST Risk Level assessments, therapy consultations, therapy observation in individual record, therapy case/progress notes for the following: Individual #305, Individual #42, Individual #74, Individual #213, Individual #139, Individual #396, Individual #251, Individual #92, Individual #378, Individual #393, Individual #212, Individual #222, Individual #223, Individual #423, Individual #342, Individual #426, Individual #97, Individual #231, Individual #28, Individual #252, Individual #286, Individual #22, Individual #402, Individual #380, Individual #39, Individual #199, and Individual #430; o Wheelchair Use; Other Ambulation Devices; Orthotics/Braces; Wounds; Falls; Injury Reports from 1/09 through 2/10; o Wheelchair/Positioner Spreadsheet and Maintenance Log, from 2/09 through 2/10; o Sample of Positioning Plan, dated 3/10; o OT/PT Evaluation Template, not dated; o PNMP Evaluation Forms, not dated; o Wheelchair Positioner; Music Therapy Evaluations; Quarterly Wheelchair Maintenance for 2009 and 2010; o PNMP Coordinator Training Competencies, not dated; o PNMP Coordinator Training Schedule for 5/10; o Staffing Budget, dated 3/10; o OT Evaluation Update, dated 3/10; o OT/PT Evaluation Updates by Residence/Address, for various dates (files listed by address); o Assessments blank forms, dated 2009; and o PSPs for Individuals on PNM Assessment List, various dates ▪ **Interviews with**: o Sara Reves, BS, OTR, Lead Occupational Therapist; o Mace Welch, Lead Physical Therapist; and o Meeting with all OTs, all PTs, PTA and COTA ▪ **Observations of**: o Observations in Homes 792, 791, 793, 779F (Falcon), 779R (Roadrunner); and o Workshops 527, 544, 796, 775

	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Staffing ratios should be reevaluated to determine the adequate number of therapists (OTs/PTs), and assistants (COTAs and PTAs) needed to meet the physical and nutritional supports of the individuals living at AUSSLC. The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules and clearly define their roles and responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion for these new positions.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> At the time of the review, the management staffing in the Facility's Habilitation Therapies Department included: Karen Hardwick, who was the Director of Habilitation Therapies and State Coordinator for Physical Nutritional Management; Sarah Reves, Lead Occupational Therapist; and Mace Welch, PT, Lead Physical Therapist. In addition to the management staff, there were a total of five OTRs, and one COTA; and four PTs, including one part-time position, and two Physical Therapist Aides. This was consistent with the Austin State Supported Living Center staffing grid, dated 3/15/10 that documented the number of budgeted positions, staff, contractors, unfilled positions, current full-time equivalents, excluding contractors and current staff-to-individual ratios. The Facility had 6.5 Full-time Equivalent (FTE) Physical Therapy (PT) positions and 8.0 FTE Occupational Therapy positions. There were no vacant OT and/or PT positions. Two of the OT positions were contracted positions. These staffing ratios should be reevaluated to determine if the Facility has the adequate number of therapists (OTs/PTs) and assistants (COTAs and PTAs) to meet the physical and nutritional support needs of the individuals living at AUSSLC. Due to the amount of coordination and documentation that will be required to achieve compliance with the SA, Habitation Therapies, in collaboration with Facility administration, should reevaluate current administrative support positions, and explore the addition of skilled technology staff. PNMP Coordinators had been hired and were in the process of being provided competency-based training. The PNMP Coordinator Position Description indicated that this position worked under the general supervision of Unit Administration, and was stationed in residential and program areas. Habilitation Therapies provided training	

#	Provision	Assessment of Status	Compliance
		and supervision for technical duties, clinical applications and documentation and training issues. The PNMP Coordinator provided services to individuals in the areas of physical and nutritional management, oral and enteral eating, positioning, mobility, communication, and other related PNMP services. Job duties included conducting competency-based training of staff; monitoring programs; monitoring availability, condition and proper use of assistive equipment; and ensuring appropriate availability and condition of PNMP instructions and illustrations. The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules and clearly define their roles and responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion for these new positions. <u>All people have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission.</u> The Occupational/Physical Therapy Services policy (#014, dated 10/07/09) stated: "Individuals will be screened for occupational and physical therapy needs within 30 days of admission by occupational and physical therapy staff." Individual #305 was recently admitted to AUSSLC. His OT/PT evaluation was completed within 30 days of admission. The assessment sections were: ▪ General Information (Background and diagnoses); ▪ Behavioral Considerations; ▪ Motor/Functional Evaluation (muscle tone/primitive reflexes, posture, strength, range of motion, gait assessment, gross motor coordination, balance, feet and shoes, fine motor function, perceptual-motor, and activities of daily living); ▪ Oral Motor/Feeding Ability; ▪ Assistive/Supportive Equipment (assistive dining equipment); ▪ Summary/Recommendations for Individual #305 were: o Individual #305 possessed the range of motion, strength, mobility and motor skills to be independent in self-help tasks and basic living skills. o Individual #305 can express basic wants/needs, as well as aspiration for the future. o Individual #305 possesses excellent fine motor skills, and by family report, delights in taking things apart and putting them together. o Individual #305 needs encouragement to eat, as he picks at his food and does not really "sit down to get the job done." A consultation request will be sent to the physician to consider Chopped with Whole Finger Foods texture. o No OT/PT equipment or programming is indicated at this time. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> The Occupational/Physical Therapy	

#	Provision	Assessment of Status	Compliance
		Services policy in Section II on Occupational and Physical Therapy Procedures (#014, dated 10/07/09) indicated that: ▪ Individuals identified with therapy needs must receive a comprehensive, integrated occupational and physical therapy assessment that will be completed within 30 days of identification of the needs; ▪ Assessments must include evaluation of functional and wheeled mobility as needed; ▪ Assessments will consider significant medical issues and health risk indicators in clinically justified manner; and ▪ Clinical data or information contained in the assessments will be analyzed and interpreted in the assessment report. The assessment format submitted was the Occupational Therapy/Physical Therapy Evaluation (POR-MR-9, not dated). The format presented assessment domains, but there were no content descriptions under the assessment domains. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.</u> Eighty-two PSPs were submitted for review. A sample of 30 individual PSPs were reviewed for OT/PT assessment dates, including the plans for: Individual #277, Individual #331, Individual #215, Individual #223, Individual #340, Individual #108, Individual #202, Individual #276, Individual #3, Individual #45, Individual #439, Individual #252, Individual #396, Individual #405, Individual #22, Individual #186, Individual #336, Individual #357, Individual #358, Individual #61, Individual #380, Individual #56, Individual #322, Individual #53, Individual #440, Individual #35, Individual #342, Individual #426, Individual #39, and Individual #204. Except for two individuals for whom a date could not be found, the great majority of individuals had had assessments completed in 2009, or 2010. The following chart provides a summary of the most recent assessment dates for the individuals included in the sample: <table><tr><th>Assessment Year</th><th>Number of Assessments Completed</th><th>Completion Percentage (Most Recent Year)</th></tr><tr><td>2010</td><td>15</td><td>50%</td></tr><tr><td>2009</td><td>13</td><td>43%</td></tr><tr><td>No Date</td><td>2</td><td>7%</td></tr></table> <u>Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.</u> As stated above with regard to Section O.1 of the SA, individuals who had a change in status (i.e., hospitalization) did not receive a	

#	Provision	Assessment of Status	Compliance
		comprehensive assessment. This indicator will receive further review during the next onsite visit. Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment. The following formats were submitted: ▪ Mat Assessment for Seating and Positioning, not dated; ▪ Mat Evaluation, not dated; and ▪ Wheelchair Evaluation and Work Order, not dated. This indicator will receive further review during the next on-site visit. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. The Occupational/Physical Therapy Services policy (#014) stated: "assessments will consider significant medical issues and health risk indicators in a clinically justified manner." The OT/PT evaluation format included diagnoses and medications, but the evaluation format did not provide an explanation of how the evaluation would address significant medical issues and health risk indicators in a clinically justified manner. Evidence of communication and or collaboration is present in the OT/PT assessments. Occupational Therapists and Physical Therapists completed a collaborative assessment.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment;	Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP. Within 30 days of development of the plan, it was implemented. The Occupational/Physical Therapy Services policy (#014) in Section II on Occupational and Physical Therapy Procedures stated that: ▪ Plans to meet recommendations made as a result of the comprehensive occupational/physical therapy assessment must be developed within 30 days of identification of need and be included as part of the PSP. ▪ Plans should be implemented within 30 days of development or sooner as required by the individual's health or safety. The following planning documents to develop an individual's PNMP were submitted: ▪ Physical Therapy PNMP Review Form; ▪ Occupational Therapy PNMP Review Form; ▪ Checklist for PNMP Clinic; and ▪ PNMP Clinic Flow sheet. This indicator will receive further review during the next onsite visit. Appropriate intervention plans are: ▪ Integrated into the PSP;	

#	Provision	Assessment of Status	Compliance
	and, for individuals who have regressed, interventions to minimize further regression.	▪ Individualized; ▪ Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and ▪ Contain objective, measurable and functional outcomes. PSPs reviewed showed that PNMPs were referenced, but not fully integrated into the PSP. This is discussed in further detail above with regard to Section F of the SA, as well as Section O.1 of the SA. Interventions are present to enhance: ▪ Movement; ▪ Mobility; ▪ Range of motion; ▪ Independence; and ▪ As needed to minimize regression. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. The Physical Nutritional Management policy in Section III on Physical Nutrition Management Plan (PNMP) Critical Elements (#012) indicated that: ▪ The PNMP shall identify specific positioning regimes as appropriate, including positioning for enteral eating, prevention of aspiration pneumonia, and complications of gastroesophageal reflux disease (GERD); ▪ The PNMP shall identify any assistive equipment used in implementation of the program , its purpose and schedule for use; and ▪ The PNMP shall define lifting/transfer, mobility and movement techniques to be used. AUSSLC's PNMP format included sections for transfer, mobility and assistive equipment. Therapists provide verbal justification and functional rationale for recommended interventions. This indicator will receive further review during the next on-site visit. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. The Occupational/Physical Therapy Services (#014), and Physical Nutritional Management (#012) policies and PNMP Definition and Purpose in the Habilitation Therapies Handbook Section V.A.1 discussed monitoring, but did not provide a monthly timeframe to review an individual's OT/PT status and PNMPs to determine if change was warranted by the individual's condition, transition (change in setting), and/or as dictated by monitoring results.	
P3	Commencing within six months of	Staff implements recommendations identified by OT/PT. As noted above in SA section	

#	Provision	Assessment of Status	Compliance
	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.	O.4, staff were not consistently implementing PNMPs. Staff successfully complete general and individual-specific competency-based training related to the implementation of OT/PT recommendations. As was discussed in further detail above with regard to SA Sections O.4 and O.6, the foundational training provided to new employees needed to be reviewed to determine if sufficient time was available to provide comprehensive foundational training in physical and nutritional supports. Individual-specific competency-based training will receive further review during the next onsite visit. Staff verbalizes rationale for interventions. This indicator will receive further review during the next onsite visit.	
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.	System exists to routinely evaluate: ▪ Fit; ▪ Availability; ▪ Function; and ▪ Condition of all adaptive equipment/assistive technology. A Wheelchair/Positioner Spreadsheet data base with the following fields was submitted: ▪ Name; ▪ Home; ▪ Type/size of frame/positioner; ▪ Request date; ▪ Priority (1=30 days; 2=60 days; 3=90 days; Emergency=3 days); ▪ Projected completion date; ▪ Therapist; ▪ Fabricator; ▪ Type of work (M=modify; R=repair; N-new); and ▪ Work Requested/completed. Quarterly Maintenance Wheelchair data base, with AUSSLC individuals in wheelchairs, with the following fields was submitted: ▪ Name; ▪ Home; ▪ Frame/positioner; ▪ January-March 2009 (identified individual-specific wheelchair maintenance date); ▪ April-June 2009 with Technician identified; ▪ July-September 2009 with Technician identified; and ▪ October-December 2009 with Technician identified.	

#	Provision	Assessment of Status	Compliance
		These databases provided information to routinely evaluate individual physical supports. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. As stated above in SA Section 0.6, monthly monitoring was occurring, but it was not consistent. Ongoing errors were documented on multiple monitoring forms without an established system to remediate individual-specific and systemic issues. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. There did not appear to be a formalized system to provide competency-based training to pulled/relief staff on individualized positioning and transferring plans prior to working with individuals. This had the potential to place individuals at risk of harm. As stated above with regard to Section O.6 of the SA, PNMP monitoring results documented ongoing non-compliance with the implementation of PNMPs. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. As noted above with regard to Section O.6 of the SA, clear documentation was not found to address responses to monitoring findings and recommendations to ensure resolution of issues identified. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs. These indicators will receive further review during the next onsite visit. Data collection method is validated by the program's author(s). This indicator will be further reviewed during the next onsite visit.	

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

1. The current therapy staffing should be reviewed to determine if there are sufficient staff (OTs, COTAs, PTs, and PTAs) able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs as well as be active members of individuals' Personal Support Teams.
2. The dual supervision of PNMP coordinators will make it necessary to coordinate their schedules and clearly define their roles and responsibilities with Unit Administration and Habilitation Therapies to eliminate confusion.
3. As required by Facility policy, OT/PT assessments should "consider significant medical issues and health risk indicators in a clinically justified

manner." Consideration should be given to modifying the format to prompt more than a list of medical diagnoses, but rather an appropriate analysis to establish rationale for recommendations/therapeutic interventions.

4. Due to the amount of coordination and documentation that will be required to achieve compliance with the SA, Habitation Therapies, in collaboration with Facility administration, should re-evaluate current administrative support positions and explore the addition of skilled technology staff.
5. The OT/PT Services, and Physical Nutritional Management Program (PNMP) policies, and/or the Habilitation Therapies Handbook should define a monitoring/review timeframe, and these requirements should be implemented consistently.
6. A system needs to be implemented to ensure that "pulled" or agency staff have the necessary competencies to implement the PNMPs with integrity.
7. Person-specific monitoring needs to be completed. In order for this to occur, such monitoring needs to be defined both on a systemic level through policy, and on an individual level in individuals' PNMPs. Please refer to additional recommendations above in Section O of this report related to monitoring.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC Dental Services policy; o AUSSLC's Dental tracking lists; o Desensitization and training/service objectives for 163 individuals from the following units: Sunrise (34 Individuals), Castner Estates (95 Individuals), Timber Creek (16 Individuals), and Woodhollow (17 Individuals); and o Medical records for the following individuals: Individual #156, Individual #119, Individual #408, Individual #43, Individual #331, Individual #404, Individual #99, Individual #376, Individual #258, Individual #242, Individual #272, Individual #385, Individual #326, Individual #293, Individual #194, Individual #7, Individual #179, Individual #92, Individual #458, Individual #374, Individual #239, Individual #88, Individual #408, Individual #369, Individual #174, Individual #311, Individual #87, Individual #422, Individual #213, Individual #335, Individual #220, Individual #224, Individual #174, Individual #263, Individual #102, Individual #408, Individual #124, Individual #52, Individual #292, Individual #127, and, Individual #260 ▪ **Interviews with**: o Rhonda Stokley, DDS, Director of Dental Services; o Fred Bibus, MD, Medical Director; o Rebecca Hall, RN, CNE; o Kim Sweeney, RN, QA Nurse; and o Jose Levy, Director of Behavioral Services
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: From the records reviewed, it appeared that beginning in mid-2009, individuals at AUSSLC generally were being seen at least every six months, and more frequently for restorative/preventative care. Prior to this time, there had been significant lapses in care. A system needs to be developed and implemented to accurately identify individuals who refuse dental care, and/or other reasons for missed appointments. This is essential so that the teams can address these issues on an individual level, and the Facility can address any systemic issues identified. From review of the dental documentation, AUSSLC uses both restraint and pre-sedation for a large majority of the individuals when providing dental services. Although the Facility was in the process of establishing programs to decrease the use of these methods, there were other SSLC that have significantly lower usage, especially regarding the use of restraint. Consideration needs to be given to developing a statewide dental committee that includes the Dental Directors of each of the Facilities to promote collaboration and consistency in policies and practices among the SSLC dentists.

	In addition, other disciplines need to collaborate with dental such as the Physical Nutritional Management Team regarding individuals who are at risk for aspiration/choking. Nursing practices with regard to monitoring individuals who have received pre-sedation prior to dental appointments need to be improved.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	At the time of the review, the Dental Department at AUSSLC had one full-time dentist, one Dental Assistant, and two Dental Hygienists. The department had a vacancy for a full-time dentist. However, the Dental Director reported she actually needed more Dental Assistants rather than a second dentist. A review was conducted of 30 individuals' dental progress notes, including: Individual #156, Individual #119, Individual #408, Individual #43, Individual #331, Individual #404, Individual #99, Individual #376, Individual #258, Individual #242, Individual #272, Individual #385, Individual #326, Individual #293, Individual #194, Individual #7, Individual #179, Individual #92, Individual #458, Individual #374, Individual #239, Individual #88, Individual #408, Individual #369, Individual #174, Individual #311, Individual #87, Individual #422, Individual #213, and Individual #335. The dental notes indicated that of the 30 individuals reviewed, 20 of them (67%), including Individual #156, Individual #119, Individual #404, Individual #99, Individual #376, Individual #258, Individual #242, Individual #385, Individual #326, Individual #293, Individual #179, Individual #458, Individual #374, Individual #239, Individual #88, Individual #369, Individual #174, Individual #87, Individual #422, Individual #213, were not seen for periods of 10 months to 15 months between early 2008 and mid 2009. In addition, the dental notes indicated that one of the individuals (Individual # 293) was not seen for over two years. No documentation was found justifying why individuals who were previously noted by the dentist to have very poor oral hygiene and significant past dental issues were not seen more frequently. However, once these individuals were seen, they all were provided dental care at least every six months, and several of these individuals were seen several times for restorative care. Although there had been past gaps in dental care for individuals, the dental notes reviewed were comprehensive and descriptive regarding the findings of the exam, the treatment plan, and the treatment provided. The dental notes clearly indicated the individual's oral hygiene status, and findings from the examination regarding the condition of the teeth. Also, the dental notes included the individual's response to the examination. In addition, there was documentation that the dentist called the physician when clinical issues arose to collaborate regarding health care issues to ensure safe practices for the individuals. Regarding annual dental assessments, the documentation was inconsistent regarding the format for documenting an annual exam. Some records included an Annual Dental	

#	Provision	Assessment of Status	Compliance
		Assessment form while others noted the annual assessment in the dental progress notes. In some cases, there was both an Annual Dental Assessment form and a progress note. There was no policy/procedure found indicating how annual dental assessments should be documented. Based on interview with the Dental Director, individuals' medical records were not consistently brought to the dental appointments. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments for the safety of the individuals. Based on the medical record reviews and interview with the Dental Director, the dentist completed some duplication of her documentation. For one appointment, the dentist documented her note in the individual's dental clinical record, in the medical record in the dental section, and in the Interdisciplinary progress notes. The Facility needs to find ways to consolidate this duplication of documentation, such as the use of a dental software program so that a single note is completed and placed in the appropriate records. Data lists reviewed from the AUSSLC's Dental Department indicated that using an Excel software program, the Dental Director was able to track on a monthly basis the number of dental services provided including: the number of restorative and preventative procedures done; number of dental emergencies; and the number of extractions performed. However, the Dental Director indicated that she needed information technology assistance in running reports to make the data in the system helpful and usable. In addition, there was no formal system in place to track refusals, or missed appointments and the reasons why, such as a lack of staffing, or other issues. Anecdotally, the Dental Director reported that at times, the unit staff was not consistently aware that individuals had a scheduled dental appointment, which would result in a missed appointment. Although a number of the dental notes included documentation reflecting missed appointments, refusals, schedule conflicts, or no shows for appointments, this data had not been collected in a way that was easy to aggregate and analyze, so that underlying issues could be identified and addressed. The Facility needs to implement a system to ensure identify the underlying reasons for missed dental appointments, and address them. At the time of the review, the Facility had not begun to monitor any of the dental requirements included in the SA. Monitoring systems need to be developed to ensure that dental practices are being implemented as required by the SA and HCG.	

#	Provision	Assessment of Status	Compliance
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	At the time of the review, AUSSLC had one broad policy addressing Dental Services. No date of implementation/review was found on the policy. The Facility needs to develop operational protocols and procedures specifically addressing each area of the policy that are in alignment with current practices, as defined by the SA and Health Care Guidelines. For example, the Dental Services policy stated that the Dental Department must establish access for care in the case of emergency. However, there was no procedure outlining how this process was to be implemented. In addition, the current Dental Services policy did not include specific criteria, such as timeframes for completing annual and emergency evaluations. A statewide Dental Manual would be beneficial. When the dental policies and procedures are developed and implemented, a monitoring system needs to be put in place to ensure that these policies/procedures are consistently being implemented. Because other disciplines have shared responsibilities for addressing certain issues such as missed and refused appointments, and individuals needing physical and nutritional support, there needs to be collaboration between the disciplines such as nursing, rehabilitation therapies, psychology and the Dental Department regarding the monitoring of certain policies/procedures. At the time of the review, there was no documentation indicating that there had been collaboration with the Physical Nutritional Management Team regarding individuals at risk for aspiration/choking. From the documentation provided by the Facility, the following were the numbers of individuals per unit who had a desensitization and/or training/service objectives in place: • Sun Rise - 34 individuals; • Castner Estates - 95 individuals; • Timber Creek - 16 individuals; and • Woodhollow - 17 individuals. Based on a review of the 163 desensitization programs or training/service objectives, it was impossible to determine when these programs had actually been initiated, and who developed them. Although there was no data provided to indicate if the programs were being conducted and/or if the individuals were making progress, the 95 programs for Castner Estates focused on desensitizing and improving oral care and tooth brushing at the unit level, while the other 68 programs for the other units only addressed strategies for desensitization at the Dental Clinic. Although both areas may certainly warrant strategies to assist the individual in allowing care to be performed, the programs should be individualized and based on the oral hygiene status and care needed to address the specific needs of the individual. Implementing daily programs at the unit level for individuals with poor oral hygiene makes sound clinical sense, and should ultimately	

#	Provision	Assessment of Status	Compliance
		assist in conducting some dental procedures at the Dental Clinic. From interview with the Director of Behavioral Services, psychology staff recently had started collaborating with the Dental Department regarding individuals who have used sedation and restraint for dental appointments. The Director of Behavioral Services indicated that individualized task analyses to address the problems that individuals were having with appointments were to be developed. All disciplines on individuals' teams need to collaborate to develop desensitization programs/strategies to assist in decreasing refusals, as well as the use of pre-sedation and restraints for dental and medical procedures. From review of the documentation for 11 individuals (Individual #220, Individual #224, Individual #174, Individual #263, Individual #102, Individual #408, Individual #124, Individual #52, Individual #292, Individual #127, and Individual #260) who received pre-sedation for dental procedures, only three contained a nurses' note documenting when the medication was given in the progress notes. In addition, only one note contained the dosage and the route of the medication given, and none contained any type of nursing assessment of the individual prior to administering the medication. Also, eight of the records contained documentation that the individuals were being monitored after the dental appointment; however, the quality of most of these notes was poor. For example, some did not contain the values of the vital signs, only the acronym "WNL" (within normal limits), which provides no basis for comparison should the individual's status change. Also, most notes stated the individual was "back to baseline" as reported by the direct support staff without any description of the individual's status. In the case of Individual #174 who received anesthesia for dental work, there was no documented nursing assessment found prior to the individual leaving the unit for the procedure. In addition, for Individual #102 where the documentation indicated there was significant sedation after the dental appointment, there was no indication that the physician was notified to perhaps adjust the dosage of the pre-sedating medication in the event it was needed for a future appointment. The Facility needs to develop and implement a system to ensure that when receiving pre-sedation for dental/medical procedures, individuals are monitored, and that this monitoring is appropriately documented. From review of the dental documentation, AUSSLC uses both restraint and pre-sedation for a large majority of the individuals when providing dental services. Although the Facility is in the process of establishing programs to decrease the use of these methods, there are other SSLC that have significantly lower usage, especially regarding the use of restraint. Consideration should be given to developing a statewide dental committee that includes the Dental Directors of each of the Facilities to promote collaboration and consistency in policies and practices among the SSLC dentists.	

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

1. Dental policies, procedures and protocols should be developed and implemented in alignment with current practices, as defined in the SA and Health Care Guidelines. Consideration should be given to developing and implementing a statewide Dental Manual.
2. Monitoring systems should be developed and implemented to ensure that dental practices are in alignment with generally accepted standards of practice, as defined by the SA and Health Care Guidelines.
3. The reasons for missed appointments and/or refusals need to be aggregated and analyzed. A formal plan needs to be developed and implemented addressing the reasons identified for refusals or missed dental appointments.
4. Dentistry should continue to collaborate with other disciplines such as nursing, rehabilitation therapies, and psychology, regarding the implementation of certain policies/procedures that have shared responsibilities regarding dental issues, such as the development of plans to reduce the need for pre-sedation medications and physical nutritional management plans.
5. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments.
6. The Facility should consider ways to consolidate the dental documentation to avoid the duplication of documentation, such as the use of a dental software program so that a single note is completed and placed in the appropriate records.
7. The Facility should provide the needed IT supports for databases used by the Dental Department to ensure that the data entered is available in user-friendly reports.
8. Dentistry should collaborate with nursing regarding the development and implementation of a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation medication for medical/dental procedures.
9. Consideration should be given to developing a statewide dental committee that includes the Dental Directors of each of the Facilities to promote collaboration and consistency in policies and practices among the SSLC's dentists.

<table>
<tr><th>SECTION R: Communication</th><th></th></tr>
<tr><td rowspan="2">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) assessments, Nutrition assessments, Consultations [e.g., gastrointestinal (GI), modified barium swallow studies (MBS), orthotics), Dental Section, PSP, BSP, Physical and Nutritional Management Plan (PNMP), Special Considerations, Annual Physical, Annual Nursing assessment, NMT individual-specific documentation, HST Risk Level assessments, therapy consultations, therapy observation in individual record, and therapy case/progress notes for the following: Individual #305, Individual #42, Individual #74, Individual #213, Individual #139, Individual #396, Individual #251, Individual #92, Individual #378, Individual #393, Individual #212, Individual #222, Individual #223, Individual #423, Individual #342, Individual #426, Individual #97, Individual #231, Individual #28, Individual #252, Individual #286, Individual #22, Individual #402, Individual #380, Individual #39, Individual #199, and Individual #430;
o OT/PT/SLP assessments, PSP, BSP, Communication program/strategies, incident reports for past three months, PNMP for Individual #210 and Individual #350;
o Speech/Language Evaluations, dated 1/10;
o Training Communication, not dated;
o Speech and Hearing Equipment Observations, for 2/10;
o AUSSLC Communication Equipment List for 2008 and 2009;
o Speech/Language/Audiology Evaluation, dated 8/07;
o Speech/Language/Audiology Evaluation, dated 8/07;
o List of Communication Dictionaries for 2008 and 2009; and
o AUSSLC Communication Assessment Master Plan for 2008 and 2009
▪ Interviews with:
o Kim Ingram, Lead Speech Language Pathologist;
o Jan Taylor, MS, CCC-SLP;
o Caryl Price, MA, CCC-SLP; and
o PNMP Coordinators
▪ Observations of:
o Home 501, Home 729, Home 730, Home 732, Home 772, Home 779F, Home 779R, Home 781, Home 782, Home 783, Home 784, Home 785, Home 786, Home 787, Home 789, Home 791, Home 792, Home 793, Home 794, and Home 795;
o Infirmary;
o Workshop 503, Workshop 510, Workshop 527, Workshop 532, Workshop 544, Workshop 732, Workshop 775, and Workshop 796; and
o Life Skills Center 512; and
o Aquadome</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
</table>

	Summary of Monitor's Assessment: The current staffing ratios for SLPs did not appear to be sufficient to support SLPs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs, provide supports in the area of functional communication, as well as be active members of individual's Personal Support Team (PST). As more individual communication evaluations are completed and communication systems developed, there will be an increase in professional time needed to complete individual-specific competency-based training, and ensure these systems become fully integrated into an individual's daily routine. Staffing ratios should be reevaluated through an analysis of the universe of unmet needs, particularly with regard to functional communication, and current caseloads to determine an adequate number of SLPs and assistant(s) required to meet the communication needs of the individuals living at AUSSLC. Seventeen (17) percent of the individuals living at AUSSLC had an augmentative device (low tech or high tech). Per observation, there were a significant number of individuals who needed communication systems, but did not have them. The number of individuals who had communication systems was low given the population supported by the Facility. The low percentage of individuals with communication systems appeared to be driven by the insufficient number of speech language pathologists available to develop and implement communication programs, provide competency-based staff training, and provide monitoring oversight to determine progress and efficacy of the systems. At the time of the review, individuals had been admitted to AUSSLC who were deaf, but they were not receiving appropriate communication supports and services. Although the Lead Speech Pathologist and Interim Director had been working to procure needed services, they were not available. Significant bureaucratic barriers had delayed individuals from having access to the use of a videophone. There were ongoing time delays and barriers in working with the Information Technology (IT) Department on the local and state levels to initiate videophone services. The videophones were not operational at the time of the on-site review. In addition, there were challenges to providing interpreters for individuals who used sign language as a primary method of communication. The Speech Department, in collaboration with administration, must ensure that adequate and appropriate supports are provided to individuals who are hearing impaired. Per interview, individuals who were visually impaired did not have professional support staff and services available to them. This significant area of individual unmet need must be addressed and resolved by AUSSLC administration. Per interview, staff were trained in AAC generic and individual-specific programs, but multiple observations demonstrated that staff did not assist or encourage individuals to use these systems. The Speech Department, in collaboration with administration and programmatic staff, will need to establish strategies to ensure functional communication becomes a priority initiative for the individuals living at AUSSLC. The Communication policy, dated 10/07/09, did not provide clear direction for the implementation of the monitoring process, including criteria for and identification of speech and hearing equipment monitors,

	definition of each monitoring performance indicator, definition of the competency-based training process for speech and hearing monitors to support confidence in monitoring results and inter-rater reliability, definition of staff re-training thresholds, explanation of validation and re-validation process for speech and hearing monitors, definition of the analysis process of speech and hearing monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration of the speech and hearing monitoring system into the Facility Risk Management and Quality Enhancement systems to provide a feedback loop to remediate individual-specific and systemic areas of non-compliance.

#	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 facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience. The Facility Speech and Language staff included the Lead Speech Language Pathologist, and two other SLPs. Austin State Supported Living Center, dated 3/15/10, that documented the number of budgeted positions, staff, contractors, unfilled positions, current full-time equivalents, excluding contractors, and current staff-to-individual ratios. The Facility had 3.0 FTE Speech Therapy positions. These were no vacant positions, and these positions were contracted. The current staffing ratios for SLPs did not appear to be sufficient to support SLPs being able to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs, provide supports in the area of functional communication, as well as be active members of individual's Personal Support Team (PST). The current caseloads of the SLPs make it difficult for the SLPs to be active participants in PSP meetings, which is a critical component of the SA. In addition, as more individual communication evaluations are completed and communication systems developed, there will be an increase in professional time needed to complete individual-specific competency-based training, and ensure these systems become fully integrated into an individual's daily routine. Staffing ratios should be reevaluated through an analysis of the universe of unmet needs, particularly with regard to functional communication, and current caseloads to determine an adequate number of SLPs and assistant(s) required to meet the communication needs of the individuals living at AUSSLC. As stated above, PNMP coordinators job descriptions indicated that these staff would provide services/supports to individuals in the area of physical and nutritional supports, as well as communication. It will be important to ensure the PNMP coordinators are available to provide assistance to the SLPs, because there were no assistants/technicians working with the SLPs.	

#	Provision	Assessment of Status	Compliance
		Supports are provided to individuals based on need and not staff availability. AUSSLC Communication Equipment List, revised 3/10/10, identified individuals with alternative and augmentative communication devices (low tech and high tech), their home and the type(s) of device(s). The following provides a list of homes and the numbers of individuals with AAC devices in each home:	

Home	# of Individuals with AAC Devices
727C	1
732D	2
732E	3
732M	1
779F	1
779R	2
788	5
789	2
791	7
792	4
793	1
794	3
732D	1
501	4
783	1
796	4
797	2
772A	4
730	2
781	2
782	1
783	5
784	3
785	1
786	1
787	4
Total	67/389=17%

At the time of the review, seventeen (17) percent of the individuals living at AUSSLC had an augmentative device (low tech or high tech). Per observation, there were a significant number of individuals who needed communication systems, but did not have a system.

#	Provision	Assessment of Status	Compliance
		The number of individuals who had communication systems was low given the population supported by the Facility. The low percentage of individuals with communication systems appeared to be driven by the insufficient number of speech language pathologists available to develop and implement communication programs, provide competency-based staff training, and provide monitoring oversight to determine progress and efficacy of the systems. Communication Dictionaries were submitted for 110 of the 389 individuals (28%) living at AUSSLC. These dictionaries documented how an individual communicates through verbalizations, gestures, actions, and other means how he/she feels, what he/she wants, and what he/she likes/dislikes. The AUSSLC Communication Equipment List, revised 3/10/10, listed shared equipment in homes such as: health care communication board; Dozen Does It general board; Put'em Around (eat); scallop switch and power select for radio/cassette player; Big Mac communicator; portable radio/cassette player; sign language reference book; sensory cabinet; sensory cabinet with seven power select and scallop switches; Dozen Does It workshop board(s); and Put'em Around (outside). The Monitoring Team's visits to homes and day programs confirmed the existence of these generic, and potentially valuable generic communication device. However, staff were not encouraging or assisting individuals to use the devices. At the time of the review, individuals who were deaf had have been admitted to AUSSLC, but were not receiving appropriate communication supports and services. Although the Lead Speech Pathologist and Interim Director had been working diligently to procure needed services, they had not been provided. Significant bureaucratic barriers had delayed Individual #210 and Individual #350 from receiving the use of a videophone. There were ongoing time delays and barriers in working with the Information Technology Department on the local and state level to initiate videophone services. The videophones were not operational at the time of the onsite review. In addition, there were challenges to providing sign language interpreters for Individual #210 and Individual #350, both of whom used sign language as a primary method of communication. The Speech Department, in collaboration with administration, must ensure that adequate and appropriate supports are provided to individuals who are hearing impaired. Per interview, individuals who were visually impaired did not have professional support staff and services available to them, for example, orientation and mobility training, adaptive devices, etc. This significant area of individual unmet need must be addressed and resolved by AUSSLC administration.	

#	Provision	Assessment of Status	Compliance
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission. The Communication Services policy (#016, dated 10/7/09) in Section II on Assessments stated: ▪ Individuals will be screened for communication needs, including augmentative communication needs, within 30 days of admission. Individual #305 was recently admitted to AUSSLC. His Speech-Language Evaluation was completed within 30 days of admission. The evaluation sections were: reason for referral, significant information, reports from significant others, observation, receptive language, expressive language, articulation, augmentative communication, voice and fluency, oral mechanism, hearing and vision, clinical impressions, and recommendations. Individual #305's recommendations were: ▪ In view of the above clinical impression's speech-language therapy is not indicated as his needs can best be addressed in the context of daily living activities. Speech and Language should be reassessed if there is a significant change in communication skills or upon recommendation of the Personal Support Team. ▪ Communication strategies were provided to assist in his communication. All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills. The Communication Services policy (#016, dated 10/07/09) in Section II on Assessments indicated that: ▪ Comprehensive communication assessments/updates will be completed according schedule set forth in the Communication Master Plan, or as indicated by need; ▪ Assessments will include evaluation of need for augmentative and alternative communication, as appropriate; ▪ Assessments will consider behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions, as indicated; and ▪ Information contained in assessments will be analyzed and interpreted n a clinically justified manner to identify individuals who would benefit form alternative or augmentative communication. Speech Language Evaluation format documented the following domains: ▪ Reason for referral; ▪ Significant information; ▪ Reports from significant others; ▪ Observation;	

#	Provision	Assessment of Status	Compliance
		▪ Receptive/expressive language; ▪ Augmentative communication; ▪ Articulation; ▪ Voice and fluency; ▪ Oral mechanism; ▪ Hearing and vision; ▪ Clinical impressions; ▪ Recommendations; ▪ Communication equipment; ▪ Language/modality preference; and ▪ Communication/active treatment instructions. Speech/communication assessment formats did not present a section to address medical issues and risk indicators that may have an impact on therapy interventions. The format(s) presented assessment domains, but there were no content descriptions under the assessment domains. <u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every three years, with annual interim updates or as indicated by a change in status.</u> Eighty-two (82) PSPs were submitted for review. A sample of 30 individual PSPs were reviewed for Speech Language and Audiology evaluation dates, including the PSPs for: Individual #277, Individual #331, Individual #215, Individual #223, Individual #340, Individual #108, Individual #202, Individual #276, Individual #3, Individual #45, Individual #439, Individual #252, Individual #396, Individual #405, Individual #22, Individual #186, Individual #336, Individual #357, Individual #358, Individual #61, Individual #380, Individual #56, Individual #322, Individual #53, Individual #440, Individual #35, Individual #342, Individual #426, Individual #39, and Individual #204. The following summarizes the numbers and percentages of individuals within the sample and the years in which assessments were completed:	

Assessment Year	# of SLP Assessments Completed	Completion Percentage (Most Recent Year)	# of Audiology Assessments Completed	Completion Percentage (Most Recent Year)
2010	7	23%	9	30%
2009	6	20%	13	43%
2008	4	13%	6	20%
2007	-	-	2	7%
Prior to 2006	9	30%	-	-

#	Provision	Assessment of Status	Compliance

No Date	2	7%	-	-
No Entry	2	7%	-	-

For persons receiving behavioral supports or interventions, the Facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP. The Communication Services policy (#016) in Section II on Assessments stated:

- Assessments will consider behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions, as indicated.

Per interview, the Lead Speech Language Pathologist worked in collaboration with the Psychology Director. The Speech Language Department (Lead Speech Language Pathologist and two speech language pathologists) completed a continuing education course entitled Teaching Verbal Behavior to Children with Autism and Related Disabilities offered by the Central Texas Autism Center. The Psychology Department and Speech Language Department were developing a plan for the implementation of an autism project at AUSSLC. This indicator will receive further review during the next on-site review.

Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral. This indicator will be reviewed during the next onsite visit.

Policy exists that outlines assessment schedule and staff responsibilities. The Communication Services policy (#016, dated 10/07/09) in Section II on Assessments indicated that: comprehensive communication assessments will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need. The Speech Department had developed a Master Plan with criteria for priority assignment for 396 individuals, which was used to schedule augmentative communication assessments:

- Priority 1 - Individuals with a Behavior Support Plan and/or Autism who did not speak. One hundred forty-three (143) individuals were identified, and 73 percent had SLP evaluations completed;
- Priority 2 - Individuals with a Behavior Support Plan and/or Autism who spoke. One hundred one (101) individuals were identified and 18 percent had SLP evaluations completed;
- Priority 3 - Individuals without a Behavior Support Plan and/or Autism who did not speak. Seventy-five (75) individuals were identified, and 13 percent had SLP evaluations completed; and

#	Provision	Assessment of Status	Compliance
		▪ Priority 4 - Individuals without a Behavior Support Plan and/or Autism who spoke. Seventy-seven (77) individuals were identified, and 10 percent had SLP evaluations completed. AUSSLC Communication Assessment Master Plan, revised 3/15/10, data base included the following fields: ▪ Admission number; ▪ Last name; ▪ First name; ▪ Middle initial; ▪ Priority; ▪ Last evaluation; ▪ Current evaluation; ▪ Status; ▪ Equipment/Annual Review; ▪ Proposed evaluation date; ▪ Communication mode (1-4); ▪ Equipment; ▪ Communication Dictionary; and ▪ Comments/notes. Findings of comprehensive assessment drive the need for further assessment in Augmentative Communication. This indicator will receive further review during the next on-site review.	
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.	Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP. The PSP contains information regarding how the person communicates and strategies staff may utilize to enhance communication. Review of PSPs documented the interventions regarding the use and benefit of AAC systems for individuals with AAC systems, but as stated above with regard to Section R.2 of the SA, there were multiple individuals who had not been assessed for AAC systems. AAC devices are portable and functional in a variety of settings are meaningful to the individual. Observations in homes and throughout the Facility revealed that staff and individuals were not using generic and/or individual-specific communication systems. Staff are trained in the use of the AAC. Per interview, staff were trained in AAC generic and individual-specific programs, but multiple observations demonstrated that staff did not encourage or assist individuals to engage with these systems. The Speech Department, in collaboration with administration and programmatic staff, will need to establish strategies to ensure functional communication becomes a priority initiative for	

#	Provision	Assessment of Status	Compliance
		the individuals living at AUSSLC. Communication strategies/devices are integrated into the PSP and PNMP. This will be reviewed during upcoming reviews. Communication strategies/devices are implemented and used. Staff and individuals living at AUSSLC were not observed using generic and/or individual specific systems to support functional communication. General AAC devices are available in common areas. As discussed earlier, there were generic communication devices in homes and throughout the facility but observations did not document staff and individuals engaging these systems.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Monitoring system is in place that: ▪ Tracks the presence of the ACC; ▪ Working condition of the AAC; ▪ The implementation of the device; and ▪ Effectiveness of the device. The Speech and Hearing Equipment Observation form, dated 2/12/10, listed the following monitoring indicators: ▪ PNMP (Communication Plans followed); ▪ Communication Equipment (equipment being used/available, used correctly, in good repair and clean); and ▪ Hearing Equipment (equipment being used/available, working properly, ear mold clean, ear plug available). Staff were to be asked: ▪ What may help the equipment be used more effectively? ▪ Show me how you use this with the resident(s). ▪ Who are the residents that use the shared equipment at home? ▪ Who are the residents that use the shared equipment at work? The Speech and Hearing Equipment Observation forms were submitted for December 2009 and January, February, March, and April 2010. The Speech and Hearing Equipment Monitoring/Observation forms were reviewed for February 2010. Six homes were reviewed, including: 730, (one form), 781 (five forms), 782 (four forms), 785 (one form), 786 (one form), and 787 (two forms). There were unresolved issues identified on the monitoring forms such as missing equipment. This is discussed above with regard to Section O.6 of the SA that addresses monitoring recommendations. The Communication Services policy (#016) in Section V on Monitoring indicated that the	

#	Provision	Assessment of Status	Compliance
		State Center shall implement a system to monitor and address: ▪ The status of individuals with identified therapy needs; ▪ The condition, availability, and appropriateness of physical supports or assistive equipment; ▪ The effectiveness of treatment interventions, including whether the interventions address the individual's communication needs in a manner that is functional and adaptable to a variety of settings and that the identified communication systems are readily available to the individual; and ▪ The implementation of communication programs carried out by direct support staff. The policy did not provide clear direction for the implementation of the monitoring process, criteria for and identification of speech and hearing equipment monitors, definition of each monitoring performance indicator, definition of the competency-based training process for speech and hearing monitors to support confidence in monitoring results and inter-rater reliability, definition of staff re-training thresholds, explanation of validation and re-validation process for speech and hearing monitors, definition of the analysis process of speech and hearing monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and/or integration of the speech and hearing monitoring system into the facility Risk Management and Quality Enhancement systems to provide a feedback loop to remediate individual-specific and systemic areas of non-compliance. Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. The Speech and Hearing Equipment Observation/Monitoring form submitted only reviewed communication systems in the home. The current monitoring forms submitted did not review communication system use throughout the Facility and/or in the community. Validation Checks are built into the monitoring process and conducted by the plan's author. This indicator will receive further review during the next onsite visit.	

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

1. The current staffing levels for SLPs and related support staff should be re-evaluated to determine if these positions are sufficient to implement individual-specific functional communication systems for individuals at AUSSLC, participate as active members of individuals' PSPs, as well as to provide supports to individuals with mealtime needs. If additional resources are needed, then requests should be made.
2. The Speech Department, in collaboration with administration, must ensure that adequate and appropriate supports are provided to individuals who are hearing impaired, including but not limited to sign language interpreters, and videophones.
3. The unmet needs of individuals who are visually impaired also must be addressed and resolved by AUSSLC administration.

4. The Speech Department, in collaboration with administration and programmatic staff, will need to establish strategies to ensure implementation of functional communication strategies becomes a priority initiative for the individuals living at AUSSLC.
5. The monitoring policy should provide clear direction for the implementation of the monitoring process, criteria for and identification of speech and hearing equipment monitors, definition of each monitoring performance indicator, definition of the competency-based training process for speech and hearing monitors to support confidence in monitoring results and inter-rater reliability, definition of staff re-training thresholds, explanation of validation and re-validation process for speech and hearing monitors, definition of the analysis process of speech and hearing monitoring results to assist in the formulation of corrective strategies to address systemic areas of deficiency for specific indicators, and integration of the speech and hearing monitoring system into the Facility Risk Management and Quality Enhancement systems to provide a feedback loop to remediate individual-specific and systemic areas of non-compliance.
6. All individuals who do not have effective means of communication should be provided with training objectives to address their needs. If augmentative devices are recommended, these should be individualized.

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 Personal Support Plans for the following individuals: Individual #332, Individual #175, Individual #210, Individual #160, Individual #32, Individual #152, Individual #217, Individual #108, Individual #358, Individual #263, Individual #372, Individual #339, Individual #53, Individual #406, Individual #94, Individual #374, Individual #78, Individual #246, Individual #304, Individual #328, Individual #206, Individual #284, Individual #42, Individual #123, Individual #276, Individual #448, Individual #335, Individual #135, Individual #238, Individual #409, Individual #326, Individual #182, Individual #364, Individual #378, Individual #8, Individual #299, Individual #167, Individual #350, Individual #75, Individual #212, Individual #389, Individual #2, Individual #124, Individual #170, Individual #344, Individual #360, Individual #95, Individual #195, Individual #219, Individual #86, Individual #56, Individual #98, Individual #68, and Individual #73; o Positive Assessment of Living Skills (PALS) for the following individuals: Individual #263, Individual #406, Individual #22, Individual #133, and Individual #28; o Vocational Comprehensive Assessment Program Planning System (CAPPS) Summary for Individual #406 and Individual #133; o Data Collection/Progress Summary sheets for the following individuals: Individual #384, Individual #406, Individual #22, Individual #133, and Individual #28; o Tracking Sheets for the following individuals: Individual #406 and Individual #133; o Personal Support Plan Quarterly Review for the following individuals: Individual #384, Individual #406 and Individual #22; and o Specific Training Objectives for the following individuals: Individual #160, Individual #217, Individual #406, Individual #94, Individual #304, Individual #123, Individual #448, Individual #364, Individual #75, Individual #212, Individual #344, and Individual #139 ▪ **Interviews with**: o Sarah Knowles, Director of Active Treatment, on 4/8/10 ▪ **Observations of**: o Home 501, Home 729, Home 730, Home 732, Home 772, Home 779, Home 781, Home 782, Home 783, Home 784, Home 785, Home 786, Home 787, Home 789, Home 791, Home 792, Home 793, Home 794, and Home 795; o Infirmary; o Workshop 503, Workshop 510, Workshop 532, Workshop 544, Workshop 732, and Workshop 775;

	- Life Skills Center 512; and - Personal Support Planning Meeting for Individual #305, on 4/7/10
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Throughout the visit to AUSSLC, it was apparent that the Facility was not sufficiently staffed to meet the needs of the individuals served. Individuals were frequently observed to be sitting idly with no interesting materials or activities to keep them engaged. General conditions of the Facility were found to be poor, with some homes lacking all but basic furniture, and others being in disrepair or poorly kept. Basic needs of some individuals were not being met as people were observed to have dirty hair, poorly fitting and worn clothing, or other indicators of limited care and support. Assessment of adaptive behavior was improved with the use of the Positive Assessment of Living Skills (PALS), and the plan to complete this annually was an appropriate goal. Training objectives designed to meet the identified needs of the individual will need to be written so that the staff have a clear understanding of the goal, schedule for implementation, needed materials, steps involved in teaching, and data collection systems. Progress on all objectives should be reviewed on a regular basis, and plans should be put in place to ensure maintenance and generalization of all learned skills.

#	Provision	Assessment of Status	Compliance
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.	Over the course of four days, between 4/5/10 and 4/8/10, a total of 89 Planned Activity Checks (PLACHECKS) were completed. PLACHECKS (Doke & Risley, 1972) involve a momentary time sample in which engagement is recorded. The observer scans the environment, noting whether each individual is engaged or not engaged at the moment of observation. A percentage of engagement is then calculated. PLACHECKS were conducted in residences (including 729, 730, 732, 772, 779, 781, 783, 784, 785, 786, 787, 791, 792, 793, 796, and 797), workshops (including 503, 510, 527, 544, 732, and 775), and a Life Skills Center (512). The following summarizes the results: ▪ An analysis of the 49 PLACHECKS collected in the residences resulted in a mean engagement score of 9.16 percent, with a range between zero percent and 33 percent. ▪ The data from the 38 PLACHECKS completed in the workshop areas reflected a range of zero percent to 100 percent engagement, with a mean of 27.26 percent. ▪ The two PLACHECKS completed in the Life Skills Center provided a range of 13percent to 40 percent, with a mean engagement score of 25.5 percent. Overall, active engagement was very low. Of those individuals who were engaged, often times the activities were repetitive and nonfunctional (e.g., moving binder coils back and forth between two binders,	

#	Provision	Assessment of Status	Compliance
		manipulating paper, handling rubber bands, etc.). The following provides more specific examples: ▪ In one workshop area, individuals were putting together mailings, yet this often consisted of a staff member directing an individual to hand him/her a single piece of paper. More complex tasks, such as checking for quality and affixing labels to envelopes, were being completed by staff. ▪ In another workshop area, Individual #358 was sleeping in a chair, positioned so that the small of his back was on the seat of the chair. ▪ In one home, there were eight individuals seated in the "sensory room." None were engaged, and there was a strong fecal odor. The staff member providing the tour needed to ask the staff to change the person who had had the toilet accident. ▪ In another home, Individual #73 was observed repeatedly slapping his face. When staff were asked about the intervention for this behavior, they reported that there was no plan for his self-injurious behavior, and that if they try to redirect him, the behavior worsens. A later check of this individual's behavior support plan found that self-injury was one of the behaviors identified in the plan. ▪ In this same house, an individual was in a bathroom with the door open without any staff attending to him. ▪ Upon approaching one home, an individual wearing only his underpants was observed standing in a window. ▪ Upon entering home 793, 13 individuals were observed, two of whom were manipulating objects. One staff member was in the office, several others in the kitchen. No staff were interacting with the individuals. The staff member in the office closed the door, leaving all individuals unsupervised for a period of time. Clearly, there was a lack of engagement for many of the individuals who live and work at Austin State Supported Living Center. As illustrated by the examples above, there were numerous observations made during which no habilitation, training, or skill acquisition opportunities were being provided the individuals. Equally concerning was the quality of life provided to the individuals who reside at the AUSSLC. Many of these practices were not consistent with the principles of normalization, and did not encourage or enhance an environment of ongoing habilitation, growth, and development of the individuals served by the Facility. For example: ▪ Throughout the week, individuals were observed to have dirty and uncombed hair, poorly fitting clothing, glasses in need of repair, and a lack of materials to keep them engaged and interested. ▪ The condition of the Aspen Unit (772A and 772B) was particularly disturbing. Common living areas were devoid of any materials other than chairs and tables.	

#	Provision	Assessment of Status	Compliance
		This is not a home-like environment by any standard. ▪ Further concerns exist regarding the number of people living together in any one home. There may be seven to 22 residents living together, many of whom exhibit challenging behaviors. This created an uncomfortable living situation that, in all likelihood, contributed to the continuation of problem behavior. Frequently, opportunities to assist individuals to acquire new skills or maintain ones they had were lost. For example: ▪ One woman was observed leaving the pool. Although she had her swimwear in a bag, her clothing was wet, apparently due to staff not teaching/prompting her to ensure that she was completely dry before putting on her clothes. Approximately 45 minutes later, she was observed in her home in the same wet clothing. It was then that she was prompted to change. ▪ Individuals may have been placed on dietary restrictions for a range of valid reasons, yet there were not alternative supports designed to help the person tolerate this change in his/her life. Some individuals might be able to learn to manage their own diets. For example, individuals could be taught that they could have unlimited access to some foods, listed on a green diet sheet. Other foods would be designated on a yellow sheet, indicating that limited access (specific amounts identified) to these was allowed each day. Other foods could be identified as off limits, on a red sheet, except during special occasions. The individual could be taught to record the foods consumed, and then could be reinforced for following their dietary guidelines. ▪ In one home visited, Individual #94 was seated in the living/dining area with her housemates for approximately 40 minutes waiting for dinner to be served. When staff were asked why the woman appeared so distressed because she was crying fairly constantly, the response was that she cries when she knows it is time to eat. This is an example of a situation where this individual should have been engaged in some alternative activity prior to the meal being served, rather than anticipating the meal for 40 minutes. ▪ Individual #459 worked at a local community grocery store. He, apparently, was independently taking the bus back to the Facility at the end of his work shift, if a staff member did not arrive in time to transport him back to the Facility. Rather than viewing this as an opportunity to teach this individual to safely use public transportation, this was viewed as a problem that had to be addressed and eliminated. On a positive note, the staff members who participated in the Personal Support Planning Meeting for Individual #305 were most respectful to the individual, taking time to explain the purpose of the meeting, and the steps involved in the process. They also were very responsive to the individual's mother who participated via conference call.	

#	Provision	Assessment of Status	Compliance
		Two issues related to habilitation that were not adequately addressed by the team included: a) when discussing sensory activities as methods to aid in calming, objective measures needed to be developed and implemented to determine efficacy; and b) prior to identifying times to wake the individual for toileting purposes, it was critical to obtain baseline measures of nighttime bed wetting.	
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.	At the time of the review, the current policy at AUSSLC required that individuals' needs be assessed at a minimum of once every three years using the Inventory for Client and Agency Planning (ICAP). Of the 54 Personal Support Plans reviewed, all but six reflected compliance with this policy. This reviewer was unable to locate an ICAP summary for Individual #448. For Individual #406, there was a note that the ICAP was being updated, and for Individual #212, there was a note that the assessment needed to be updated. Although the ICAP for Individual #326 was completed almost four years previously, the note suggested that the results were still current. This was not consistent with the Facility's policy, and most likely was not an accurate reflection of the individual's current strengths and needs. Concerns remain, however, as an assessment once every three years is not sufficient to determine an individual's strengths and needs because they change from year to year. Further, the ICAP is not an adequate assessment tool with regard to providing a comprehensive assessment of the individual's preferences and needs related to all domains of life. The State and staff at AUSSLC are to be commended for introducing the Positive Assessment of Living Skills (PALS) to help determine appropriate skill acquisition programs for individuals. This 16-section assessment addresses the following areas: self-determination, self-care, adaptive equipment, communication, sensory characteristics, relationships, home living skills, meal management, time management, leisure, campus living, money management, conceptual skills, telephone skills, mobility skills, and community living. Twenty-five out of the 54 of the Personal Support Plans reviewed indicated that this assessment had been completed in either 2009 or 2010. A review of five recent assessments using the PALS suggested, however, that not all areas of need were evaluated. For example: ▪ For Individual #263's assessment dated 2/8/10, only four areas were assessed, including self-care, personal management under sensory characteristics, cleaning and organization under home living, and money management. ▪ For Individual #406's, assessment dated 2/16/10, only five areas were assessed, including self-care, communication, sensory characteristics, home living, and money management, all of which were incomplete. ▪ The assessment completed on 2/8/10 for Individual #22 was more comprehensive with nine sections completed.	

#	Provision	Assessment of Status	Compliance
		▪ Only four areas were assessed for Individual #133 (no date of assessment was provided, but the goals were written for 2010-2011). ▪ The last assessment provided for Individual #28 was completed on 1/5/10, and may not have been copied in full. The sections that were provided suggested that only five areas were assessed with four of these sections incomplete, including home living, meal management, leisure, and community living. The Vocational CAPPS Summary was reviewed for two individuals. While this document provided important information about work related skills, it did not provide an assessment of job preferences.	
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:	The staff at AUSSLC should be commended for the emphasis placed on Person Directed Planning. A review of the materials used in training this approach to intervention included valuable information. Of particular note was the comprehensive review of guardianship. However, there were a couple of areas of concern, including: ▪ One area of concern was a skit that was included in the materials provided in document TX-AU-1004-V4. A part of the skit included a speaker stating: "Look it's the DOJ/Columbus fairy, 'Ohhhh no!!!'" This is followed by the following description: "[Settlement Agreement Coordinator] walks by holding a sign, (with DOJ and Columbus sign on her) 'I'm going to close you ALL down if you don't let her have it' and laughs in an evil laugh. She waves her magic wand." This does not encourage staff to respect the seriousness of the implementation of the SA, nor does it encourage a positive working relationship with the Monitoring Team. ▪ Further, in the same training packet, there were examples of addendums to Personal Support Plans. The examples incorporated the names of actors, performers, and Disney characters. By using real case scenarios with names redacted or changed, a greater level of respect for individuals, and appropriate training in the process may result. A review of data collection systems was conducted. Instructions on Data Collection/Progress Summary sheets often noted that staff should "…record the level of assistance required to do each step." Yet a review of data collected indicated that staff either recorded a "Y" or "N" regarding performance. Only one data point was recorded on days of data collection, and in some months data was recorded only four to five times. Other data sheets, labeled "Tracking Sheets," reflected one data point per month that identified the level of prompting required for completion of the objective. This data was insufficient to determine an individual's progress on an objective. This results in an inability of staff to accurately determine the need for revisions to be made to programs to ensure progress. It was difficult to determine whether training was provided on a daily basis, several times each week, or only one to two times each month. Reports found in	

#	Provision	Assessment of Status	Compliance
		sampled Personal Support Plan Quarterly Reviews also noted missing or "substandard" data collection and training implementation. Without sufficient training on all skill acquisition programs, the likelihood of growth and development is poor. Equally concerning were the reports of direct support professionals when asked about their ability to carry out their job responsibilities. With the staffing shortages experienced at AUSSLC, it was extremely difficult for staff to spend the time needed to effectively teach the skills identified in individuals' Personal Support Plans. As noted by one staff member interviewed, "… data collection is not accurate…we can't do the training objective… we do the best we can." Until an adequate number of staff are hired and effectively trained, there will be little likelihood that the needs of the individuals will be addressed. During the next monitoring visit, the Monitoring Team will review the assessment process in greater detail, and provide the Facility with additional information about changes that need to be made to the system.	

	(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	A review of a sample of Specific Training Objectives identified a number of concerns. These included:
		▪ For many of the objectives reviewed, there were prolonged periods of time, for example, three to four months, during which the individual must demonstrate performance at the established acquisition criterion. However, it was often unclear how many trials of the skill were expected on each designated training day.
		▪ In other cases, training was limited to only one day per week (for example, objectives for Individual #160, the objective for making chocolate milk for Individual #123, and the objectives for Individual #364). Individual #448 was to learn to tolerate the dentist's chair, but she was scheduled to practice this activity only one time each month. Such limited opportunities for training do not ensure skill acquisition.
		▪ Further, there were not always clear descriptions of the behavior the individual was expected to perform. For example, Individual #160's objective to focus on work was not clearly defined.
		▪ In many cases, the objective indicated that the individual would perform the skill with one or more verbal prompts from staff without clear guidelines for the development of independent performance, with a fading of these prompts.
		▪ Other concerns regarding specific individuals included the following:
		  o Individual #94 was expected to complete 20 units of work. The reinforcer for work completion was verbal praise delivered to this person who is deaf.
		  o Individual #304 was learning to place an item in the location indicated	

#	Provision	Assessment of Status	Compliance
		(through a pointing gesture) by a staff member. It was unclear how this was a functional skill for this individual. This same individual was expected to learn to leave completed items in a designated area, because she was reported to throw materials often. Although there was a note that she had no motivation to complete work, if she did do her work, she was to be praised. For an individual who had "no" motivation to work, praise likely was not a sufficient reinforcer for the development of this skill. o Several objectives for Individual #212 indicated that she enjoyed participating in sensory activities, yet in the training section there was a note that she will push sensory materials away or mouth her clothing. It was unclear how her assumed preference for these activities had been determined, particularly because she appeared to engage in some clear escape behaviors. o Individual #344 was expected to learn to use a "hip talker." However, there was a note that he did not like to use or wear this device. o There was an objective for Individual #139 that described her learning to brush her gums and tongue. However, the specific target behavior was learning to brush her teeth. Under the method section, there was a note advising staff to ensure that she does not brush her gums, which was inconsistent with the stated objective. Further instructions noted that this skill should be taught using a backward chain, but there were not clear instructions for implementing this type of teaching strategy. Finally, the objectives noted that staff should record if there were problems or refusals. There were no further guidelines. It was unclear whether refusals triggered a revision to the program, and if so, how many refusals must occur before this was brought to the attention of the appropriate staff member.	
	(b) Include to the degree practicable training opportunities in community settings.	While all Personal Support Plans indicated that the individual would have the opportunity to participate in both on and off campus activities on a regular schedule, there was evidence of objectives written to address acquisition of specific community-based skills in only seven out of the 54 plans (13%) reviewed, including for Individual #175, Individual #304, Individual #206, Individual #335, Individual #238, Individual #326, and Individual #124. Each of these objectives focused on making a purchase. Opportunities for participation in off-campus activities ranged from one time per month to four times each month. Further there was no planning for the generalization of identified skills to community settings.	

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

1. As is discussed with regard to Section D of the SA, a priority needs to be placed on the recruitment of capable staff, followed by a commitment to providing appropriate training, supervision, and support to all direct support professionals.
2. Consideration should be given to enhancing the overall quality of the environments in which the individuals live, work, and recreate. To promote adequate habilitation and skills training, individuals should have access to materials that are of interest to them, that are in good working order, and that support the development of functional skills. Homes should be cleaned daily with damaged or broken furnishings replaced in a timely fashion. Particular attention should be paid to individuals' hygiene/grooming, and their access to comfortable and attractive attire.
3. Strategies also should be developed to help enhance overall active engagement. This may include the hiring of additional staff, acquisition of additional and varied materials, expanded range of activities available, including vocational opportunities, and enhanced supervision of staff and training in all environments. A system of conducting regular PLACHECKS will allow the Facility to gain important information, while also providing positive feedback and constructive criticism to ensure continued improvement.
4. Assessment of adaptive behavior should occur at a minimum of once each year. The PALS or some similar tool should be used, because it offers a more comprehensive assessment of an individual's skills than the ICAP. Following a complete assessment of the individual's needs, objectives should be designed to help the individual develop functional skills that will allow for greater independence and improved quality of life.
5. During PSP meetings, for each individual, community settings should be identified in which skill acquisition goals and objectives will be implemented to enhance the goal's meaning and function.
6. Preference assessments are also recommended to ensure that potentially effective reinforcers are incorporated into all training objectives.
7. Further, it is recommended that individuals with training in Applied Behavior Analysis or special education be recruited to help develop specific objectives for individuals and to train staff in effective teaching techniques.
8. Competency-based training is recommended for all direct support professionals so that training objectives can be implemented as designed. Ongoing contact between those teaching the individuals and those developing the teaching plans should occur to ensure that problems are addressed in a timely manner so that individual growth and development is maximized.
9. It is recommended that skill acquisition programs be written to include the following: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill. Additionally, there should be a comprehensive list of the materials needed and any necessary preparation of the environment prior to a teaching session. The number of trials expected on each designated training day should also be noted. Lastly, specific guidelines for teaching the skill must be provided. This should include relevant discriminative stimuli, prompting strategies, shaping guidelines, and steps involved in teaching a behavior chain.
10. Data on skill acquisition programs or training objectives should be presented graphically to ensure appropriate monitoring of individual progress, and resulting program revision when necessary. Data should also be collected on the maintenance and generalization of newly learned skills.

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 10/30/09; o List of Individuals Referred to Community since July 1, 2009; o List of Individuals who Have Requested Community Placement since July 1, 2009; o List of Individuals who Have Transferred to a Community Setting since July 1, 2009; o List of Individuals Assessed for Placement since July 1, 2009, revised; o List of Individual Placed in the Community since July 1, 2009; o List of Alleged Offenders Committed to the Facility Following Court Ordered Evaluations; o List of Community Training Educational Activities from 7/1/09 through 3/5/10; o Description of the Community Living Options Information Process (CLOIP); o DADS CLOIP Notification Worksheet Complete Monthly Reports, for July 2009 through February 2010; o List of Individuals who Have Had a Community Living/Discharge Plan Developed since July 1, 2009; o Community Placement Obstacles From 2/25/09 to 2/25/10, dated 2/25/10; o AUSSLC Community Placement Report, for the period between 7/1/09 and 2/28/10; o For the week of the onsite visit, lists of: facility meeting related to transition and discharge, meetings with MRA staff regarding transition and discharge, post-move monitoring visits, and individual and/or family training or educational activities; o Description of Training Curricula Related to Community Living; o Community Living/Discharge Plan (CLOIP) format; o Post-Move Monitoring Checklists for the following individuals: Individual #20, o Draft Community Living Discharge Plan for individual moving from Corpus Christi State Supported Living Center to the Austin area; o Position Description for Admissions/Placement Coordinator (APC), undated; o Position Description for Post Move Monitor, undated; o Most recent PSPs, PSPAs, related assessments, Specific Program Objectives (SPOs), and monthly/quarterly reviews for the following individuals: Individual #177, Individual #393, Individual #146, Individual #8, Individual #459, Individual #276, Individual #218, Individual #339, Individual #401, Individual #277, Individual #242, Individual #360, Individual #233, Individual #94, Individual #93, Individual #291, Individual #263, Individual #409, Individual #32, and Individual #68; o Most recent PSP, related assessments, Community Living/Discharge Plan, site review documentation prior to the individual's move to the community, and post-move monitoring documentation for the following individuals: Individual #391, Individual #240, Individual #20, Individual #209, and Individual #176

	▪ **Interviews with**: o Mary Birdsong, Admissions/Placement Coordinator; o Holly Lindsey, Post-Move Monitor; o Individual #459; o Individual #133; and o Individual #291 ▪ **Observations of**: o QMRP Meeting, on 4/5/10; o Post-Move Monitoring Visit for Individual #20, on 4/6/10; o Visits to various homes and day programs on campus; and o Telephone CLDP meeting for individual moving from Corpus Christi SSLC to a community home in the Austin area, on 4/7/10
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Individuals' PSPs did not consistently identify all of the protections, services and supports that needed to be provided to ensure safety, and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. PSPs, including the Living Options Discussion Records (LODRs), also did not clearly identify barriers to individuals moving to the most integrated setting appropriate to meet their needs. As a result, action plans to address such barriers had not been identified. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Although it appeared from the narrative portions of the CLDPs that teams had discussed thoughtfully many of the essential supports required by individuals, teams did not consistently translate this discussion into a clearly identified set of essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to, and after the individual's transfer to the community. Post-move monitoring had not been completed for all of the individuals who had transitioned to the community. For the sample of five individuals reviewed, 25% of the required visits had occurred. The post-move monitoring that had been completed identified some issues with regard to the provision of services at the community sites. The follow-up to rectify issues identified appeared to be rigorous, and included notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community Mental Retardation Authority staff of the need for follow-up.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from AUSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. Facility staff raised concerns, however, regarding the absence of Medicaid Waiver slots between approximately May 2009 and September 2009, and the ongoing impact that this had with the community provider system. As has been discussed in other reports, individuals who had been expected to transition during this time period, had their transitions put on hold pending the availability of Waiver funding that would become available with the start of the new fiscal year. This appeared to be due to the State running out of Waiver slots/funding to accommodate the need for them. The hold that was put in place affected some of the individuals at AUSSLC whose teams had recommended that they transition to the community. As staff at the Facility reported, because some transitions were underway, providers had a number of up-front costs, such as purchasing or leasing homes, hiring staff, training staff, etc., that an unexpected hold on transitions significantly impacted. Unless a provider had significant reserves, it was difficult to withstand such a freeze on funding availability. Understandably, according to Facility staff, for some providers, this experience had made them reluctant to consider opening new homes and/or day/vocational programs.	

#	Provision	Assessment of Status	Compliance
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	In response to the Monitoring Team's pre-visit document request, the Facility did not provide any Facility policies related to transition and discharge. If the Facility is adopting the State's policy in full, this should be indicated in its policy manual. If not, then a Facility policy should be developed/revised to address transition and discharge processes and practices.	
	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 two major requirements of this section of the SA are discussed separately below: Identification in PSP of needed protections, services and supports: As is further discussed in the section of this report that addresses Section F of the SA, as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals needed to ensure their safety and the provision of adequate habilitation. In all of the PSPs reviewed, concerns were noted with regard to their completeness. Some of these issues related to thorough and adequate assessments not being completed (e.g., nursing, physical and nutritional management, and communication); services and supports not being adequately integrated with one another (e.g., psychology and dental/medical, nursing and dental, and medical and habilitation therapies); protections, services, and supports not being adequately defined, such as a lack of specificity about the supports that direct support professionals need to provide to protect and support individuals with regard to behavioral, therapeutic, or healthcare issues; and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychology and habilitation, physical and nutritional supports, and communication). A Living Options Discussion Record (LODR) was included as part of individuals' PSPs. In the 20 PSPs reviewed, there were various versions of this form that included different sections. The LODRs variably included an optimistic vision for the person; discussion notes about the individual and LAR's awareness of community living options; preferences of the individual and LAR; the supports needed by the person served in various areas, including safety, mobility, medical, behavioral/psychiatric, work/day activities, and quality of life; MRA input and recommendations, permanency plans, as appropriate; and a determination of the most integrated setting. The quality of the LODRs varied widely. For example, the LODR for Individual #263 provided some thoughtful insights regarding the individual's mother's concerns about any potential transition to the community, documented the team's discussion regarding one barrier in particular, and set forth some of the characteristics that would be necessary in a new home to meet Individual #263's needs, as well as preferences. The LODR for Individual	

#	Provision	Assessment of Status	Compliance
		#93 provided little detail, and showed no effort to educate the individual about community options, despite the team's conclusion that: "The team agreed that [Individual #93] may not fully understand her option of living in a community setting." An additional concern about the LODRs was the lack of integration of these documents within the overall PSP. In a person-directed planning process, the discussion, for example, about the "Optimistic Vision" for the individual should lead the team's entire discussion about the protections, supports and services to be provided to the individual in no matter what setting the individual will be served. Very few statements regarding the optimistic or ideal vision were found in the sample, but those that were should not only have applied to the discussion about living options. Likewise, it was not clear why the LODR included a section that described the supports and services needed by the person. Again, the overall PSP should define these protections, supports, and services clearly. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two 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 the perspective provider agencies are able to support the individual appropriately; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. <u>Identification of obstacles and strategies to overcome them</u>: Generally, in the PSPs reviewed, obstacles to an individual's movement to the most integrated setting appropriate to his/her needs and preferences, and/or strategies to overcome such barriers were not clearly identified. In two out of the 20 plans reviewed (10%), the Living Options Discussion Record section identified some obstacles, and in one of these 20 plans (5%), a plan to overcome the stated barriers was identified. It is important to note that both of these plans were facilitated by the same QMRP. In each of these two plans, for Individual #8 and Individual #263, the team had identified one barrier, although from the narratives, it appeared that more than one barrier existed. In addition, it did not appear that the full array of strategies to overcome the barriers had been identified. For example: ▪ For Individual #263, the individual's mother was reluctant to consider transition to the community. Although the team listed a number of reasons for this reluctance, the team did not set forth strategies to overcome the mother's	

#	Provision	Assessment of Status	Compliance
		reluctance. The team did identify strategies to overcome the individual's reluctance to visit or stay in new settings in the community. The plan included action steps, but not timeframes for completion or persons responsible. A measurable, formal training objective was related to this barrier as well. An additional barrier was the individual's unwillingness to ride in a van daily. This was viewed by the team as a problem because of the need for the individual to go to a day program daily. Although the team had not contemplated this, one potential way to overcome this barrier would be to identify a home that was in walking distance of an appropriate day program. Individual #263's team is encouraged to continue to creatively address the barriers to a transition to community living. ▪ For Individual #8, her team identified her "maladaptive behavior" as the "greatest barrier to community placement." The LODR documented the guardian's preference that Individual #8 have six consecutive months with no occurrences of false allegation or other inappropriate behavior. It is important to note that such behaviors can be addressed in community settings, so the individual's behaviors were not actually the barrier. Rather, the barrier may have been the lack of availability of a provider to provide the needed supports. The team noted that the individual had a BSP that addressed these behaviors, but no additional strategies, such as identifying a provider with the capacity to provide the necessary supports in the community were identified by the team. On a positive note, the Post-Move Monitor had begun to attend a sample of PSP meetings to provide teams with feedback regarding the community living options discussion. During the review, the reviewer observed the QMRP Meeting that occurred on 4/5/10. The Post-Move Monitor participated in the meeting, and provided a handout entitled "Community Living Options Discussions." This handout, as well as the discussion that the Post-Move Monitor led during the meeting appeared to be helpful in providing the QMRPs with ideas about structuring the discussion about the most integrated setting appropriate for the individual. Based on the few PSPs that the Post-Move Monitor had monitored, she reported that teams required support in areas such as using the discussion about the optimistic vision for the individual to structure not only discussion about community placement, but also to integrate this vision into the overall plan for the individual. Another area in which the Post-Move Monitor indicated teams needed assistance was in facilitating discussions about living options with families and/or guardians who were reluctant to have these discussions.	
	2. The Facility shall ensure the provision of adequate education about available	AUSSLC, in conjunction with the Mental Retardation Authorities (MRAs), had engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. This had	

#	Provision	Assessment of Status	Compliance
	community placements to individuals and their families or guardians to enable them to make informed choices.	taken a number of forms, including: ▪ On November 6, 2009, a provider fair was held. This event was planned in conjunction with the MRAs with whom the Facility regularly works, as well as a number of providers. According to the Admissions/Placement Coordinator, the fair was well attended by individuals, staff, and families. ▪ Visits to community group homes and day programs were occurring on one Friday each month. Such visits offered individuals and Facility staff the opportunity to obtain first-hand knowledge of what community supports were available, to meet provider staff, and potentially other people with whom they could have the opportunity to live or work. The MRAs were responsible for working with community providers to offer these community exposure trips. AUSSLC Social Work staff were responsible for identifying individuals to participate in these trips. Efforts were being made to include as many individuals as possible, by ensuring that individuals who had not already had an opportunity to participate in one of the trips were provided the opportunity to do so. AUSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the MRA Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In addition, MRAs also had met with PST members to provide training on services and supports that were available in the community. For example, this occurred on 10/23/09. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This would allow someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support.	
	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,	In response to a request for a list of individuals who had been assessed for placement since July 1, 2009, AUSSLC provided a list that contained 265 names of which four (2%) were identified as having been assessed as appropriate to "move from campus to community." However, the accuracy of this list is questionable. The Facility also provided a list of individuals who had been referred to the community since July 1, 2009. This list contained 12 names. Presumably, each of these individuals' teams had recommended transition to a community setting. However, only one of the 12, Individual	

#	Provision	Assessment of Status	Compliance
	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.	#391, was identified on the list of individuals who had been assessed as being appropriate to "move from campus to the community." This column was marked "No" for the remaining 11 individuals. This discrepancy was confirmed through record review. For example, Individual #459's PSP, dated 8/12/09, clearly identified the team's decision to refer him for transition to the community. He was on the list of individuals referred to the community, but on the list of individuals assessed for placement, the column for "move from campus to community" was marked "No." In reviewing a sample of PSPs, teams had completed the Living Options Discussion record including a section in which teams documented their decision with regard to the "most appropriate living option for the individual at the current time." At times, it was unclear what criteria teams were using to make their decisions. This was complicated by the fact that barriers to placement were not consistently identified. The following provides an example of this issue: ▪ Individual #93's LODR provided minimal information. As noted above with regard to Section T.1.b.1 of the SA, despite concluding that the individual did not understand her options, the team did not develop a plan to assist her in gaining a greater understanding. The team documented its discussion of the supports Individual #93 would require in the community, all of which appeared to be fairly easily provided. However, the team's conclusion was that Individual #93's "current placement remains appropriate." During upcoming monitoring visits, the Monitoring Team will continue to review the Facility's progress in this regard, including the process being used by team to assess individuals for placement.	
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:	Community Living Discharge Plans were reviewed for five individuals. This sample was drawn from the list of 10 individuals who at the time of the review, had transitioned to the community since July 1, 2009. At AUSSLC, the CLDPs contained a substantial amount of extremely valuable information regarding the individuals, and their needs for protections, supports, and services. However, the narrative information included in the plans was not consistently translated into measurable action steps, and/or essential supports and services. The process that was in place at AUSSLC needs to be refined to ensure that individuals are provided the supports they need when they move to the community. This is discussed in further detail below. With regard to timeliness, based on the documentation provided for the sample of five individuals who had transitioned to the community, the Monitoring Team could not determine exactly when the individual had been accepted for, and the individual or LAR	

#	Provision	Assessment of Status	Compliance
		agreed to services in the community setting. The CLDPs did not include dates on which these decisions had been made or communicated. However, for all but one of the individuals, the CLDP was developed a couple of weeks prior to the individual transitioning to the community. Individual #176 was the one exception. Her CLDP was developed approximately a month and a half before her transition. Individual #391's CLDP was completed on the same day as his discharge. For the remaining three individuals, their CLDPs were developed approximately two weeks prior to their transition to the community. A couple of weeks did not appear to be adequate time for a transition plan to be developed and adequately implemented. It is recommended that this process begin much earlier.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, the CLDPs did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and the steps that were identified were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. The monitoring activities were identified in the CLDPs, including the role of the MRA, as well as the role of Facility staff in the post-move monitoring and follow-up process. The following provide examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process: ▪ Generally, all of the individuals who were transitioned had some plans being implemented at the Facility, such as Behavior Support Plans, Physical and Nutritional Management Plans, and Nursing Care Plans. None of the five CLDPs (0%) defined the Facility staff's role in assisting community provider staff to learn about these plans and their implementation. ▪ Although based on interview, it appeared that AUSSLC staff were assisting in the transition by accompanying individuals to their new homes, and attending portions of pre-move visits, this was not formalized in the CLDPs reviewed. Sometimes this was mentioned in the narrative regarding activities that had occurred before the meeting. But again, because the CLDPs were being developed sometimes days before a transition, these activities were not defined as measurable action steps.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be	Based on the sample reviewed, teams generally identified target dates for the completion of actions steps included in CLDPs. However, teams did not consistently identify the persons responsible for action steps included in CLDPs for which Facility staff or others were responsible. Rather, the name of the provider agency or "MRA" was listed.	

#	Provision	Assessment of Status	Compliance
	completed.		
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	From the sign-in sheets provided with the five CLDPs that were reviewed, all of the teams (100%) had reviewed the CLDPs with the individuals and their guardians prior to transition from the Facility to the community. Community provider staff also participated in the meetings.	
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.	It was unclear what process was in place to ensure that written updates to assessments were completed within 45 days prior to the individual's leaving the Facility. The five CLDPs reviewed did not include the dates of the assessments referenced in the documents. The assessments that the Facility provided to the Monitoring Team for review were those that had been completed for each of the five individuals' most recent PSPs. For none of the five individuals were the PSP assessments all conducted or updated within 45 days of the individuals' transitions to the community.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The five CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was still refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. In some instances, team had clearly discussed a number of essential supports, and these were listed in the narrative section of the CLDP. However, the majority of these supports had not been translated into the chart that listed the essential supports, and that was used by the Post-Move Monitor to ensure that necessary protections, supports, and services were in place. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. These factors made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. The following provides only a few examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ For Individual #391, the narrative of his CLDP included a description of a number of essential supports. For example, the narrative stated that Individual #391 "has threatened suicide several times while at the AUSSLC and needs professionals available who can evaluate the credibility and risk of him attempting to hurt himself. He also, when upset, has threatened to kill staff members and/or his parents prior to engaging in targeted behaviors. [Individual #391] needs staff who can, if necessary, restrain him and attempt to	

#	Provision	Assessment of Status	Compliance
		calm him. If unable to do so staff need to be able to maintain the restraining until he receives emergency medication, if deemed necessary by a physician/psychiatrist to support behavioral management." However, the grid that included essential and non-essential supports did not identify these specific supports. For example, the grid stated that Individual #391 needed 24-hour awake staff, staff who were trained on the BSP, and the provider had to have a "working arrangement with a psychologist and psychiatrist." Measurable supports such as a psychiatrist/physician who was available 24 hours a day, seven days a week to order emergency medication as needed, a psychologist with expertise in working with individuals with intense behavior needs who would be available on an on-call basis, staff who were competent in the application of restraint, and/or the level of staffing (e.g., a ratio) were not included. The narrative of his plan also stated that Individual #391 "has shown a preference for male staff members. He seems to comply more readily with individuals who relate to him in a friendly, upbeat manner. Such individuals are usually either in their twenties, or bigger and taller men…" These preferences were not incorporated into his essential/non-essential supports. Although a provider agency may not be able to guarantee such a configuration of staff, these preferences should have been incorporated into the plan as a goal for the provider to work towards, at a minimum, involving such individuals in Individual #391's life. ▪ Individual #20 had a BSP that addressed pica. His CLDP clearly indicated that he needed a "home and yard free of small objects." However, the CLDP did not include the same requirements for his day program. As noted below with regard to Section T.2.a of the SA, the Post-Move Monitor found that his day program was not free of small items that he could ingest, and toxic substances had not been locked during one visit. Although the Post-Move Monitor was addressing this issue with both the day program provider, and the residential provider who contracted for day program services, the CLDP did not identify an environment free of potential pica objects as a requirement for the day program. The involvement of a psychologist was included in the plan as a non-essential support that could be provided within the first 30 days after the transition occurred. For an individual with a significant history of pica as well as other behavioral issues, this was not adequate. Moreover, the only requirement for the individual's day/vocational program that was included in the CLDP was that the "Individual is enrolled in and attending a day program he enjoys." For an individual who requires close supervision and was reported to have difficulty remaining on task, this broad requirement was not sufficient to ensure that Individual #391 had a day program that adequately met his needs. His CLDP identified a number of his preferences, such as for walks, trips on which he could purchase items such as ice cream, and areas that were not crowded or noisy. His	

#	Provision	Assessment of Status	Compliance
		team could have utilized some of his preferences in setting forth the requirements for day activities. The team also could have identified in more detail the level of supervision that Individual #391 required in a day/vocational setting to ensure that he was both engaged, and safe. With regard to Monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, this appeared from the records reviewed to consist of a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared to be based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions do not represent adequate proof that the essential services required by the CLDPs are in place. None of these forms for the sample reviewed provided any additional documentation to show that the MRA representatives had actually confirmed that the individualized essential supports were in place.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	AUSSLC was at the beginning stages of developing the quality assurance processes to address this component of the SA. The QE processes that were in place for the PSP planning process are discussed in detail above with regard to Section F.2.g of the SA. The monitoring tool discussed in that section, the Personal Support Plan Meeting Monitoring Checklist, included a number of appropriate indicators addressing the Living Options discussion and planning components. In fact, three of the six completed forms (50%) identified issues with some component(s) of the living options discussion, and/or resulting planning process. However, as it noted above, the Facility's QE Department had not yet begun aggregating the information gained from these tools so that systemic issues could be identified, analyzed, and addressed. In addition, tools to review the quality of the PSPs themselves were still in the development stages. In addition, the Post-Move Monitor had begun to attend a sample of PSP meetings. As the Post-Move Monitor explained to the QMRPs during the 4/5/10 QMRP meeting, the State had recently initiated a process of having the Post-Move Monitor attend a sample of approximately 20 PSP meetings a month to provide technical assistance, as well as to monitor teams' living options discussions. It did not appear that a formal process was in place, for example, a specific monitoring tool, to document the findings of this monitoring. As it was explained, information was going to be provided to the APC, and	

#	Provision	Assessment of Status	Compliance
		sent to the State based on observations of team meetings. Based on staff interview, Facility staff had been told that State Office was in the process of deciding on a more formal format for capturing this monitoring information.	
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.	Based on a review of PSPs and interviews with staff, AUSSLC was at the very initial stages of identifying obstacles to placement on an individual basis. As a result, the Facility had not yet collected sufficient data for analysis and submission of a report to the State. The Monitoring Team looks forward to reviewing such reports as part of future reviews. The Facility had collected information about the barriers for a small group of individuals, including individuals who had requested community placement, but whose teams had not recommended transition to the community. The resulting report was entitled "Community Placement Obstacles from 2/25/09 to 2/25/10." The report listed eight individuals, with the obstacles to referral from community living, and summarized this data. The reasons listed included "LAR Choice" for 75 percent of the individuals, "Behavior/Psychiatric" for 12.5 percent, and "Citizenship/Funding Issues" for 12.5 percent. No plan to address the issues identified was included with the information. This analysis showed the beginning stages of identifying obstacles in an aggregate fashion. However, as this document illustrated, it would be more helpful if obstacles to placement were more specifically defined. The broad categories of "LAR Choice," and "Behavior/Psychiatric," for example, provided little information about what the obstacle or barrier was. In order for the State and the Facilities to adequately address barriers, they should be: 1) defined with sufficient detail to allow the State to identify and address issues related to the current community system; and 2) identify the protections, supports, and/or services that are currently lacking or not available to allow transition to the community. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, or the timeliness with which services can be accessed in the community (e.g., certain types of medical services) may be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.	

#	Provision	Assessment of Status	Compliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not 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.	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. The report listed individuals who had been referred by their teams for community placement between 7/1/09 and 2/28/10, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. The list included 12 names of individuals referred, none of whom had had their referrals rescinded. The second page of the document listed nine individuals who had been transitioned to the community during this time period.	
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	Timeliness of Checklists: The SA anticipated that post-move monitoring would commence by December 26, 2009, for individuals transferred to community settings. To obtain a baseline measurement with regard to this activity, the Monitoring Team	

#	Provision	Assessment of Status	Compliance
	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.	requested a sample of the post-move monitoring checklists for five individuals. Based on the documentation provided, two of the five individuals (40%) had had post-move monitoring visits conducted. Of the 12 required visits, three (25%) had been documented as having been completed on time. At the time of the review, the Post-Move Monitor had only been working at the Facility for five weeks. Hopefully, with the addition of this staff person, the visits will be conducted as required. In fact, this staff person already had conducted some extra visits to individuals whom she and the APC agreed needed additional oversight and monitoring. <u>Content of Checklists</u>: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists completed had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if onsite visits were conducted, which documents were reviewed, and if staff and/or the individual were interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place. 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. Generally, it appeared that issues were being identified, and followed through to conclusion. Notes identifying actions taken were documented on the forms. Often, this appeared to involve relentless follow-up activities, including calls to the provider agency, as well as the MRA. This illustrated a strong commitment to ensuring that individuals receive the protections, supports and services that they need. This is commendable, and should continue.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely	On 4/6/10, the reviewer accompanied the Post-Move Monitor on a visit to the community day program of Individual #20. As is discussed above with regard to Section T.1.e of the SA, this individual had a behavior plan that addressed pica, a behavior that had the potential to place this individual at risk. The Post-Move Monitor thoroughly reviewed the environment, interviewed staff, and reviewed records. However, all of these activities were not completely documented on the monitoring form. The Post-Move Monitor identified a number of issues, and documented these on the form. She also conducted and documented extensive follow-up with both the day program provider, as well as the residential provider who had the contracting responsibility with the day program provider. Particularly, given the fact that the CLDP did not include any essential	

#	Provision	Assessment of Status	Compliance
	for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	supports with regard to day activities, and the only non-essential support was that the individual have a day program that he enjoyed, the Post-Move Monitor effectively reinforced the need for the individual to: 1) have a pica-safe environment; 2) be engaged in self-help skills, such as feeding himself; and 3) have access to recreational options identified in his CLDP. As is discussed above with regard to Section T.1.e, one of the reasons that the clear and complete identification of essential and non-essential supports is of utmost importance, is to facilitate the post-move monitoring process. If the Post-Move Monitor was only following the essential and non-essential supports identified in CLDP for Individual #20, the only review she would have completed at the day program would have been a review to determine if he enjoyed his placement. For an individual with the critical need for supports with regard to his pica behavior, this would have been wholly inappropriate. One of the issues that the Post-Move Monitor addressed verbally with both the day and residential providers was the total lack of any meaningful activity provided for Individual #20 during the review. Likely because the requirement was that he "enjoy his day program," this was not included in the written report. The day provider indicated that Individual #20 was difficult to engage in activities. As was discussed above with regard to Section T.1.e. of the SA, Individual #20's CLDP did not adequately define the day services that he required, including for example, the need for particular staffing ratios, the type of activities related to his preferences that should be available on a regular basis, and/or the type of therapeutic supports that should be available to assist staff in designing programs that would be beneficial for and of interest to Individual #20. Such definition would have both assisted in ensuring that the residential provider contracted with a day provider who could effectively meet the individual's needs, as well as facilitating the monitoring process designed to ensure that the individual had the supports he required.	
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)		

#	Provision	Assessment of Status	Compliance
	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 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.	Between 7/1/09 and the time of the review, there had been no alternate discharges of individuals served by the Facility.	

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

1. The State should ensure that funding requests are made to the legislature to facilitate the transition of individuals from the Facility to community settings, as recommended by individuals' teams, and agreed to by the individual and LAR.
2. If the Facility is adopting the State's policy on the Most Integrated Setting Practices in full, this should be indicated in the Facility's policy manual. If not, then a Facility policy should be developed/revised to address transition and discharge processes and practices.
3. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
4. Consideration should be given to beginning the process of developing the CLDP much sooner in the transition process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
5. Consideration should be given to identifying essential and non-essential supports as a standard part of developing annual PSPs. In addition to the resulting documents being helpful to direct support professionals and others at AUSSLC, it would begin this process much earlier for individuals who eventually transition to the community.
6. Essential and non-essential supports need to be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process needs to be better defined.
7. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) may be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
8. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.
9. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.
10. With regard to Post-Move Monitoring, clear expectations should be established with regard to the process that needs to be used for monitoring, and the documentation that needs to be maintained.
11. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place, and/or steps being taken by the provider agency to ensure that such supports and services are provided.
12. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.
13. If the MRAs are going to continue to be responsible for ensuring that essential supports are in place before the individual departs from the Facility, then the process for confirming this needs to be substantially improved. As required by the Settlement Agreement, the State needs to ensure that supports considered to be essential to the individual's health and safety are verified as being present. This will require more than conversations with staff, but will entail onsite monitoring, review of documentation, observations, as well as interview. Documentation should include verification of each and every essential support identified in the CLDP, as well as the methodology used to verify their existence.

14. With regard to monitoring activities related to the Facility's performance with regard to this section of the SA, the Facility should:
    a. If not already done, set expectations with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, and the follow-up activities that are expected to occur; and
    b. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC policy entitled Refusal of Treatment by Individual or Parent/Guardian, dated July 2004; o AUSSLC policy entitled Individual/Legally Authorized Representative "Decision-Making Authority" for Treatment and Services, dated January 2008; o AUSSLC policy entitled Human Rights Committee, dated February 2004; o AUSSLC policy entitled Appeal of Agency and Human Rights Committee Decisions, dated May 2000; o AUSSLC Guardianship Status list, undated; o AUSSLC WH Guardianship Status list, dated 3/10/10; o AUSSLC Guardianship Status list, dated 3/9/10; o AUSSLC TC Guardianship Status list, dated 2010; o List of individuals by home with guardianship status, requested on site, undated; o Positive Assessment of Living Skills, undated; o Inventory for Client and Agency Planning, copyright 1986; o List of Residents Obtaining Guardianship Since July 2009; and o List of Residents Referred for Guardianship Since December 2009 ▪ **Interviews with**: o Leslie Banks, Social Worker
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: At the time of the review, DADS Central Office was still in the process of developing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. AUSSLC did not have a specific guardianship policy, but had some policies related to the informed consent decision-making process. The Social Work staff at AUSSLC had assigned priority ratings to individuals needing guardians based on information obtained from individuals' teams. Of the 389 individuals served by AUSSLC at the time of the review, approximately 133 (34%) did not have a current guardian, and according to staff, almost all of these individuals needed a guardian. However, the assessment tools being used by the Facility were inadequate to assist teams in identifying an individual's specific capacities or incapacities for providing informed consent in various areas, and/or in identifying supports that could potentially increase an individual's decision-making capacity. AUSSLC was in the process of attempting to identify guardians for individuals who needed them, and had access to some valuable resources to assist them in accomplishing this. For example:

	▪ AUSSLC was fortunate to be able to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Unfortunately, the waiting list for this program was long. It was estimated to be approximately two years. ▪ In addition, the local Travis County Probate Court operated a Guardianship Assistance Program. This program allowed family members who wanted to petition the court for guardianship to do so at no cost to the family member. ▪ The Facility also had developed an excellent working relationship with the Travis County Probate Court. Once a number of petitions had been filed for guardianship, and the necessary review process had occurred, the Facility worked with the Court to set up a "Guardianship Day." On the designated day, the Court came to AUSSLC, and held the guardianship hearings onsite. As a result of these efforts, since July 2009, 10 individuals had obtained guardians. The Facility also provided a list of 29 individuals who had been referred for guardianship since 12/09. Ten (10) of these individuals had been referred to Family Eldercare, and the remaining 19 had family members who were interested in becoming guardians, and their families had been referred to the Guardianship Assistance Program. For an additional six individuals, their families had agreed to pursue guardianship, but were doing so on their own, without the assistance of the Guardianship Assistance Program. Other families were in the process of considering petitioning for guardianship. According to staff, the week prior to the Monitoring Team's review, 66 individuals had been identified who were on the list of individuals requiring guardians, but for whom nothing was in process. In the intervening week, Social Workers had taken action for approximately 13 of these individuals. For the remaining 53, a meeting was being held to develop a plan to address their need for guardianship.

#	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	Staff indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent. This policy was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. AUSSLC did not have a specific guardianship policy, but had policies that referenced guardianship and/or consent, including: Refusal of Treatment by Individual or Parent/Guardian, dated July 2004; Individual/Legally Authorized Representative "Decision –Making" Authority for Treatment and Services, dated January 2008; Human Rights Committee, dated February 2004; and Appeal of Agency and Human Rights Committee Decisions, dated May 2000. None of these provided a description of the processes to be used for: 1) determining an individual's capacity to make informed decisions; or 2) identifying an individual's level of priority for pursuing guardianship. Based on staff interview and document review, each individual served by the Facility had been assigned a priority level for the need for guardianship. The following were the priority levels and their definitions:	

#	Provision	Assessment of Status	Compliance
	comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	▪ Priority 1 – Those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources; ▪ Priority 2 – Those who are able to express their wishes, have less restrictive programming, and may have a volunteer or advocate not affiliated with the SSLC who assists in advocating for them; and ▪ Priority 3 – Those who have current Legally Authorized Representative (LAR)/Guardians. Based on staff interview, on at least an annual basis, individuals' teams discussed the need for guardianship. According to documents provided, the assessments being used to assist teams in making these decisions included the Positive Assessment of Living Skills, and the Inventory for Client and Agency Planning. Neither of these assessment tools included an in-depth review of an individual's capacity to make decisions about various topics, for example, health care, programming, release of information, etc. Likewise, neither of these assessments was designed to identify supports that might assist an individual to make certain decisions. Staff interviewed reported that once a team made a decision or recommendation that a guardian needed to be obtained for an individual, it was the Social Worker who identified the level of priority. It is not clear why there was not team discussion regarding the priority level. Based on a list provided to the Monitoring Team on site of the current guardianship status of individuals, of the 389 individuals served by AUSSLC at the time of the review, approximately 133 did not have guardians, or their guardianship had lapsed, in some cases due to the fact that their guardian was deceased. Based on staff interview, most of these 133 individuals had been determined by their teams to require guardianship, and had been assigned a priority level. This represented approximately 34 percent of the individuals served at AUSSLC.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall	Based on staff interview as well as document review, there had been a number of attempts made to obtain guardians for individuals. For example, AUSSLC was fortunate to be able to make referrals to a private, nonprofit guardianship agency called Family Eldercare. The model used by Family Eldercare involved the use of a combination of staff and volunteers. A volunteer was frequently assigned to develop a relationship with the individual who was the subject of the guardianship, and to develop knowledge of the individual's preferences and desires. Staff members from Family Eldercare were the	

#	Provision	Assessment of Status	Compliance
	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.	care/case managers, and were responsible for the actual decision-making with input from the volunteers. Criteria for acceptance by Family Eldercare included no family involvement, or family who had clearly stated that they had no interest in ever becoming the individual's guardian. The waiting list for services from this agency was fairly long. Staff estimated that the wait time was approximately two years. In addition, the local Travis County Probate Court operated a Guardianship Assistance Program. This program allowed family members who wanted to petition the court for guardianship to do so at no cost to the family member. This resource appeared to be helpful in assisting Facility staff to identify guardians for people who needed them. The Facility appeared to be actively engaged in educating families about this program through team meetings, and Social Worker contact with families. The Facility also had developed an excellent working relationship with the Travis County Probate Court. Based on interview, once a number of petitions had been filed for guardianship, and the necessary review process had occurred, the Facility worked with the Court to set up a "Guardianship Day." On the designated day, the Court came to AUSSLC, and held the guardianship hearings onsite. This made it more convenient for family members, as well as the individuals who needed to attend the hearings. According to a list provided by AUSSLC, since July 2009, 10 individuals had obtained guardians. For two of these 10 individuals, family members had been appointed as their guardians. For the remaining eight individuals, Family Eldercare had been appointed as their guardians. The Facility also provided a list of "Residents Referred for Guardianship Since December 2009." This list included the names of 29 individuals. Ten (10) of these individuals had been referred to Family Eldercare, and the remaining 19 had family members who were interested in becoming guardians. For those 19 individuals referrals had been made to the Guardianship Assistance Program. For an additional six individuals, their families had agreed to pursue guardianship, but were doing so on their own, without the assistance of the Guardianship Assistance Program. According to staff, the week prior to the Monitoring Team's review, 66 individuals had been identified who were on the list of individuals requiring guardians, but for whom nothing was in process. In the intervening week, Social Workers had taken action for approximately 13 of these individuals. For the remaining 53, a meeting was being held to develop a plan to address their need for guardianship. For a number of these individuals, their families were involved, but not currently interested in pursuing guardianship. A referral to Family Eldercare was inappropriate for these individuals, so other	

#	Provision	Assessment of Status	Compliance
		alternatives needed to be identified. The Facility also was tracking guardianship dates in an effort to maintain current guardianships. Each year, the current guardian was required to submit an annual report to the Court. By tracking these dates, the Facility was able to offer assistance to guardians as needed to complete the annual report, thereby ensuring that the guardianship did not lapse. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators might be appointed to assist the court in evaluating the need for guardianship, as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports, as well as verbal information regarding individuals who become the subject of guardianship proceedings. A meeting is being scheduled with the Monitoring Panel and the State to further discuss the guardianship process. However, at this juncture, it is unclear what, if any, role the State views Facility staff as having with regard to guardianship proceedings.	

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

1. The State should finalize the State policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.

2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, AUSSLC should develop a policy on guardianship to reflect the State policy.
4. Based on any additional information provided in State policy regarding prioritization for guardianship, AUSSLC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as needed.
5. AUSSLC should identify additional resources for guardians, particularly for those individuals who do not have current family interest in pursuing guardianship, and are not eligible for participation in the Family Eldercare program, as well as for individuals who it is expected will be on the waiting list for a guardian for a long period of time.
6. If alternative guardianship resources cannot be identified, the State should consider seeking or providing funding for another guardianship program in the Austin area that would be responsible for the identification, training, and oversight of guardians, similar to the program offered by Family Eldercare.

<table>
<tr><th>SECTION V: Recordkeeping and General Plan Implementation</th><th></th></tr>
<tr><td></td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
Review of Following Documents:
DADS policy #020 entitled “Recordkeeping”, dated 9/28/09;
AUSSLC Retention Schedule/Purging Scheduled, dated 2/11/10;
Ordering Tabs Correctly for Problem Oriented Record (POR) for Admission, undated;
Brief Instructions for Revised Retention Guidelines – Other Hospitals, undated;
Checklist for Admissions Documents, undated;
Talking Points for Meeting about Availability of PORs for New Admissions;
AUSSLC Table of Contents for Policy and Procedure Manual;
Problem Oriented Record Audit Tool, dated 12/30/09;
Summary of POR audit findings for 2/09 (probably supposed to be 2/10 because the date of the template is 12/30/09);
POR Chart Information Summary, undated;
POR Audit Tool used prior to 2/1/10, undated;
Email from Julie Dennis to Gail Tigue, dated 1/27/10, with Subject Line “Filing;”
Email between Julie Dennis and Rhonda Stokley, on 1/19 and 1/20/10, with Subject Line “Dental Exams;”
Email from Julie Dennis to six QMRPs, dated 9/15/09, Subject Line “POR Audit;” and
List of records reviewed for each of the following months, December 2009, and January, February and March 2010
Interviews with:
Gail Tigue, Client Records Coordinator; and
Tammy Snyder, Director of Quality Enhancement</td></tr>
<tr><td></td><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td></td><td>Summary of Monitor’s Assessment: At the time of the monitoring visit, AUSSLC staff were aware of the new Table of Contents for the unified record that the State had developed. The Records Management Department had begun to develop a plan to convert the records to the new format.

Since December 2009, the QE Department had conducted at least 12 record reviews on a monthly basis. In February 2010, the audit tool being used was changed to include a more comprehensive list of items that needed to be present in the file. It was not clear that the new tool addressed all of the requirements of Appendix D of the SA. For example, it appeared that the tool was designed to determine the presence or absence of items, and, if such items were current. Requirements in Appendix D of the SA such as legibility, accuracy, appropriate signatures, proper dating of entries, etc. did not appear to be considered in the audit process.</td></tr>
</table>

	During the review, issues were noted with regard to the availability and quality of the individual records. This had the potential to impact staff's ability to utilize records in making medical treatment and training decisions. The Facility's QE staff had identified a number of similar issues. The QE Department was making efforts to inform appropriate staff about problems identified in specific individuals' records, and was developing a monthly summary report that aggregated information for the records reviewed. However, the QE reports did not appear to result in systemic actions being developed and implemented to correct existing problems.

#	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.	At the time of the monitoring visit, AUSSLC staff were aware of the new Table of Contents for the unified record that the State had developed. The Records Management Department had begun to develop a plan to convert the records to the new format. Two unified records coordinators were being hired, and the deadline for converting the records to the new format reportedly was October 2010. The Records Coordinator described a process of training the unit clerks on the new Table of Contents. Reportedly, some supplies had arrived, and others were being ordered to complete this project. While on site, the Monitoring Team identified some issues related to individuals' records. Some of these are discussed below with regard to Section V.4 of the SA. The following provide additional examples of practices that were potentially inconsistent with Appendix D of the Settlement Agreement: ▪ One of the requirements included in Appendix D is for records to be maintained securely. At AUSSLC, it appeared that different homes had different storage capacity. For example, some had locked rooms in which records could be kept, while others did not. Reportedly, some records were kept in areas such as laundry rooms, which increased the likelihood of damage or loss of records. This is an issue that the Facility should evaluate to ensure that records are maintained both confidentially and securely. ▪ While on site, it was noted that on several occasions that when an individual was sent to a community hospital or emergency room, the entire medical record was taken as well. This practice violates privacy regulations and should be stopped. Information packets need to be sent that include pertinent information for the receiving facility to safely treat the individual. ▪ A review of a number of individuals' medical records indicated that there were some problematic issues with the legibility of some of the nursing and physician notes rendering some of them impossible to read. There were several instances in which it was difficult to identify the professional title of the staff who wrote the progress note due to legibility issues. In addition, some signatures were difficult to decipher.	

#	Provision	Assessment of Status	Compliance
		▪ Also, there were inconsistencies in the use of military time on a number of forms contained in the records.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. In reviewing policies, it was noted that many had not been reviewed for over a year, and in some cases for years. There did not appear to be an expectation, or at least one that was enforced, that policies would be reviewed regularly, and updated as appropriate. It also was unclear if any review and approval process was in place, for example, by executive staff and/or State office staff to ensure the adequacy of policies and their consistency with State policy.	
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.	According to the Director of Quality Enhancement as well as documentation reviewed, since December 2009, the QE Department had conducted at least 12 record reviews on a monthly basis. In February 2010, the audit tool being used was changed to include a more comprehensive list of items that needed to be present in the file. Based on a written summary provided by the QE Department, the auditors reviewed records to ensure the following were occurring/present: ▪ Required documentation; ▪ Consultation follow-up; ▪ Medical/dental treatments; ▪ Programming; and ▪ Progress reports. Based on a sample of documentation provided, it appeared that as individual issues were identified, the QE Department made contact with staff who might need to take action. For example, in some instances, a clinician was contacted to determine if a particular examination had occurred, and in other instances, the records management department was contacted to determine if the issue was related to tardiness in filing an item in the record. The following were some of the trends the QI Department reported it had identified: ▪ Medical documentation not being found in the records; ▪ Rights assessments, PSPs, and other assessments not being found in the records; and ▪ Quarterly reports not being completed in a timely manner. The Facility also submitted summary data for February 2010. (Although the document	

#	Provision	Assessment of Status	Compliance
		was labeled as February 2009, the data were summarized on the new template that was developed in 12/09.) As is discussed in further detail below with regard to Section V.4 of the SA, this summary data identified a number of problematic trends, a number of which could result in inadequate coordination of care, and flawed decision-making. It did not appear, though, that this data had been analyzed thoroughly to determine the underlying issues, and/or action plans developed to address such issues. As is discussed in further detail above with regard to Section E of the SA that addresses Quality Assurance activities, it is essential that analysis of the data that the QE Department and others are collecting be used to improve the delivery of protections, supports, and services. With regard to the tool being used to audit records, it was not clear that it addressed all of the requirements of Appendix D of the SA. For example, it appeared that the tool was designed to determine the presence or absence of items, and, if such items were current. Requirements in Appendix D of the SA such as legibility, accuracy, appropriate signatures, proper dating of entries, etc. did not appear to be considered in the audit process.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ It was noted that a number of documents were not in the medical records and had to be located, because they had not been filed in a timely manner. This was a consistent problematic issue throughout the review process while onsite. The Medical Director, Chief Nurse Executive, and the QE Nurse verified that there were ongoing problems with record keeping due to the lack of adequate staff available to file documents in the records. For example, a number of chest x-rays were not found in the records for individuals who had positive PPDs. ▪ Based on an interview with the Dentist, medical records were not consistently brought to the dental appointments. As is noted above with regard to Section Q.1 of the SA, the Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments. This was consistent with the findings of the Facility QE Department. As noted above with regard to Section V.3 of the SA, the QE Department had been completing monthly record reviews. According to summary data provided for the month of February 2010, critical data necessary to make treatment and training decisions was missing. Although a number of documents had high rates of compliance for being present in the records, the following shows a sample of some of the problematic percentages of compliance for the 12 records the QE Department reviewed: ▪ Resuscitative status – 40%;	

#	Provision	Assessment of Status	Compliance
		▪ Special medical considerations, such as pace maker information – 66.7%; ▪ Annual Physical Exam – 66.7%; ▪ Diabetic record – 50%; ▪ Fluid Intake/Output record – 50%; ▪ Breast Exam information – 66.7%; ▪ Quarterly Drug Regimen Reviews – 33%; ▪ DISCUS – 33%; ▪ OT/PT Consultations – 70%; ▪ Vocational Evaluation consultations and/or updates – 70%; ▪ Lifetime Skills Assessments – 40%; ▪ PALS Checklist/Summary – 50%; ▪ Behavior Support Plan – 71.4%; ▪ Safety Plan for Crisis Intervention – 57.1%; ▪ Approvals, HRC Review of and Progress Notes for Safety Plan – 50%; ▪ Restraint Order form – 50%; ▪ Restraint Checklists – 57%; and ▪ Personal Support Plan Quarterly Review – 41.7%. One of the items on the audit tool addressed whether the record provided information that was adequate for use in routine decision-making. Despite the number of deficiencies noted in the records, the summary data showed that 100% of the records met this standard. It is unclear how this conclusion was drawn for records that were missing critical pieces of information, such as resuscitative status, annual physical exams, diabetic records, fluid intake/output records, quarterly drug regimen reviews, PALS checklists, Safety Plans for Crisis Intervention, etc. As is also discussed above with regard to Section V.3 of the SA, a thorough analysis of these data needs to be completed to identify the underlying causes for complete and up-to-date records not being available. These reasons could be varied. Both the QE Department and Records Management Coordinator identified potential issues, including but not limited to the varied duties of Unit Clerks, leading to delays in filing information; misunderstandings about who is responsible for filing what; staff pulling items from records and not returning them or misfiling them; and documents and/or assessments/evaluations not being completed in a timely manner. Once potential causes are more systematically identified, an action plan(s) should be developed to address the identified issues. Such an action plan should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. As the plan(s) is implemented, it should be monitored to ensure the desired outcomes are being achieved. If not, the plan(s) should be modified.	

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

1. Facility management should ensure that the Records Management Department has the support it needs to complete the conversion of records to the new format as expediently and accurately as possible, so as to reduce the impact on the delivery of supports and services.
2. Once the State issues final guidance with regard to the new format for records, the Facility should develop a recordkeeping policy, and update its recordkeeping procedures to ensure consistency with the State policies, procedures, and Appendix D of the SA.
3. The Facility needs to stop the practice of sending individuals' medical records to community hospitals when individuals are sent for evaluations and assessments. Information packets need to be sent that include pertinent information for the receiving facility to safely treat the individual.
4. Taking into consideration the need for to protect the privacy and security of records, the Facility should review the current record storage resources that are available in homes and day programs across campus, and make changes, as necessary.
5. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
6. If the monitoring of records does not yet include all of the elements of Appendix D, such as legibility and completeness of records, then modifications should be made to the tool(s) being used to incorporate these items.
7. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified. Such action plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. As the plans are implemented, they should be monitored to ensure the desired outcomes are being achieved. If not, the plans should be modified.
8. If one does not already exist, a procedure should be established for Facility policies to be reviewed regularly, updated, as appropriate, and formally approved at the Facility-level and/or State-level. Such a review should be completed to ensure compliance with the Settlement Agreement, as well as applicable laws and regulations.
9. The Facility should ensure that documents are timely filed in the medical and programmatic records, so that pertinent clinical information is readily available to clinicians and others needing this information when making decisions regarding treatments and health care services. The Facility should determine if adequate staff supports are currently available to ensure the timely filing of records.
10. The Facility needs to develop and implement a system to ensure that medical records are brought for all dental appointments.

Health Care Guidelines

SECTION I: Documentation

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

- **Review of Following Documents**:
  - Individuals' medical records as noted in previous sections

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: A review of a number of individuals' medical records indicated that there were some problematic issues with the legibility of some of the nursing and physician notes rendering some of them impossible to read. Most progress notes reviewed included the complete date and time. However, there were several instances in which it was difficult to identify the professional title of the staff who wrote the progress note due to legibility issues. In addition, some signatures were difficult to decipher.

Also, the format of the progress notes was inconsistent regarding the use of the SOAP (Subjective, Objective, Assessment, and Plan), or DAP (Data, Assessment, and Plan) format. Also, there were inconsistencies in the use of military time on a number of forms contained in the records. No inappropriate late entries were found in the records reviewed. Although there were a number of comprehensive and clear progress notes written by different disciplines, the communication between disciplines was not readily apparent from most of the notes reviewed.

While on site, it was noted that on several occasions that when an individual was sent to a community hospital or emergency room, the entire medical record was taken as well. This practice violates privacy regulations and should be ceased immediately. Information packets need to be sent that include pertinent information for the receiving facility to safely treat the individual.

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

1. The disciplines should ensure that all entries in the medical records are legible, accurate and clearly written to facilitate effective interdisciplinary communication, and to provide a means of assessing and evaluating individual care. The full signature and professional title of the writer also needs to be legible.
2. The disciplines should document communications with the interdisciplinary team members to include the content of discussions, and any health care decisions or recommendations that result.
3. The disciplines should consistently document the content of integrated progress notes concerning health problems in the appropriate format selected by the Facility (i.e., SOAP or DAP).
4. The Facility needs to stop the practice of sending individuals' medical records to community hospitals when individuals are sent for evaluations and assessments. Information packets need to be sent that include pertinent information for the receiving facility to safely treat the individual.

SECTION II: Seizure Management

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

- **Review of Following Documents**:
  - Medical records for the following individuals: Individual #48, Individual #432, Individual #29, Individual #297, Individual #193,

Individual #261, Individual #84, Individual #39, Individual #336, Individual #254, Individual #302, and Individual #327

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: A review of the medical records for 12 individuals with a seizure disorder found that there were a number of Seizure Records that were not completed by nursing. A number of the Seizure Records did not contain a set of vital signs, assessments, nursing actions, and possible precipitating factors. However, there were some Seizure Records that had exceptional documentation from the direct care professionals and nurses that included an assessment of bowel sounds to identify possible constipation. None of the records reviewed contained a graph of monthly seizure activity, or a cumulative record of seizures that occurred each year.

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

1. A system should be developed and implemented to monitor the documentation requirements regarding seizure activity.
2. Training needs to be provided to nurses regarding the documentation requirements and assessment process regarding seizure activity.
3. Statewide forms for seizure documentation should be considered that are in alignment with the Healthcare Guidelines.

SECTION III: Psychotropics/Positive Behavior Support

Steps Taken to Assess Compliance: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K).

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K) for information related to the use of psychotropic medication and Positive Behavioral Support Plans.

Recommendations: Please see the recommendations for Section J and Section K of the Settlement Agreement.

SECTION IV: Management of Acute Illness and Injury

Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION V: Prevention

Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION VI: Nutritional Management Planning	
Steps Taken to Assess Compliance: Please see sections above that address Section O of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Section O of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION VII: Management of Chronic Conditions

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

- **Review of Following Documents**:
  - Individuals' Nursing Care Plans as noted in previous Nursing sections

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: A review of Nursing Care Plans for chronic conditions such as Hepatitis, constipation, hypertension, seizures, and issues with skin integrity found that there was a significant lack of interventions addressing the prevention of complications related to the chronic condition. In addition, assessments listed in the Nursing Care Plans were only focused on the signs and symptoms of the illness, not activities or interventions designed to relieve the particular symptoms of the chronic condition. In essence, the Nursing Care plans focused on illness rather than health promotion.

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

1. Nursing Care Plans' focus should shift from assessing for only illness to health promotion and proactive, preventive healthcare.

SECTION VIII: Physical Management

Steps Taken to Assess Compliance: Please see sections above that address Sections O and P of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections O and P of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION IX: Pain Management

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

- **Review of Following Documents**:
  - Nursing Quarterlies and Annual Assessments and Nursing Treatment Plans noted in previous sections

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: The current practice regarding pain assessments at AUSSLC is to conduct an assessment every quarter on the Nursing Quarterly Assessments. However, in most cases this assessment indicated that the individual was not experiencing pain at the time of the assessment. In order to assess if the Facility is appropriately assessing and managing the issue of pain, the Facility needs to develop and implement a system to track individuals who experience chronic and acute pain so that these cases can be reviewed for compliance with the Healthcare Guidelines.

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

1. The Facility should consider developing and implementing a system to monitor and track individuals who experience both chronic and acute pain in order to assess clinical care and outcomes regarding pain management and compliance with the Healthcare Guidelines.

List of Acronyms

Acronym	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ASL	American Sign Language
AUSSLC	Austin State Supported Living Center
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BID	Twice a Day
BM	Bowel Movement
BSC	Behavior Support Committee
BSPRC	Behavior Support Peer Review Committee
BSP	Behavior Support Plan
CAPPS	Comprehensive Assessment Program Planning System
cc	Cubic Centimeter
CCC	Certificate of Clinical Competence
CDC	Centers for Disease Control
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Assessment, and Plan
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRR	Drug Regimen Reviews
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual

DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DWR	Desired Weight Range
ECU	Environmental Control Unit
ED	Emergency Department
EEG	Electroencephalogram
EGDs	Esophagogastroduodenoscopies
ENT	Ear, Nose and Throat
ER	Emergency Room
FA	Functional Analysis
FAST	Functional Analysis Screening Tool
FBA	Functional Behavioral Assessment
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HSM	Health Status Meeting
HST	Health Status Team
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
IDT	Interdisciplinary Team
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
IT	Information Technology
IV	Intravenous
J-tube	Jejunostomy Tube
LAR	Legally Authorized Representative
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBS(S)	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligram
MH	Mental Health
MHMR	Mental Health/Mental Retardation

MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Assistant
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NEO	New Employee Orientation
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
NPO	Nothing by Mouth
O&M	Orientation and Mobility
OIG	Office of Inspector General
OT(R)	Occupational Therapy(ist)
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PDP	Person Directed Planning
PEG	Percutaneous Endoscopic Gastrostomy
PFW	Personal Focus Worksheet
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior
PNMT	Physical Nutritional Management Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNS	Physical and Nutritional Supports
PO	By mouth
POR	Problem Oriented Record
PP	Permanency Plan
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
P&T	Pharmacy and Therapeutics
PT	Physical Therapy(ist)
PTA	Physical Therapist Aide
PFW	Personal Focus Worksheet
QA	Quality Assurance
QAM	Every morning
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional

RC	Residential Coordinator
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAC	Settlement Agreement Coordinator
SAMS	Self-Administration of Medications
SFBA	Structural and Functional Behavior Assessment
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathology(ist)
SOAP	Subjective, Objective, Assessment and Plan
s/p	Status Post
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSO	Staff Service Objective
STAT	Immediately or Without Delay
STD	Sexually-transmitted disease
TID	Three times a day
TST	Tuberculin Skin Test
UTI	Urinary Tract Infection
VRI	Viral Respiratory Infection
WNL	Within Normal Limits