

United States v. State of Texas

Monitoring Team Abbreviated Report

Austin State Supported Living Center

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Introduction

In 2009, the State of Texas and the United States Department of Justice (United States) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences, including the Austin State Supported Living Center (AUSSLC). Beginning in April 2010, the Monitoring Team began conducting reviews as required by the Settlement Agreement of AUSSLC, and has conducted reviews every six months since.

On March 29, 2012, in a letter to the United States, the State of Texas requested an abbreviated review of AUSSLC. The State made this request in order to dedicate intensive resources and staff time to respond to the Department of Aging and Disability Services (DADS) Survey and Certification Team's directed plan of correction to address outstanding deficiencies at the Facility. In support of its request, "DADS stipulates that, since the last monitoring tour of the facility in November 2011, Austin has not made any significant improvements that would result in additional findings of compliance in the substantive areas of the Settlement Agreement between the United States and the State."

The Monitor proposed options to the parties for an abbreviated review. The United States and State agreed upon the following format for the abbreviated review:

1. The full Monitoring Team would visit AUSSLC for three days during the week of May 7, 2012, to conduct an abbreviated review and to provide technical assistance.
2. Visit activities may include:
 - a. Informal meetings with the discipline leads to ascertain the departments' perceptions of their current status, review action plans, and provide recommendations and technical assistance regarding future directions;
 - b. Limited onsite reviews of individual department-chosen records to reflect the records departments believe closely conform to the requirements of the Settlement Agreement;
 - c. As appropriate, observations of individuals and discussions with residential and day/vocational staff to assess protection from harm, and basic health and safety assurances; and
 - d. As appropriate, conversations with direct line clinical staff (e.g., nurses, primary care practitioners, psychologists, psychiatrists, therapists, etc.) to determine the existence of basic systems and resources necessary for them to do their jobs.
3. Records Requests – AUSSLC need not provide any documents prior to the review. During the review, the Monitoring Team may request only limited documents (e.g., spreadsheets or other summary documents that staff are able to print during discussions with the Monitoring Team to provide an overall picture of timeliness of supports and services). For example, the Monitoring Team may request lists of psychiatric evaluations completed using the new format, list of individuals with dates of approvals of restrictive practices, etc.
4. Report – Following the review, the Monitoring Team will issue a brief (i.e., 30 pages or less) report recognizing the State's stipulation that AUSSLC has not made any significant progress since the last review, identifying any major safety or health issues noted, briefly outlining status of Facility's plans to comply with each section

of the Settlement Agreement, and making recommendations related specifically to plans of improvement.

Given the many responsibilities that the Directed Plan of Correction required, as well as additional issues that staff had had to address due to significant problems with the gas lines on campus, the Monitoring Team sincerely appreciates staff's willingness to spend time sharing information about their plans for improvement and the current status of some of the activities related to implementation of the Settlement Agreement, as well as candidly discussing the challenges they were working to overcome.

At the time of the review, AUSSLC was in the process of implementing the Directed Plan of Correction that DADS Survey and Certification Team required. The Facility was not accepting admissions, and since the last review, no individuals had been admitted to the Facility.

Since the Monitoring Team's last review, many staffing changes had occurred at the Facility. This should help to strengthen the existing team. However, a number of basic issues that had been problematic since the Monitoring Team had begun monitoring continued to negatively impact the Facility's ability to deliver adequate and appropriate protections, services, and supports. Some of these issues will take some time to resolve, such as high overtime use. Given the many issues that require attention, it is essential for Facility Administration to clearly prioritize issues and set forth short-term and long-range plans to structure the needed improvements. Although there was no question that the Facility had many challenges to address, in a short period of time, changes had begun to take place in some areas and a number of such action plans had been developed or were in the discussion phase. The Monitoring Team looks forward to its next onsite visit, and hopes that the plans discussed during this abbreviated review will have been implemented, others will have been developed, and they will have had positive changes in the lives of individuals AUSSLC supports.

Based on the limited review the Monitoring Team conducted, for each section of the Settlement Agreement, the following report summarizes the topics the parties agreed upon. No findings are made with regard to the Facility's compliance with the Settlement Agreement.

SECTION C: Protection from Harm - Restraints

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

- The State had developed a new policy regarding the use of restraint, which AUSSLC was preparing to implement. Members of the Monitoring Team reviewed the policy, which provided a comprehensive review of restraint, in detail with the DADS Psychological/Behavioral Services Coordinator and staff members from AUSSLC. The plan was to replace the Safety Plan for Crisis Intervention with a Crisis Intervention Plan. Templates for the ISP Action Plans to eliminate restraints were provided to the Monitoring Team. The Crisis Intervention ISP Action Plan to eliminate restraints identified steps to complete, including the following: a) functional analysis; b) revision of Positive Behavior Support Plan (PBSP); c) examination of potential medical issues; d) review of habilitation and training plans, including communication, coping skills, and

work preferences; e) consideration for counseling; f) environmental review; g) community integration; h) staff training; and i) data systems. If these plans are implemented as designed, there should be a resulting benefit to the individuals served, because they represent an interdisciplinary review of factors that may be contributing to the problem behavior that results in restraint. The three Monitoring Teams will provide comments to the State on the overall policy.

- The Restraint Report reflected overall decreasing trends in the use of physical, mechanical, and chemical restraints from 9/09 through 12/11. However, there was a slight increasing trend observed in crisis physical restraints (which the Facility called “emergency restraints”). In spite of the overall reduction in the use of restraint, there remained a number of individuals for whom restraint was a frequent occurrence. The Facility should implement the new Crisis Intervention Action Plan with these individuals as soon as possible.
- A memo dated 5/10/12 from the Director of Behavioral Services to the Settlement Agreement Coordinator indicated that since 11/11, there were no minutes from the Dental Task Force. This would suggest that this group had not met to discuss and/or address continued efforts to reduce restraint and/or sedation for identified individuals during dental exams and/or procedures. Attention to this requirement of the Settlement Agreement is essential to ensure the health and safety of the individuals served.
- Although the Monitoring Team’s limited review did not allow confirmation of reported activities, Facility staff indicated that:
 - Steps had been taken to ensure that restraint use was tracked on a daily basis through entry into a database. The Director of Behavioral Services reportedly reviewed all restraints on a weekly basis and issued a monthly report. The Incident Management Review Team was expected to review restraint use on a daily basis.
 - The completion of restraint checklists reportedly was being monitored. The Director of Behavioral Services noted improvement.
- The Restraint Reduction Committee was scheduled to resume meeting monthly. The Behavior Support Committee had continued to meet on a regular basis.
- In coordination with the efforts of the Quality Assurance Department, monitoring tools and protocols related to restraint were to be established.
- The Facility had received support through consultation with the Director of Behavioral Services at LBSSLC and from the State Office.
- The actions the Facility described as next steps generally were appropriate and should assist the Facility to move closer to compliance with the provisions of Section C.

Monitoring Team’s Recommendations Related to Plans of Improvement:

- A priority should be placed on implementing the guidelines included in the Crisis Intervention Action Plan template for the individuals who experience frequent restraint (i.e., more than three times in a rolling 30-day period).
- The Dental Task Force should renew its efforts in reducing the use of restraint and/or sedation for dental exams and procedures. Development of dental desensitization plans with adequate schedules of implementation should be addressed for identified individuals.

- Based on past problems, the timeliness and completeness of restraint checklists should be monitored and corrective actions taken, as needed.
- Using data related to restraints, as well as incidents and allegations, the Director of Behavioral Services, the assigned Psychologists, and the Interdisciplinary Teams should expand and strengthen their efforts to ensure that habilitation strategies are individualized, implemented consistently, and take advantage of community resources in order to teach skills and behaviors that will reduce and eliminate the need for restraint. For example, Facility staff identified Residences 791, 796, and 797 as concerns due to the number of individuals with challenging behaviors living together. These might be appropriate residences on which some focused improvements could be targeted to reduce behaviors and the potential for restraint.
- Close coordination should occur between the Director of Behavioral Services, the Risk Manager, and the Incident Management Coordinator in the analysis of data about restraint use and the occurrence of serious incidents.

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

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

- The Facility had restructured the supervision of the risk management and incident management functions under a new Director of Risk Management and Incident Management. A new Risk Manager was to be appointed. The current Incident Management Coordinator was on leave.
- Since March 1, 2012, the Avatar system had been in effect for unusual incident investigations.
- The Facility continued to struggle with the timely completion of injury reports. All injury reports were not being generated at the time the injury was witnessed and or discovered. Reportedly, this was being addressed at the Unit level by the Director of Residential Services and Unit Directors and is discussed and monitored by the Incident Management Review Team. The analysis and trending of the injuries that were reported had been stopped for the time being.
- Restraint episodes were to be entered online.
- On April 1, 2012, a Client Injury Specialist was hired to focus on injury reporting and remedial actions, and to provide technical assistance.
- The Incident Management Review Team meetings were restructured. They were now intended to be to be more focused, concise, and attentive to systemic as well as individual concerns.
- Facility staff acknowledged that sufficient and timely information about serious incidents was not being provided to the Interdisciplinary Teams. However, no evidence was provided of the actions being taken to remedy this concern.

All of the Facility's plans appeared reasonable and should assist the Facility in moving towards compliance with the Settlement Agreement. However, a number of details were yet to be resolved with regard to the reorganization of the functions of risk management and incident management. For example, it had not yet been decided whether or not a restructuring of the current investigation team would occur.

Timeliness and completeness of incident reporting continued to be of concern. As noted above, all injury reports were not being generated at the time the injury was witnessed and

or discovered, and portions of injury reports had not been completed. As a result, the Facility did not have up-to-date data on all injuries. Also, at the Sunrise Unit Meeting held on 5/8/12, there was a review of 44 injury incidents for which information was missing from either the Qualified Developmental Disabilities Professional (QDDP), nursing, or direct support professionals. Ten of these incidents had occurred in April and two had occurred in March. The administrative assistant who chaired this meeting reported that she was unable to assign responsibility to a staff member, nor was she able to identify a date by which this information should be provided.

The restructuring of the Incident Management Review Team meetings to provide greater attention to systemic concerns was positive. However, based on the Monitoring Team's limited review, the timeliness of response to directives issued at these meetings continued to be of concern. For example, after two days, there was no evidence of follow-through to the instructions given regarding issues at Residence 793.

Monitoring Team's Recommendations Related to Plans of Improvement:

- In its efforts to reduce the number of serious incidents, the Facility should consider expanding its strategies for monitoring the living environments and habilitation activities afforded to the individuals served. As has been previously recommended, the Facility should evaluate placement of young adults in the same residence as individuals who are significantly older, and have different interests, needs, and experiences.
- The unit meetings should be conducted so that staff are responsive to reports of injuries, falls, individual-to-individual aggression, medical issues, restraint, or any other reported incident. Information regarding the incident and actions taken to address the incident should be provided and identified in a timely manner.
- The Facility should consider its methods for providing incident-related information to the Interdisciplinary Teams in order to improve and enhance individualized strategies for protection from harm.

SECTION E: Protection from Harm – Quality Assurance

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

- At the time of the Monitoring Team's visit, the primary focus of the Quality Assurance Department had been to assist Departments to develop monitoring tools related to the provisions of the Settlement Agreement. The plan was for the Quality Assurance Department to provide subject matter expertise and ensure inter-rater reliability.
- The Quality Assurance/Quality Improvement Council was supposed to reconvene in the near future (specific date not yet determined).
- A database for injury reports had been established. The analysis and trending of injuries was to be initiated (date unspecified).
- At the time of the Monitoring Team's visit, there were five staff auditors in the Quality Assurance Department and one Quality Assurance nurse. An additional position was being requested.

These plans, while limited, were reasonable and should begin to move the Facility towards compliance with the requirements of the Settlement Agreement. However, additional work will be required if a robust and effective Quality Assurance process is to be developed and implemented. The goals and objectives for each Department should be articulated in order

to provide a foundation for the monitoring and other quality assurance procedures, such as the development and implementation of key indicators and outcome measures. The protocols for remedial action also need to be designed and implemented.

While the Director of Quality Assurance was aware that his Department was responsible for overall quality assurance at the Facility, including quality assurance efforts related to all Sections of the Settlement Agreement, a decision had been made to focus initially on protection from harm. The Director acknowledged that additional planning was required to address the remaining programmatic and clinical areas. At the time of the review, one of the barriers to the Quality Assurance Department expanding its efforts was the necessary focus on implementation and oversight of the Directed Plan of Correction. Hopefully, the regulatory issues can be quickly addressed, and the scope of the Quality Assurance Department's efforts broadened.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The Facility should establish a coordinated approach to the collection of data, its analysis, and the implementation of any remedial actions. A strong working relationship should continue to be built between the Incident Management Coordinator, the Risk Manager, and the Quality Assurance Director.
- While it is reasonable to implement the new plans for the Quality Assurance Department on an incremental basis, it would be important for the Department to develop an overall plan and timeframe for the development and implementation of its overall quality assurance strategies.
- The Quality Assurance Department should be involved in the observation of the quality of life at the Facility. In particular, there should be focused attention to the individualization of supports, the composition of the individuals living together, the personalization of the environment, and the intensity of habilitation activities.

SECTION F: Integrated Protections, Services, Treatments and Supports

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

- Members of the Monitoring Team observed two Individual Support Plan (ISP) meetings. Some strengths were noted, including more extensive work done prior to the meeting with the use of the ISP Meeting Guide, more facilitation from the QDDPs to elicit information from team members and ask clarifying questions, some real collaboration and creative thinking to address an individual's functional communication needs, and inclusion of the direct support professionals' knowledge. However, a number of issues previously discussed continued to exist, including a lack of adequate assessments; lack of use of assessment information and data available [e.g., functional skills assessment (FSA), behavioral data, etc.]; inadequate discussion of action plans, such as the development of measurable outcomes for risk factors or new action plans to move the individual towards greater independence (e.g., with work, home life, etc.); limited incorporation of individuals' strengths and preferences into the action plans developed; minimal discussion and integration of plans, such as Behavior Support Plans (BSPs), with just an overall question to the team requesting approval for implementation; limited discussion about community integration opportunities; limited discussion of incidents and allegations; and inadequate discussion of the most integrated setting

appropriate for the individual, which is discussed in further detail with regard to Section T.

- Attendance and assessment databases reportedly were beginning to be populated. The remaining portions of the ISP tracking database were anticipated to be available in June 2012.
- Facility staff recognized that assessments, which are an essential component of individual planning, were still a major problem due to a variety of issues, including staffing vacancies or new staff, assessment content, and management issues related to holding staff accountable for the quality and timeliness of assessments. Facility staff reported that State Office was assisting with this issue by reviewing and revising assessments across all disciplines.
- Training was planned for QDDPs and Active Treatment staff regarding the assessments for which they were responsible, including FSAs and Preference and Strength Inventories.
- State Office consultants had begun to provide QDDPs with shoulder-to-shoulder training from the start of planning process through to completion of the document. The Monitoring Team strongly supports this plan/model. As an on-the-job training model, it should also allow assessment of QDDPs' competence and identify areas in which additional training or supports are needed.
- AUSSLC recognized that QDDPs and staff from the various disciplines needed to be in residences more often, modeling and working with staff to identify issues with existing plans. An "Individual Resident 45-Minute Observation and Monthly Monitoring Form" had been designed for QDDPs to use. It included some important questions and areas of focus. The Monitoring Team agrees regular presence of QDDPs and clinical staff in program areas is an absolutely key activity. Creativity will be needed to allow QDDPs time away from their desks and into the residences and day/vocational programs more frequently, including off hours.
- Plans also were in place to initiate use of an electronic monthly report. This should assist the QDDPs in their overall monthly review, and, hopefully, will help teams to identify areas where individuals are not progressing so that they can meet to discuss issues, as necessary.
- A Relocation Approval Committee had been formed to ensure thoughtful and systematic transitions of individuals within the Facility. It will be important that this group respond in a timely manner to concerns raised by individuals' ISP teams.
- Overall, it appeared that some positive plans were in place to address the many issues requiring improvement.
- At the time of the review, the major barrier to progress towards compliance with the Settlement Agreement appeared to be the necessary attention to the issues that regulatory reviews had identified. In addition, the Facility had hired many new QDDPs. Although this provided an opportunity to train staff using the new policies and procedures for ISP development, this also was a significant challenge given the centrality of the QDDPs' role in the entire planning and plan implementation process.

Monitoring Team's Recommendations Related to Plans of Improvement:

- In addition to recommendations the Monitoring Team has made in previous reports, although the QDDP Department currently had many responsibilities to which attention needed to be paid, in the long-term the Department might want to look at a similar

model to what another Facility's QDDP Educator recently put in place for initial on-the-job training. It included a few-week orientation during which the QDDPs cycled through the different departments to learn about roles and responsibilities, etc., as well as intensive training with regard to specific QDDP skills and competencies.

- In implementing the 45-Minute observation and monitoring tool, it would be helpful to develop some brief instructions to ensure that the data collected is reliable and valid. For example, terms such as "purposeful activities" should be defined, and methodologies should be identified, including the observations and review records that QDDPs should conduct to confirm information requested on the form.

Section G: Integrated Clinical Services

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

- The Facility had a newly written procedure for both on-campus consultation and off-campus consultations. This included provision of guidance for each step of the process.
- Missed appointments also were tracked. However, the procedure for tracking missed appointments was not submitted.
- The Facility had a tracking sheet for certain preventive/diagnostic tests, including: mammograms, colonoscopies, and DEXA scans.
- The medical morning meetings appeared to include critical thinking related to individuals that were hospitalized, going to the Emergency Room (ER), those for whom the on-call primary care physician (PCP) was called, as well as consultation reports. The minutes included attendance of all department representatives, with a sign-in sheet for verification. Although the Monitoring Team's review was limited, these meetings and minutes were important examples of the integrated services Section G.1 requires.
- The written procedure and in-service training concerning consultations provided an important foundation for the Facility's efforts to comply with Section G.2.
- Some of the potential barriers to compliance included: 1) The Medical Director was newly appointed and had not worked at a State Supported Living Center (SSLC) in the past in this capacity. Although it was positive that this position had been filled, the new Medical Director should continue to be provided support from the State Office Coordinator of Medical Services. 2) The consultation procedure/process was new, and will require monitoring/periodic analysis to ensure it is effective, efficient, and sustainable; and 3) A PNMT did not exist.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The Facility should track departmental attendance at the medical morning meetings.
- The contribution of the various departments for the many individuals listed in the morning report was unclear. A brief medical update was provided, however, this should be expanded to include an additional brief entry listing the contributions of the other clinical departments, when applicable.
- When the PNMT is re-established, a representative should participate in the medical morning meeting.
- Other inter-disciplinary meetings should maintain attendance rosters (and track attendance), along with a brief description of the information provided by each of these departments (such as Neurology meetings with PCP and psychiatry attendance, the PNMT, and IDT annual and follow up/addendum meetings).

- A formal process should be developed to track the follow-through on recommendations sent to IDTs from the medical morning meeting. Individual Support Plan Addenda (ISPA) development should be routed back to the morning medical meeting for discussion to determine if they meet the intent and purpose of the original recommendations.
- All recommendations made in the medical morning meetings should be tracked to completion, including ISPA's. Tracking should include numbers and percentages of recommendations made and completed.
- A quarterly report of the medical morning meeting activity should be created for review by the medical staff and Facility Administration.
- The Medical Department is encouraged to track all missed appointments (i.e., reason for appointment, specialty/type appointment, the date, the residence, the reason for the missed appointment, and completed appointment date.)
- A formal missed appointment policy and procedure should be developed and implemented.

Section H: Minimum Common Elements of Clinical Services

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

- The Pharmacy Department was tracking timeliness of both completed QDRRs, and response time by the PCP and psychiatrist.
- The Dental Department was tracking annual dental evaluations to ensure completion within 365 days of the prior one.
- There was no information concerning inter-disciplinary tracking of health care to ensure the individuals' medical diagnoses/functional concerns were addressed, and they received all of the clinical services needed (as applicable) for quality assessment and treatment.
- Potential barriers that the Monitoring Team identified included: 1) No information technology (IT) initiative was in place to develop an Excel or other information management system to allow monitoring of the many medical and clinical needs of the individuals; 2) The clinical departments needed further guidance in order to make progress in this section; and 3) No information was provided to determine whether annual medical assessments were being tracked for timely completion, whether a change in health status was followed by essential clinical assessments by departments, based on the signs and symptoms of the change in health status, and/or if individuals with on-call issues/acute problems reported during the medical morning meeting, or referred to the ER, had been provided adequate assessments either prior to or after identification of change of status. No system appeared to be in place to record and monitor timely assessments by applicable clinical departments when there was a change in health status.

Monitoring Team's Recommendations Related to Plans of Improvement:

Given that the Facility did not have a specific plan to address the requirements of Section H, as it moves forward with efforts to comply with this section, the Monitoring Team encourages the Facility to review the previous reports from the Monitoring Team, including the many recommendations related to Section H.

SECTION I: At-Risk Individuals

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

- The Monitoring Team requested to meet with the Physical Nutritional Management Team and Section Lead for Section I to discuss the At Risk Individuals. At the time of the review, the Facility indicated that no existing Physical Nutritional Management Team existed due to staff vacancies, and no staff person was designated to address progress or issues related to Section I.
- Since no one had been assigned to this area, it was unclear if there had been any type of reliable tracking conducted regarding the lists of individuals with Infirmiry admissions, hospitalizations, and/or on the At Risk list for the Facility.
- At the time of the review, the Facility provided no action plans addressing Section I.
- Although the Facility continued to implement the review of health risks and the risk ratings, as the Monitoring Team observed during an ISP for Individual #102, based on the Monitoring Team's limited observations and document review, the process of using clinical data to consistently justify the risk ratings, and the development of functional and measurable Risk Action Plans was not adequate.
- Based on the Monitoring Team's observations, positive expansion of the Morning Medical Meetings included some discipline discussions during which review was conducted of acute clinical issues, hospitalizations, and Infirmiry admissions, resulting in timely communication of changes in status to all disciplines. Although this was only one small piece of what the Settlement Agreement requires regarding Section I, it was a formal and timely method to review the needs of the individuals experiencing acute changes in status while the At Risk system was being rebuilt.

Monitoring Team's Recommendations Related to Plans of Improvement:

Due to the critical clinical at-risk health issues that Section I addresses, plans for implementation based on the priority needs of the individuals should be promptly formalized and implemented, and a section lead assigned responsibility for the oversight and leadership of this section.

SECTION J: Psychiatric Care and Services

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

- During the interviews, both Drs. Murry and Stonedale indicated that the routine and quarterly review of the individuals' psychiatric status over the last several months had not been disrupted by the environmental stressors that had been present at AUSSLC.
- During interviews, Psychiatry Department staff reported that continued progress had been made in reducing polypharmacy with psychotropic medications. Based on the Monitoring Team's limited review of the polypharmacy data included in the summary graphs that ranged from April 2011 through March 2012, as well as the minutes of the Polypharmacy Meeting for the last six months, it appeared that this had remained an area of focus. More specifically, the historical data indicated that at the time of the prior November 2011 Monitoring Review, 30 of the 157 individuals (19%) receiving psychotropic medication were prescribed medication regimens which met the criteria for polypharmacy. The most recently tabulated data (March 2012) indicated that this frequency had been further reduced to 22 of the 154 (14%) of individuals receiving psychotropic medication at that time. Thus, this represented a further five percent reduction in the rate of polypharmacy.

- During an interview, the Director of Behavioral Services noted that there had been a transient increase in chemical restraint use during January 2012, which prompted a Multidisciplinary Meeting/Review. The review included the Departments of Psychiatry, Medicine, and residential services, as well as others. The narrative section that was contained within the tracking data for all forms of restraint (i.e., mechanical, physical, and chemical) indicated that this increase also coincided with the highest period of environmental disruption, in terms of residential relocations. Although it was not clear if the multidisciplinary planning meeting directly contributed to the subsequent decline in the frequency, the attempt to respond in a concerted manner to a recognized problem was important and positive.
- During the interview with the Psychiatrists, it was noted that the progress on the completion of Comprehensive Psychiatric Evaluations (CPEs) for all of the individuals who were receiving psychotropic medication had been impeded by the environmental disruptions and the resignation of one of the Staff Psychiatrists. The list of individuals who had completed CPEs as of 5/3/12 included 47 of the 150 individuals (31%) who were receiving psychotropic medication. The number of individuals receiving psychotropic medication was provided during the 5/9/12 interview with the members of the Psychiatry Department. It differed from the 154 individuals contained in the March Polypharmacy report. The reason for this difference was not explored during the interview. The Psychiatrists also noted that a number of CPEs had been partially completed. The Monitoring Team did not evaluate the quality of these documents.
- Reportedly, during the last six months, the Clinical Pharmacist had continued to complete the Quarterly Pharmacy Reviews. During the interview with members of the Pharmacy Department, they noted that these reviews had indicated some lapses in the completion and timely review of the MOSES/DISCUS side effect evaluations, which reportedly had been addressed. Due to the limited nature of the Monitoring Team's review, these reports were not confirmed.

Monitoring Team's Recommendations Related to Plans of Improvement:

In addition to the maintenance of their current initiatives, the areas in which the Monitoring Team would recommend focused attention in the coming months are the completion of CPEs that meet the standards of the Settlement Agreement for all of the individuals who receive psychotropic medication at AUSSLC, and the completion and prescriber review of the MOSES/DISCUS side effect ratings in a timely manner, as the internal Pharmacy audits had identified as an area of need.

SECTION K: Psychological Care and Services

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

- At the time of the visit, the Facility had three vacancies for associate psychologists with one position soon to be filled, and another offer made. Including the Director of Behavioral Services, the department employed four Board Certified Behavior Analysts (BCBAs). Two additional psychologists had completed the coursework towards certification. At the end of the fall semester, two others were expected to have completed the required coursework.
- The internal peer review Behavior Support Committee meeting minutes reflected feedback in the form of one of two checklists indicating compliance, noncompliance, or no applicability regarding identified components of the evaluation or plan reviewed.

Many pages were devoted to simply noting compliance or lack thereof. More useful information was found when specific recommendations were provided. Concerns included the following: 1) recommendations were not consistently provided when noncompliance was noted; 2) timelines for addressing recommendations were inconsistently identified; 3) when timelines were identified, revisions were often overdue; and 4) the author of the plan was not always present. Further, only three members of the behavioral services staff several attended meetings.

- External peer review meeting minutes revealed thoughtful comments related to behavior support plans. AUSSLC psychology staff attendance was limited to two to six participants.
- Human Rights Committee (HRC) meeting minutes and observation of the HRC meeting reflected discussion with accompanying recommendations from the members. As identified previously, timely response to these recommendations was not ensured.
- The spreadsheet used to track Psychology Department tasks reflected continued delay in securing necessary consents for BSPs. As noted in the past, this impeded timely introduction of strategies to support improved behavior and quality of life for the individuals served.
- AUSSLC reportedly had incorporated the results of functional behavior assessments into individuals' psychological evaluations. While two evaluations completed within the last six months both referenced functional behavior assessments, only one included descriptive assessment of the targeted problem behaviors.
- Reportedly, since 11/11, 78 Comprehensive Psychological Assessments had been completed.
- Staff reported no progress had been made with regard to data collection and its accuracy. The Data Work Group continued to meet, but no determinations had been made regarding changes to standardize the data collection system.
- The training instructions for a new checklist entitled "Identification of Challenging Behavior" directed staff to complete it at ISP and ISPA meetings, but this was not apparent at the ISP meeting held for Individual #288.
- A draft three-page Clinical Care/Observation Log reviewed a number of important variables including appearance and hygiene, food consumption, seizure activity, etc. It included rating scales regarding targeted problem behavior. Because these were gross estimates of behavior frequency and severity, they were not likely to provide the degree of objective information that will be necessary to assess behavioral improvement or worsening. In its response to the draft report, the State indicated this document would be individualized. However, without further review of its implementation, the Monitoring Team remained concerned about its usefulness.
- The Psychology Department had revised its competency-based training on BSPs and Safety Plans. The Psychology Assistant provided initial training, with the Associate Psychologist completing further in situ training. This was a promising practice.
- AUSSLC had developed a BSP Treatment Integrity Form, a two-page document requiring staff to examine treatment components across 10, one-minute intervals: a) environmental set-ups; b) antecedents; c) behaviors to increase and staff response to the same; and d) behaviors to decrease and staff response to the same. Positive feedback and constructive criticism was then summarized. When implemented as planned, this tool should prove helpful in determining treatment integrity and improving staff competency.

- Potential barriers that the Monitoring Team identified included: 1) Staff continued to believe that individuals could not learn to communicate without making every attempt to teach individuals an appropriate, alternative form of communication to replace their identified target behaviors; 2) Monitoring guidelines indicated that psychologists should spend 45 minutes observing one individual per residence per month. In residences with more than 12 residents, over the course of a year, some individuals would never be observed. This very limited monitoring schedule will do little to ensure high levels of treatment integrity or reliability of data; 3) As noted with regard to Section S, limited opportunities for habilitation and training will seriously impede the development of positive behavior change.

Monitoring Team's Recommendations Related to Plans of Improvement:

- When completing evaluations or developing plans, staff should refer to the checklists the Behavior Support Committee uses for guidance. However, to reduce the amount of paperwork generated and more efficiently address needed changes to these same documents, the BSC might consider generating a simple document that notes the documents discussed, followed by its recommendations.
- To ensure a clear understanding of the discussion that leads to revisions the BSC recommends, staff responsible for the documents' development should be in attendance.
- Further, timely implementation of changes the BSC recommends should be completed by the identified due date.
- Staff should review feedback external peer review provides and, when agreed upon, incorporate this feedback into the individual's plans (i.e., ISP, PBSP) and daily programming.
- Because internal and external peer review offers opportunities to expand one's knowledge of Applied Behavior Analysis and positive supports, a greater number of staff should participate.
- The Human Rights Officer (HRO) should develop a system to ensure psychology staff provide timely responses to the concerns and recommendations HRC members make.
- The Director of Behavioral Services and the HRO should develop a system to ensure all necessary consents for BSPs and accompanying safety plans are obtained in a timely manner.
- While indirect assessment (e.g., rating scales) can be helpful in understanding staff perspectives regarding challenging behavior, greater emphasis should be placed on descriptive assessment when completing activities to determine the function the identified problem behavior serves for the individual.
- In response to the Director of Behavioral Services' inquiry about data collection systems for direct support professionals, staff should look at simple systems of measurement that staff could be trained to use with integrity. For example, times of day could be identified when the problem behavior is most likely to occur and staff could collect samples of behavioral data during these times. It might be helpful to provide written guidelines with accompanying examples for staff to review prior to the implementation of new data collection systems.
- As psychology staff implement the new format for training direct support professionals and evaluating treatment integrity, increasing opportunities will be available for them

to spend time in the environments in which the individuals live, work, and recreate. This should result in greater monitoring than is currently occurring.

Section L: Medical Services

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

- The vacancy for Director of Physician Services position had been filled. For the one additional vacancy, a PCP had been recruited.
- Each PCP now conducted clinics in the residences, and an LVN was assigned to assist with clinic responsibilities.
- A close working relationship appeared to have developed between the Interim Medical Director and Nursing Administration, including joint efforts in developing numerous nursing policies and procedures. Facility Administration supported these initiatives. These ongoing efforts at coordination and teamwork between the departments will be key in assisting the Facility to comply with this and other sections of the Settlement Agreement.
- A formal agenda was followed at each medical morning meeting with essential components completed at each meeting. Based on the Monitoring Team's limited review of minutes and observations of meetings, this meeting included interdisciplinary attendance, and represented a structured approach to review changes in health care.
- Reportedly, the Medical Department was current with the clinical death review process.
- Plans were in place for the Medical Compliance Nurse to be trained in database management.
- The Medical Department had been allowed to use off-site transportation for individuals' appointments (i.e., taxis).
- The Medical Department was tracking preventive testing for mammograms, DEXA scans, and colonoscopies.
- During the ISP meeting members of the Monitoring Team attended, the PCP was an active participant of the IDT.
- Potential barriers that the Monitoring Team identified included: 1) The newly appointed Director of Physician Services had not had experience in working within an SSLC. The State Office Coordinator of Medical Services should continue to provide the new Director with necessary guidance; 2) IT support did not appear to be available to the clinical departments; 3) The QA Department had not been oriented as to the scope of its involvement with the Medical Department, including its role with external and internal medical peer review audits; 4) No system was in place for IDTs to provide feedback with regard to morning meeting recommendations, or in relation to consults the PCP referred to the IDT; and 5) No timelines appeared to be assigned to concerns requiring closure.

Monitoring Team's Recommendations Related to Plans of Improvement:

As the Facility moves forward in its efforts to comply with Section L, consideration should be given to the following areas that the Monitoring Team would view as priorities:

- Provision of training to the Medical Program Compliance Nurse in database management.
- Development and implementation of an efficient monitoring system to track recommendations from all sources until closure.

- There was need for data tracking and analysis (e.g., attendance, contribution, closure on assigned task, etc.) of each department at the morning medical meeting.
- Creation of a quick reference log/table in identifying recommendations from the morning medical meeting needing closure. For many of the hospital admissions and ER visits, interdisciplinary discussion should result in a recommendation [e.g., record review for a specific discipline, ordering of labs, need for further consult, second opinion, review of physical environment, review of day programming, etc.) that would need closure.
- Analysis of the activities of the morning medical meeting, including the percentage of hospital admissions/ER visits with recommendations, and clinical areas lacking recommendations, the number of recommendations originating at the medical morning meeting per month, the number of recommendations referred to the IDT, the number of remaining recommendations needing closure at the end of each month, the average length of time from medical morning meeting recommendations to closure of the recommendations, and the number of concerns with closure documented each month.
- Development and analysis of a quarterly report of the data related to ER visits, hospitalizations, and Infirmery admissions, including tracking the diagnoses for hospitalizations/ER visits, and length of stay for hospitalizations. Quarterly reports reviewed at medical staff meetings should be followed by action steps/changes in clinical practice patterns. Documenting such new processes, clinical pathways, procedures, or protocols that derive from this information should be included in sequential quarterly reports.
- Review in a quarterly report and at the end of the year (calendar or fiscal) of cumulative data related to clinical death reviews for any trends, with the goal of providing guidance to the Medical Department/Facility Administration in improving clinical practice patterns or other departmental services. Tracking of recommendations from the clinical death reviews to resolution/closure should include dates of implementation.
- Involvement of the QA Department according to the state guidelines/policy/protocol in providing timely corrective action plans and monthly follow-up for the external and internal medical review audits.

SECTION M: Nursing Care

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

- Since the last review, a significant number of changes had taken place regarding the Nursing Leadership positions, including the recent appointments of a new Chief Nurse Executive, an Infection Control (IC) Nurse, a Case Manager Supervisor, a QA Nurse, a Nurse Educator, a Hospital Liaison Nurse, and Nurse Managers for the Infirmery, and the Castner residence. In addition, the Nurse Operation Officer (NOO) position was vacant, and the Physical Nutritional Management Team (PNMT) Nurse had been on an extended unforeseen leave of absence. Since many of these staff had only recently completed the New Employee Orientation, and most were, not unexpectedly, unfamiliar with the systems, policies and procedures or lack thereof within the scope of their current positions. However, with the potential for increased communication between nursing and other disciplines, and the on-going development of the Morning Medical Meetings in reviewing acute clinical issues, the new face of nursing may actually have an advantage in assessing, and modifying the current systems at AUSSLC in efforts to ensure that they are clinically sound and meet the needs of the individuals. However,

there were basically no plans of improvement addressing Section M at the time of this review.

- At the time of the review, the Nursing Department had a total of 137 allotted positions for Nursing. Overall, the total nursing vacancies included seven RN positions, and nine LVN positions, which was a slight decrease in vacancies from a total of 20, since the last review.
- From interviews with the Chief Nurse Executive (CNE) and IC Nurse, although both the current IC Nurse and the previous IC Nurse were working at the Facility, little communication had occurred between them regarding IC systems, such as the process to ensure data reliability, and the current status of the immunization database. Thus, the data the Facility submitted regarding individuals who had experienced an infectious process since the last review was not reliable. This made it difficult to accurately analyze the data for problematic trends, especially during the months when the gas was not available resulting in issues with hot water being consistently available, and diverting staff's attention to manage additional duties. According to discussions with the CNE, IC Nurse, and brief discussion with the Employee Health Nurse, at a time when infection control should have been in the forefront, IC had provided very little oversight, and this continued at the time of the review.
- At the time of the review, virtually no interface had occurred between the new IC Nurse, the recently appointed Environmental Specialist, Director of Facility Supports Services, and the new Custodial Manager related to oversight and management of environmental conditions. Although each described similar environmental issues they assessed, during a tour of Residence 797, each had very different reasons for the items they assessed, as well as different solutions for problems based on their area of expertise. Collaboration between these departments is critical to ensure that both technical and clinical issues are adequately addressed.
- Due to problems the Facility identified, the CNE and State Medical Director developed and implemented a written procedure to ensure that nurses noted and implemented physician/practitioner orders in a timely manner.
- The Facility was in the process of appropriately reviewing and modifying the Emergency system (311 Urgent/6200 Emergent) that included providing staff with examples and guidelines defining Urgent, and Emergent, and actions to be taken in either scenario.
- The Facility was in the process of resurrecting the medication variance system that had been left without oversight for a period of time. Beginning on April 16, 2012, all units at the Facility were to begin to conduct a medication count on each shift in order to timely identify any variances consisting of overages or missing medications. However, from participation in a meeting addressing medication variances, it was clear that the Nursing, Medical, and Pharmacy Departments needed to open lines of communications in order to comprehensively review this area, and develop appropriate strategies to decrease the number of medication variances at the Facility.
- In April, the Facility found from an audit that some Comprehensive Nursing Assessments were up to nine months delinquent. In response to this finding, in May 2012, the Facility had developed and implemented a promising protocol addressing how coverage would be maintained for Case Managers regarding their workload in the event that there was a vacancy, so that individuals would not be without a Case

Manager to complete the required documentation such as Comprehensive Nursing Assessments.

- The Facility recently had begun to train nurses regarding emergency equipment, and staff indicated this training would continue on a quarterly basis.

Monitoring Team's Recommendations Related to Plans of Improvement:

- At the time of the review, the Facility did not have any action plans addressing Section M of the Settlement Agreement, such as the development of clinically appropriate nursing care plans or the quality of nursing documentation, and/or nursing assessments. While developing action plans to address the requirements of Settlement Agreement for Section M, the Facility should be mindful of the areas that affect clinical care issues, and based on priority, develop and implement plans accordingly. In developing action plans, the Monitoring Team encourages the Facility to review the many recommendations regarding Section M included in previous reports.

Section N: Pharmacy Services

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

- A Category F medication variance (i.e., an error occurs that reaches the individual, the error may have contributed to and resulted in temporary harm to the individual and required hospitalization) occurred, but AUSSLC did not appear to have used a comprehensive approach to determine the etiology and/or contributing factors, such as a root cause analysis. The information submitted did not include the rationale as to how the steps taken would prevent the Pharmacy and Nursing Departments from failing to identify another serious medication variance.
- The psychiatric polypharmacy reviews continued to track intra-class polypharmacy and polypharmacy of three or more psychotropic medications.
- The chemical restraint Clinical Review by Pharmacy was expanded and divided into core requirements, which appeared to be a positive improvement.
- Once identified, the Pharmacy Department had a process to review Adverse Drug Reactions (ADR).
- A calendar of due dates, and deadline dates for all QDRRs was created for the next 12 months.
- On 4/16/12, in order to reduce medication variances, as well as to identify and complete medication variance reports in a timely manner, the Nursing Department began a medication count at end/beginning of each shift witnessed by two nurses.
- In response to a spike in chemical restraint use in January 2012, the Pharmacy Department called an interdisciplinary meeting to discuss etiology of the increase.
- Based on the Monitoring Team's limited review, the Pharmacy Department appeared to have made progress in its efforts to comply with Section N, including creation of forms and content expectation of forms to guide the pharmacist in completing the components necessary for compliance. The Facility had done work to address the requirements of Sections N.1, N.2, N.3, N.4, N.6, N.7, and N.8.
- Potential barriers that the Monitoring Team identified included: 1) Justification of anticholinergic use will require coordination and cooperation from the Medical Department; 2) There did not appear to be adequate collaboration or communication between the Nursing and Pharmacy Departments concerning medication variances; 3) Medication variances internal to the Pharmacy Department appeared to be numerous,

requiring further review/ analysis; 4) Policy #053 did not account for the need for the Pharmacy Department to receive all medication variances in a timely manner; 5) The current process contributed to delays in reporting medication variances, because the Nursing Department was attempting to complete the investigation process prior to submission of the initial error report; 6) The totals in the medication variance report from the Nursing Department appeared to be low, based on the large number of doses administered monthly at AUSSLC; and 7) No information was available concerning ADR training for nurses, PCPs or direct support professionals.

Monitoring Team's Recommendations Related to Plans of Improvement:

In addition to reviewing the Monitoring Team's recommendations from previous reports, consideration should be given to the following areas that the Monitoring Team would view as priorities:

- There should be further guidance from the State Office and consistency in communicating significant side effects of new medication orders.
- The PCPs should provide assistance in determining the benefit of anticholinergics and medication regimens with anticholinergic drug loads, with written documentation of benefit outweighing side effects. As part of this justification, the Facility should demonstrate monitoring of anticholinergic side effects per individual with the impact on the quality of life listed.
- A systemic approach should be used in the justification of polypharmacy, referencing documentation of use of the polypharmacy through various sources.
- The Pharmacy Department's chemical restraint clinical review should include a current drug-drug interaction review and listing of significant potential side effects/risks of the medication.
- The content of the psychiatry section of the chemical restraint clinical review should be standardized.
- New-hire and annual staff training on ADRs should be completed.
- Follow-up studies for Drug Utilization Evaluations should be conducted to determine clinical impact.
- The Pharmacy Department should be sent reports for all medication variances from all departments in a timely manner to allow timely monitoring, as well as early identification and correction of adverse trends. The Pharmacy Department should conduct a quarterly review of all medication variances (pharmacy, nursing, medical), including analyses, and development and implementation of action steps completed with measurable outcomes. The reports should include a current status of previous action steps currently that remain in the process at the end of the quarter.
- The Pharmacy Department should assist the Nursing Department in creating system approaches to resolve/prevent medication variances, including the large numbers of returned medications.
- For significant medication errors of Category E or greater, an in-depth analysis and systemic review should be conducted, such as a root cause analysis.
- Steps should be taken to minimize the investigation time and completion of each medication variance.

SECTION O: Minimum Common Elements of Physical and Nutritional Management

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

- The Director of Habilitation Therapies (HT) reported that since January 2012, AUSSLC had not had a "functioning PNMT." The PNMT SLP, PT, and OT had resigned. In addition, the status of the return of the PNMT Nurse from medical leave was unknown. The Director of HT had hired an OT for the PNMT, who was currently on a PNMT at another State Supported Living Center. However, the OT was not scheduled to join the AUSSLC PNMT until August 2012. The Director of HT was recruiting a SLP and PT for the PNMT.
- A review of hospitalizations from November 2011 to May 2012 revealed that 10 individuals on the PNMT caseload had a discharge diagnosis of aspiration pneumonia and/or pneumonia. Three of the 10 individuals had been hospitalized multiple times. An additional thirteen individuals who were not on the PNMT caseload had been hospitalized with a discharge diagnosis of aspiration pneumonia/pneumonia. The Director of HT reported the PNMT previously had a caseload of 23 individuals. This supported the urgency to re-establish a functioning PNMT as soon as possible to provide supports to these individuals, as appropriate, and their IDTs. A non-functioning PNMT was a major barrier to the Facility's providing supports to individuals at highest risk due to health and PNM concerns.

Since the last review, the following initiatives to achieve compliance with Section O had been started. However, the ongoing implementation of these initiatives had been negatively impacted by therapy staff shortages. More specifically:

- The PNMP template had been revised to include risks, outcomes, individual-specific triggers and activities of daily living. To date, based on staff interview, 78 PNMPs had been revised. Therapy staff shortages delayed the revisions of PNMPs and no timeline had been established to complete PNMP revisions.
- A PNMP audit tool had been developed, but had not been implemented. The implementation of individual-specific PNMP auditing should provide data to allow staff to identify both positive aspects of PNMPs as well as areas requiring improvement.
- Due to issues related to sterilization of equipment caused by the gas outage on campus, the HT Department had been assigned responsibility for monitoring the presence of individual-specific mealtime adaptive equipment at all meals and snacks. Consequently, in February 2012, compliance monitoring was put on hold. However, the Director of HT had developed a spreadsheet to track and trend monitoring results and corrective actions completed prior to February. The Director of HT's review of the monitoring database identified that staff noncompliance concerns had not been resolved. On a positive note, the monitoring database developed to track/trend monitoring results was a significant move forward in providing data to allow staff to analyze and address staff compliance with PNMPs.
- Based on interview with the Director of HT, the Meal Management Protocol that addressed mealtime supervision and monitoring was to be re-implemented. Staff positions responsible for mealtime supervision and/or mealtime monitoring were to be delineated. The purpose of the revision was to identify a consistent mealtime supervisor presence in dining rooms for all meals. The Monitoring Team's mealtime

observations indicated that mealtime supervision continued to be an area in need of improvement.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The Facility should re-establish a functioning PNMT as soon as possible to provide supports to those individuals at highest risk for health and PNM concerns.
- The Facility should consider appointing an interim PNMT Nurse to complete established responsibilities outlined in the action plans for Section O.1 and the Facility PNM policy. This included attending Medical Morning meetings, reviewing all Post-Hospitalization Nursing Assessments, completing PNMT Nurse Post Hospital Assessment/Evaluation, and attending post-hospitalization IDT meetings for individuals with discharge diagnosis of aspiration pneumonia/pneumonia.
- When the PNMT is functioning, training should be provided to IDTs on the State and Facility PNMT policy.

SECTION P: Physical and Occupational Therapy

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

Since the last review the following initiatives to achieve compliance with Section P had been started. However, staff shortages had impacted the ongoing completion of initiatives to achieve compliance with Section P. More specifically:

- Four OTs and two PTs had resigned. There was one full-time OT to provide services and supports to the 340 individuals at AUSSLC. However, a contract OT began employment on May 7, 2012 (i.e., contract duration of three months, but potential for extension of time), but she had not been assigned a caseload. A third OT was scheduled to begin employment in July 2012. Five PT positions were allocated. There were three full-time PTs and a fourth PT began employment on 5/3/2012.
- IDTs identified 126 individuals who were blind or deaf/blind. In March 2012, a contract was initiated with a certified Orientation and Mobility Specialist. At the time of the review, 26 of the 126 individuals had been assessed. Three of these individuals' IDT members had received training on assessment recommendations. In addition, five individuals were receiving interpreter services. It was positive these individuals were provided these services and supports.
- The State Coordinator of Specialized Services, in collaboration with the Director of HT, was working to revise the OT/PT assessment template. On 5/11/12, the Director of HT was providing training to the OTs and PTs on the revised assessment template. On 5/14/12, an Assessment of Current Status pilot was scheduled to begin. The revised assessment template placed more emphasis on risk services and supports, and functional skill development, which were positive additions. An OT/PT assessment audit tool was to be developed and implemented, which was a positive step forward in providing data to allow staff to analyze and address the quality and the presence of key elements in an OT/PT assessment.
- Action plans "in process" or "not started" for Section P included, but were not limited to: development and implementation of an audit tool for OT/PT comprehensive and current status assessments; development and implementation of an assessment tracking log for completion of assessments in a timely manner, and reporting results of assessment audits; and integration of an individual's OT/PT

recommendations into skill acquisition programs and daily schedule. These were positive initiatives. However, these initiatives had not been started.

- At the time of the review, three Assistive Technology (AT) staff were responsible for cleaning wheelchairs. The limited number of AT staff resulted in wheelchairs being cleaned on a quarterly basis. Wheelchairs require cleaning on a more frequent basis to ensure the wheelchairs do not become means for the spread of infection. On a positive note, the Facility had hired an Environmental Specialist to complete environment surveys in homes and day programs. The environmental survey should include an assessment of the cleanliness of individuals' wheelchairs.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The filling of allocated OT and PT positions should continue to be a high priority to enable the reassignment of therapy teams to IDTs.
- The Director of HT should develop and implement an OT/PT assessment audit tool to assess the quality and the presence of key elements in the assessments.

Section Q: Dental Services

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

- At the time of the Monitoring Team's review, only two staff (one dentist and one dental assistant) were performing clinical duties in the Dental Department. This staffing had remained unchanged since the Monitoring Team's last visit. The workload was unsustainable, and as of April 1, 2012, the number of dental examinations was reduced. The lack of a full complement of clinical staff in the dental clinic will likely lead to delays in dental care. Since the Monitoring Team's last visit, the number of individuals in the poor oral hygiene rating category increased at AUSSLC.
- The Dental Department had initiated monthly exam report reviews and monthly exam status reports, as well as quarterly missed appointment reports. The monthly and quarterly reports provided a useful analysis. Self-monitoring is an important aspect of the Settlement Agreement.
- With regard to staffing, the Dental Department continued to interview for a second full-time dentist position. A position for a dental hygienist had been filled effective 5/1/12.
- Based on the Monitoring Team's limited review, since the Monitoring Team's last visit, improvement occurred in the rate of completion of the annual dental exams within 365 days. Beginning in January 2012, success rate of annual exam completion exceeded the Dental Department's goal of 90%. The Dental Department piloted a schedule to attempt to improve efficiency using an exam-by-home system, which was discontinued April 2012, because it did not improve prior efficiency and created redundancy. Appointments for annual exams were scheduled 30 days or more in advance, which reportedly contributed to the successful completion rate. To reduce the rate of refusals for annual exams, some of the exams were completed in the individuals' homes. It will be important for AUSSLC to continue monitoring completion rate, and for timely changes to occur within the Dental Department based on such data.
- From December 2011 through April 2012, 426 staff were trained in oral hygiene.
- The number of missed appointments and refusals appeared low.
- Since the Monitoring Team's last visit, there were a number of new orders for suction tooth brushing. Of 18 individuals receiving suction tooth brushing, eight had obtained new orders for this in the past six months.

- A decision tree worksheet was created to provide direction in determining individuals that would benefit from sedation/desensitization. Total dental restraint use declined from March 2011 to April 2012.
- Policies and procedures were updated.
- Tracking of missed appointments/refusals appeared to include reasons for each, with documentation of communication to the IDT and residential services. This was an important process to maintain.
- Potential barriers that the Monitoring Team identified included: 1) Since November 2011, the Dental Department remained understaffed with only two clinical personnel for ongoing dental care of the entire campus. Additionally, a second dentist has not been hired. For each dentist, there was a need for one or two dental assistants to ensure proper positioning and cooperation of the individual; 2) Reportedly, delays of one to four months occurred in obtaining equipment to begin suction tooth brushing (from the time the order was written); 3) Progress in implementing desensitization plans, and tracking of progress could not be determined based on the information submitted. Plans appeared to be in the development/creation phase. There was no information concerning impact on dental services; 4) There was documentation of lack of communication in some residences concerning oral hygiene in-services; 5) The percentage of individuals with poor oral hygiene scores increased; and 6) The Dental Department appeared to have no assistance from information technology in developing a Dental Department database using Excel or other software programs.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The Facility Administration is encouraged to assist in ensuring a full complement of clinical staff is available in the Dental Department.
- IT assistance should be provided to the Dental Department.
- Residential services should review the reasons for poor oral hygiene in the home (e.g., inadequate staffing, lack of training due to lack of knowledge of the training schedule, staff working double shifts with decreased attention to oral hygiene when this occurs, etc.), as well as the reasons for lack of communication with the Dental Department.
- The Dental Department should ensure missed and refused appointments trigger follow-up ISPAs with meaningful action steps. The Dental Department should track the ISPAs in a log format to ensure the IDTs have met and discussed these dental concerns in a timely manner.

SECTION R: Communication

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

- The Facility had five allocated SLP positions. At the time of the review, only two full-time SLPs were on campus, and a third SLP was on leave until July 2012. A fourth SLP was scheduled to begin employment on May 16, 2012. The Director of HT planned to interview two SLP candidates.
- A new assessment format (i.e., Assessment of Current Status) was under development for Speech/Communication Services. However, the format had not been finalized and was not available for review.
- Action plans "in process" or "not started" for Section R included: the development and implementation of an assessment audit tool; identification of all individuals with a need for an alternative and augmentative communication (AAC) system through assessment;

revision of priority criteria for Speech Language Assessment Master Plan; integration of communication supports and skill expansion activities within active treatment and/or activities of daily living; and an audit of Behavior Support Plans for integration of communication supports and replacement behavior. These action plans were appropriate to move AUSSLC forward towards compliance with Section R. However, these initiatives had not been started.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The SL Assessment of Current Status should be finalized and implemented.
- The Director of HT should develop and implement an audit tool to assess the quality and the presence of key elements in SL assessments.
- The SLPs should continue to identify individuals with a need for an AAC system and provide the system.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs

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

Based on verbal reports from staff, the Facility had begun to implement the following initiatives:

- An intense schedule of training had been initiated to introduce all direct support professionals to active treatment. QDDP and Active Treatment staff were to have more training, and discipline-specific training was to be provided to professional staff.
- Active Treatment Coordinators were identified as the staff responsible for the completion of functional skills assessment, the development of skill acquisition plans, training of staff in implementing these plans, and tracking of progress. All Active Treatment Coordinators (ATC) were scheduled to receive shoulder-to-shoulder training from DADS consultants.
- The State had introduced a new skill acquisition plan template. Noteworthy additions included specific consequences for both correct and incorrect responses, plans for maintenance and generalization, and a plan for training or integration in the community.
- The Facility had initiated a contract with a consulting orientation and mobility specialist to provide services to individuals with visual impairments. The feedback provided in the evaluation for Individual #369 provided simple, yet important strategies for staff to employ.
- Sign language interpreters had been made available for portions of the day for individuals who were deaf. For the individual for whom this was observed, it appeared to be an effective strategy for supporting positive behavior change.
- The Facility had begun tracking the completion of assessments of functional and vocational skills in preparation for the annual ISP meeting.
- In February, 76 staff, including residential supervisors, unit directors, psychologists, and QDDP staff were trained to use a new Daily Observation form. Twenty-four questions related to engagement in training, residential environment, individual residential programming, and injuries/restraints were to be addressed. Although it included a number of important questions and areas of review, the methodology for implementing the form was not clear (e.g., would it be applied to one individual or

all individuals in the residence), or how inter-rater reliability would be established between raters.

- The Facility had developed a protocol for addressing repeated absence from work or day programming services by having the interdisciplinary team meet if the individual missed five days or 10 sessions of active treatment within a rolling 30-day period. While this new policy was promising, a review of the steps taken to address the work refusal for Individual #49 suggested that this individual's refusals had not been adequately addressed.
- The Facility had hired a job procurement coordinator to investigate community-based employment for individuals, while also exploring ways to improve the onsite workshop.

Potential barriers to implementing the Facility's plans included:

- Documentation showed high use of overtime. In addition to potential impacts on the health and safety of the individuals, high overtime use had the potential to negatively impact the provision of appropriate habilitation and training.
- Supervision remained a concern. As shared during the exit meeting, during the Monitoring Team's observations, low levels of staffing were observed in a number of residences, or staff were not present in the areas in which individuals were located, including individuals with complex needs. This had a negative impact on the provision of habilitation training.
- Similarly, the lack of engagement observed at the Facility remained a concern. While there has been an attempt to teach all staff about active treatment, this was evident in only two of the residences visited.
- Materials had been provided to the residences in an effort to support active treatment. As discussed onsite, concerns related to safety due to the lack of adequate supervision included the availability of scissors to individuals without safety skills, and drawers of materials labeled nail polish, nail polish remover, hair and/or body spray in unsupervised areas.
- The activity materials available in most environments were standardized items not reflective of individuals' interests.
- As the ISP meeting for Individual #288 showed, although staff reported improvements to both the summary findings and the resulting recommendations found in the Functional Skills Assessments, this assessment remained compromised. The team for Individual #288 did not review this information. Further, other disciplines reported on progress or the lack thereof without referencing objective data.

Monitoring Team's Recommendations Related to Plans of Improvement:

- Team members should bring their assessments to individuals' annual ISP meetings. At the meetings, the ATC should review the findings of the FSA and subsequent recommendations.
- Staff should discuss objective data at individuals' annual ISP meetings so that progress can be reported accurately and incorporated into the upcoming year's plan.
- Psychology staff should complete a structured preference assessment to assist in identified personal preferences at individuals' annual ISP meetings.

- Active Treatment Coordinators should work closely with residential supervisors and other direct support professionals to identify activities of interest to the individuals served.
- Examples of plans to teach shoe tying were included in the Draft Policy on habilitation and training (Policy #017). The State should ensure examples include information from the most recent template, specifically training/implementation in the community.
- The protocol developed to address repeated absences from day programming provided an outline for the interdisciplinary team's timely response, but teams were not required to meet if they had "already met." The timeline for previous meetings was not identified (e.g., would once in a 12-month period be sufficient to address this problematic pattern of behavior?). When an individual begins displaying repeated refusals to attend work, staff should review changes in the work environment, alternative work activities, or reinforcement systems to address this pattern of behavior in a timely manner.
- Staff should ensure that guidelines outlined by the orientation and mobility specialist are included in the individual's ISP and PBSP, and staff should receive timely training on them.
- Direct support professionals should receive on-going supervision and feedback. Administrative and clinical staff should make regular visits to the residences, workshops, and active treatment centers to ensure the provision of adequate habilitation.
- When individuals reportedly experience behavior worsening following placement in a new residential situation, the Relocation Approval Committee should review the situation in a timely manner (i.e., months should not pass without review and decision-making).
- With regard to the new Daily Observation form, it would be helpful to develop some brief instructions to ensure that the data collected is reliable and valid. As the form is used, modifications might need to be made.

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

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

- Since the last review, a new Placement Coordinator position had been created and filled. In addition, a number of State Office staff had been assigned to assist AUSSLC with the activities related to Section T. Additional staff had been or were being hired for Community Transition Specialist positions, and would be located at AUSSLC.
- At least temporarily, these staffing resources were being used to remove some of the requirements related to the transition process from the QDDPs to allow them to work on improving ISPs, which are central to the transition process. State Office staff also were assisting in setting up overall transition processes and training staff.
- One of the State Office consultants and the Admissions Placement Coordinator had been advocating strongly for resources necessary for the department, such as a dedicated vehicle and other equipment/supplies. A number of these requests had been fulfilled.
- The Facility recognized more education was needed in relation to community options. As a result, the Facility was planning two provider fairs in conjunction with the Local

Authorities, including one during the week, and one on a weekend to make it more accessible to families.

- By adding prompts, the Facility planned to enhance the shells for assessments used in the transition process. As discussed at a meeting about a Community Living Discharge Plan (CLDP) on 5/8/12, it is essential that the Facility make improvements to assessments to provide teams developing CLDPs with adequate information, and to provide necessary historical and summary information to the new provider.
- Since the last review, five individuals had transitioned to the community. An additional three individuals were scheduled to move the week of or week after the Monitoring Team's review.
- The Facility had an assertive plan for transitioning individuals on the referral list as of the end of February 2012 (i.e., 15 individuals) by the end of August 2012, and identifying other individuals who might want to move to the community or another Facility. At the time of the review, an additional seven individuals had been referred after the end of February, and were in an active referral process as well. One of the State Office consultants had developed a more detailed transition timeline and process, and the QDDPs were trained on it on 5/10/12. The process was consistent with the Settlement Agreement, but shortened the timeframes for the transition process considerably from previous processes. Based on discussions with staff from the Facility as well as State Office, although a goal had been set for transitions to occur for the 15 individuals referred prior to the end of February, there was a commitment to ensure that appropriate protections, services, and supports were identified, and safe and successful transitions occurred.
- Based on limited ISPs attended, teams still seemed confused about process for reviewing professional team members' recommendations regarding an individual's ability to move to the most integrated setting, providing a consensus recommendation to the family/individual, and identifying supports person would need that are not present. In one case, the team appeared to believe that the individual needed prerequisite skills or behaviors to move to the community.
- Potential barriers that the Monitoring Team identified included: 1) As Facility staff identified, access to reliable and readily available transportation was necessary to fulfill the requirements of Section T (i.e., multiple contacts with community providers in relation to the transition planning, implementation, and follow-up activities); 2) Based on previous transitions as well as past discussions with staff, availability of adequate community supports to meet the needs of individuals with complex behavioral and/or mental health needs, as well as those with complex medical needs was a potential barrier; 3) Although efforts were being made to improve ISPs, concerns remained about the adequacy of the ISPs to inform the CLDP process. As a result, the CLDP process remained a challenge. As illustrated during the CLDP review that occurred on 5/8/12, a potential barrier to safe and successful transitions was inadequate CLDPs, including but not limited to incomplete and inadequate essential and nonessential supports.

Monitoring Team's Recommendations Related to Plans of Improvement:

- As discussed during the review, it is absolutely essential that CLDPs be strong and implemented as written to ensure individuals are safe, and lead meaningful and productive lives in their new settings. As discussed, this is a team process, not one person's job. Although staff clearly were committed to improving this process, it was

not clear exactly how the improvements would be made. Given the expectations that referrals will increase, it is essential that a plan for improving the transition process be quickly developed and implemented. In doing so, the Monitoring Team encourages State and Facility staff to refer to the specific recommendations in previous reports related to CLDPs.

- As the Monitoring Team's previous reports have stated, an important role of CLDPs is to provide a roadmap to the team as they are searching for appropriate supports in a community setting. As such, a full set of essential and nonessential supports should be developed as early on in the process as possible, and the teams should identify providers able to provide the protections, services, and supports listed.
- Teams should be provided additional training or technical assistance in relation to reviewing professional team members' recommendations regarding individual's ability to move to a more integrated setting, providing a consensus recommendation to the family/individual, and if applicable, identifying supports person would need that are not available.

SECTION U: Consent

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

- Since Monitoring Team's last review, the Facility hired a Guardianship Coordinator, allowing the Facility to focus more on this section of the Settlement Agreement.
- Based on the documentation the Facility submitted for the last review, more than 230 of the individuals at the Facility had guardians. Since the last review, in checking documentation available for all listed Legally Authorized Representatives (LARs), the Guardianship Coordinator identified significant issues related to current Letters of Guardianship not being available for approximately 150 of the individuals with guardians. However, in a short time, using a number of methodologies ranging from sending requests to LARs for copies of guardianship papers to assisting LARs in submitting needed paperwork to the Court, this number had been cut approximately in half. In addition, the Guardianship Coordinator worked with the Records Department to add guardianship paperwork to the Active Records. These activities were essential to ensuring that the correct person provided consent.
- In April 2012, through ongoing work with local probate court, two days of hearings were held on the AUSSLC campus, resulting in approximately 18 individuals obtaining new guardians. An additional individual obtained a guardian outside of this process, and since the last review, a number of successor guardians also were appointed. One individual obtained a limited guardian, which was a less restrictive option than full guardianship.
- With regard to training, on 3/30/12, training was provided to QDDPs and others from DHHS guardianship expert. The Guardianship Coordinator also attended the Texas Guardianship Association, which was a good networking and educational opportunity.
- The Facility continued to foster a relationship with a local nonprofit guardianship agency. The agency had begun working on a grant to try to identify funds to allow them to serve more individuals from AUSSLC.
- On 3/7/12, the State Guardianship Policy was issued. The Facility's action plan included steps to develop a related Facility policy. Although the timeframes might be ambitious, the Facility presented a reasonable action plan to implement the prioritization piece set forth in the State policy. However, what was still missing was

the assessment of an individual's functional decision-making capacity, which technically should come before the prioritization process.

Monitoring Team's Recommendations Related to Plans of Improvement:

- A major component upon which the State Office still needed to provide guidance was related to assessing functional capacity. Facility staff recognized that once this was available, it would require training of and significant work for IDTs.
- The Facility should continue to expand options related to less restrictive alternatives to guardianship as well as capacity for potential guardians, including working with nonprofit agencies, identifying potential grants, identifying advocates, developing materials and resources to assist individuals to understand more complex decision-making factors, etc.

SECTION V: Recordkeeping and General Plan Implementation

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

- Based on interviews with staff, a system had been developed to make sure records were in the residences at end of week, or properly signed out.
- In addition, the check-out form had been revised to state that the records needed to be back at end of day on which they were signed out, and the destination had been added to the form.
- The Facility recognized that it had fallen behind on completing record audits. However, the two new Unified Records Coordinators (URCs) were expected to begin conducting audits in May 2012. This was an important priority for the Department to ensure records were complete and accurate. Facility staff identified the next step as developing a method for using data to identify and correct any potential individual record or systemic issues. The two URCs also had plans to conduct record reviews simultaneously to begin establishing inter-rater reliability.
- The Individual Notebook Committee reportedly was in the final stages of developing a table of contents using the minimal requirements the State Office provided.
- The Facility was in the process of making revisions to the active records to bring them in alignment with a new Table of Contents.
- The Records and Training Departments had worked together to add a component to the yearly Observation of Signs and Symptoms class to address related records issues, such as requirements for signatures and dates, and checking out records.
- Based on coordination with staff from the Lubbock State Supported Living Center, AUSSLC had begun to have initial discussions about other plans, such as using the QA/QI Council to approve policies, and revising the process for tracking documents that were sent for filing. With regard to the latter, Facility staff recognized the current system was not working, and acknowledged the importance of resolving this issue due to its potential to impact the quality of services. At the time of the review, the Records Department was working closely with the Medical Department to address an issue related to the timely filing of laboratory results. A solution had not been identified, but discussion was ongoing.

Monitoring Team's Recommendations Related to Plans of Improvement:

At this time, the Monitoring Team does not have any recommendations in addition to those included in previous reports.

Appendix A Acronyms

<u>Acronym</u>	<u>Meaning</u>
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
AT	Assistive Technology
ATC	Active Treatment Coordinator
AUSSLC	Austin State Supported Living Center
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Plan
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
DADS	Department of Aging and Disability Services
DSP	Direct Support Professional
ER	Emergency Room
FSA	Functional Skills Assessment
HRC	Human Rights Committee
HRO	Human Rights Officer
HT	Habilitation Therapies
IC	Infection Control
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
LAR	Legally Authorized Representative
OH	Oral Hygiene
NOO	Nurse Operations Officer
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PNM	Physical and Nutritional Management
PNMT	Physical and Nutritional Management Team
QDDP	Qualified Developmental Disability Professional
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
URC	Unified Records Coordinator

Appendix B Documents Reviewed

General

- List of Admissions, Deaths, and Returns to the Facility, from 10/11/11 to 4/30/12;
- AUSSLC Organizational Chart;
- List of individuals served by residence;
- Overtime Hours Paid AUSSLC graph and actual numbers for September 2009 through February 2012;
- Direct Support Professional (DSP) Series Position Fill and Projected Annualized Turnover Rates graph from August 2009 through April 2012;
- Regulatory Report and Plan of Correction, including lists of individuals comprising survey sample, for reviews completed, 1/20/12, 2/23/12, 3/8/12, and 4/5/12;
- Regulatory Report for review completed 4/30/12;
- AUSSLC Human Rights Committee Agenda with attachments, dated 5/9/12; and
- Overtime reports for Residences 784 and 794.

Section C

- Restraint Report for Second Quarter, FY 2012;
- List of injuries occurring during restraint use, from 5/1/11 to 5/1/12;
- PBSP, ISP, and Social History for Individual #33, Individual #344, Individual #369, and Individual #376;
- SSLC Policy 0001.1: Use of Restraints, dated 4/10/12;
- ISP Action Plan templates for Crisis Intervention, Mechanical Restraint, and Protective Mechanical Restraint;
- Lists of Restraints by Type, Emergency Psychotropic Medication, Dental Restraints – Mechanical and IV Sedation, and Pre-Treatment Sedation Orders – Medical and Dental, from 11/1/11 to 5/4/12; and
- Memo from J. Levy to M. Dennis regarding Dental Task Force, dated 5/10/12.

Section D

- Statistics for abuse, neglect, and exploitation, Prevention and Management of Aggressive Behavior Basic and Unusual Incident Training;
- Injury Assessments for Individual #42, dated 4/12/12 and 5/7/12; and
- Investigations for Individual #369: 40878256, 40883238, and 41311381.

Section E

- Regulatory Reports, dated 4/5/12 and 4/30/12.

Section F

- List of QDDPs with assigned residences and caseloads, updated 5/2/12;
- List of individuals with most recent ISP date;
- 45-Minute Observation and Monitoring Form (blank), revised 4/17/12;
- Intra-Facility Move Procedures with attachments, revised 3/13/12; and
- Draft ISP Meeting Guide for Individual #102.

Section G

- Draft ISP for Individual #102, dated 5/7/12; and
- Presentation Book for Section G, including: AUSSLC – Health Services: On Campus Consultation Procedure, dated April 2012; Training roster for “Medical Meeting to Review Settlement Agreement Section G,” dated 3/30/12; Sample form of “Consultation Report” with additional section “Primary Care Provider’s

Recommendation;" Sample form "Eye Clinic Consultation;" Gynecology Consultation report for Individual #308, dated 4/27/12; Orthopedic Consultation report for Individual #178, dated 4/20/12; Orthopedic Clinic on 4/16/12, and 5/7/12, ENT Clinic on 4/26/12: roster of individual name, residence, reason for appointment, and recommendation provided to PCP for follow-up; AUSSLC Medical Services Department Medical Morning Meeting Notes for 4/11/12, 4/27/12, 5/7/12, and 5/8/12; Daily Medical Meeting Attendance Roster for 4/11/12, 4/27/12, 5/7/12, and 5/8/12; "Off campus appointments/on campus appointments" for 5/7/12, 5/8/12, 5/9/12, 5/10/12, and 5/11/12; Missed Appointment Notice form for Individual #448 for neurology clinic on 4/30/12; Untitled tracking form for vision clinic on 4/18/12, indicating reason for visit and number of missed appointments; Audit tool "Consultation Monitoring tool: AUSSLC" used by medical program compliance nurse; AUSSLC – Health Services: Off Campus Consultation Procedure, dated April 2012; "Missed Appointments since Nov 14, 2011 – current" [last entry 5/2/12]; "DEXA Scans waiting to be done;" "Colonoscopy Waiting List to be done;" "Mammogram Waiting List to be done;" "Mammograms completed in last 2 years;" "DEXA scans completed in last 2 years;" "Colonoscopy completed;" Podiatry appointment list for 4/18/12; and Blank agenda form for AUSSLC Medical Services Department Medical Morning Meeting.

Section H

- Draft ISP Individual #102, dated 5/7/12.

Section I

- Draft At Risk Individuals policy, dated 4/17/12;
- Draft State Supported Living Centers – Risk Guidelines, dated 4/17/12;
- Draft Instructions – Use of Integrated Risk Rating Form, dated 4/17/12;
- Draft Annual Integrated Health Care Plan, dated 4/20/12;
- AUSSLC Integrated Risk Ratings list of individuals;
- Memo addressing Choking Incidents, dated 5/3/12;
- Swallowing Incidents for 2011, and 2012;
- Hospital Visits related to Pneumonia;
- List of Infirmery Admissions;
- List of Medical Emergencies;
- Deaths since October 2011; and
- List of Hospital Admissions.

Section J

- Selected sections of the medical records for Individual #327 and Individual #49;
- Total number of individuals residing at AUSSLC and total number receiving psychotropic medication;
- List of individuals with completed CPEs as of 5/3/12;
- Physical, chemical, and mechanical restraint data from September 2010 through February 2012;
- Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS, with scores and completion dates for all individuals who are followed in Psychiatric Clinics, individuals prescribed psychotropic medications and/or Reglan;
- Facility-wide data regarding polypharmacy, including intra-class polypharmacy;
- List of individuals prescribed psychotropic medication, including medication and psychiatric diagnosis;

- Polypharmacy data for April 2011 through March 2012;
- Lists of current Psychiatrists and number of hours worked per week; and
- List of Policies and Procedures developed by Psychiatry Department over the last six months (none).

Section K

- List of Psychology Department Staff, dated 5/7/12;
- Psychology Department Meeting minutes, from 11/1/11 through 5/1/12;
- Behavior Therapy Committee Meeting minutes, from 11/14/11 through 4/30/12;
- External Peer Review minutes, dated 10/28/11, 12/9/11, 1/6/12, 2/10/12, 2/27/12 to 2/28/12, 3/10/12, and 4/20/12;
- Human Rights Committee Meeting minutes, from 11/3/11 through 4/27/12;
- Human Rights Training Package;
- Updated list of Human Rights Committee membership, dated 5/12;
- Positive Behavior Support: Process for Addressing Challenging Behaviors (AUSSLC Directed Plan of Correction);
- Identification of Challenging Behavior checklist, revised 4/18/12;
- Description of training regarding Identification of Challenging Behavior checklist;
- Spreadsheet used to track completion of psychology department tasks, dated 5/8/12;
- Psychological Evaluations for Individual #397 and Individual #336;
- Clinical Care/Observation Log template;
- Unit orientation – Psychology Department training flowchart;
- PBSP/SPCI Competency-Based Training – Competency Check Form;
- PBSP/SPCI Competency-Based Training – Competency Check Form – In Situ Training;
- Positive Behavior Support Plan Treatment Integrity Form;
- Regulatory reports, dated 1/19/12, 1/20/12, 2/23/12, 3/16/12, 4/5/12, and 4/30/12;
- Proposed Directed Plan of Correction in response to regulatory reports from 1/19/12 through 3/16/12; and
- Letter from V. Benson to S. Fox, dated 2/27/12.

Section L

- From 6/17/11 through 5/2/12, list of individuals who have been seen in the Emergency Room, including the date seen at the ER and the reason for the visit;
- From 6/4/11 through 5/2/12, list of individuals who have been admitted to the hospital, including date of admission, reason for admission, and discharge diagnoses, and date of discharge from the hospital;
- From 4/30/12 through 5/1/12, list of individuals who have been admitted to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to home unit;
- From 11/1/11 through 5/1/12, list of individuals who died since the Monitoring Team's last visit, including date of death, death certificate, whether autopsy was done (copy of autopsy report if so), medical problem list current at time of death, and physician's death review;
- Medical External Peer Review audit (raw data) from 4/10/12 and 4/11/12, Round 5;
- Medical Internal Peer Review audit (raw data) from 4/13/12 to 4/16/12, Round 5;

- Blank form/template for AUSSLC Medical Services Department Medical Morning Meeting Agenda;
- Minutes of medical morning meeting, dated 5/7/12 and 5/8/12;
- AUSSLC Nursing Protocol: Process for Routine Preventive Care, dated May 2012:
 - Preventive Health Care Screening Monitoring Tool, dated 1/10/12;
 - Preventive Care tracking sheet for each individual, undated; and
 - Preventive Health Care Guidelines, SSLCs, dated 8/30/11;
- AUSSLC Nursing Protocol: Process for Block Orders/180 Day Orders, dated May 2012;
- AUSSLC Nursing Protocol: Process for Medical Clinic Physician's Orders During Normal Business Hours and After Hours, dated May 2012;
- AUSSLC Nursing Protocol: Process for Physician's Orders in the Homes for Normal Business Hours and After Hours, dated May 2012;
- AUSSLC Nursing Protocol: Process for Backfill in Case Management, dated May 2012;
- AUSSLC Nursing Protocol: Process for On-Campus Consultations, dated May 2012;
- Draft: Routing of O Campus Consultations, undated;
- Draft: Routing of Off Campus Consultations, undated;
- AUSSLC Nursing Protocol: Process for Off-Campus Consultations, dated May 2012;
- AUSSLC Competency-Based Training Roster for Consults/Consult reports;
- AUSSLC Medical Services Policy: Management of Consultation Reports, dated 8/16/11;
- CLDP for Individual #424; and
- Draft ISP and Special Considerations document for Individual #102, dated 5/7/12.

Section M

- Resumes for the following: Nurse Operations Officer, Infection Control Nurse, Nurse Educator, Hospital Liaison, Quality Assurance Nurse, Infirmery Nurse Manager, and Castner Nurse Manager;
- Nursing recommendations generated from the past two Mortality Reviews for Individuals #1, and Individual #199;
- Medication Reconciliation reports from January through April 2012;
- Medication Variance data graphs for Castner, Sunrise, and Woodhollow for January and February 2012;
- External Variance Discovered by Pharmacy Department/Node of Variance reports for January through April 2012;
- Medication Error Summary and data;
- AUSSLC List of Individuals and most recent staffing dates;
- 311 Urgent/6200 Emergent process documentation;
- AUSSLC Integrated Risk Ratings list of individuals;
- Memo addressing Choking Incidents, dated 5/3/12;
- Swallowing Incidents for 2011, and 2012;
- Hospital Visits related to Pneumonia;
- List of Infirmery Admissions;
- List of Medical Emergencies;
- AUSSLC Infection Control list of Individuals;
- Deaths since October 2011; and
- List of Hospital Admissions.

Section N

- Single patient intervention reports in WORx system from 11/1/11 to 5/3/12, copies of selected computer screen snapshots, and physician orders and follow-up orders in response to pharmacy intervention communication to PCP;
- DADS SSLC Statewide Policy and Procedure: Policy #053 Medication Variances, effective 9/15/11;
- “SSLC Medication Variance Guidelines,” dated 1/24/12;
- Medication Variances presentation, undated;
- “Medication Variance Training 2011,” and “Missing Medication Variance Training;”
- Medication Variance data (nursing) January to April 2012 procedural table (i.e., home, category, variance type, node of variance, nurse by name);
- Graphs for each Residential Unit January 2012, February 2012, medication variances according to home;
- External Variance Discovered by Pharmacy Department/node of variance Medication Reconciliation January 2012 to April 2012 medication variance reason by residential unit/home;
- AUSSLC Procedure: Daily Medication Counts, initiated 4/16/12;
- Pharmacy Department’s internal medication variances and corrective action plans November 2011 to April 2012, Internal Pharmacy Variance Trends November 2011 through April 2012, Internal Pharmacy Variance by Severity November 2011 through April 2012, Corrective Action Plan Category F Medication Variance March 21, 2012, and Pharmacy Staff Meeting Notes: Medication Variance from December 9, 2011 to May 5, 2012;
- Chemical Restraint Clinical Review tracking log October 2011 to October 2012;
- Chemical restraint pharmacy reviews, from 1/1/12 to present;
- Chemical Restraint Meeting minutes, dated 2/1/12;
- QDRR schedule and completion dates, from 12/23/11 through 4/4/12;
- Ten most recent QDRRs, including for: Individual #251 (4/27/12), Individual #92 (4/27/12), Individual #262 (4/27/12), Individual #430 (4/27/12), Individual #78 (4/27/12), Individual #357 (4/27/12), Individual #403 (4/27/12), Individual #408 (4/27/12), Individual #452 (4/27/12), Individual #115 (4/27/12); and
- Pharmacy and Therapeutics Committee Agenda and handouts, dated 5/9/12.

Section O

- Presentation Book for Section O;
- State and Facility Physical and Nutritional Management (PNM) Policy/Protocols;
- Medical Morning meeting minutes and sign-in sheet for 5/8/12;
- Multiple AUSSLC Regulatory documents;
- Individuals reviewed by the PNMT;
- List of individuals hospitalized from 6/17/11 to 5/2/12; and
- Action Plans for Section O.

Section P

- Presentation Book for Section P;
- Orientation and Mobility Assessment for Individual #280 and Individual #369; and
- Action Plans for Section P.

Section Q

- List of individuals who within the past six months: for newly admitted individuals, were seen for dental services, including date of admission, and date of initial

evaluation; have refused dental services with dates; have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; have had a tooth/teeth extraction, with dates; have been seen for dental emergencies, with dates; have had preventive dental care with dates; have had restorative dental care, with dates; and were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, with dates;

- In the past six months, per month, absolute number and percentage of individuals utilizing: 1) general anesthesia/IV sedation, 2) oral sedation, and 3) mechanical restraints for dental exam and treatment;
- For those completing annual exams in past six months, oral hygiene rating in each exam listed per individual and date of exams; and
- Presentation Book for Section Q, including: monthly exam report review (December 2011, January 2012, February 2012, March 2012, and April 2012); monthly exam status (December 2011, January 2012, February 2012, March 2012, and April 2012); Oral Hygiene (OH) report for 4/11 to 9/11, and 11/11 to 4/12; OH ratings/exam/date 11/11 to 4/12; Supplemental Facility OH ratings for 11/11 to 4/12; Facility OH ratings 4/11 to 9/11; oral hygiene trainings 12/11 to 4/12; Clients receiving suction tooth brushing services updated 5/7/12; extractions 11/11 to 4/12; Quarterly Missed Appointment Report Review 1/12 to 3/12, Quarterly Missed Appointment Report 1st Quarter 2012; email correspondence concerning missed appointments; sample form for “Informal Assessment: sedation/desensitization decision tree worksheet;” graph of dental restraints 3/11 to 4/12; updated policies to be consistent with Facility terminology and changes in processes, including: AUSSLC Dental Clinic: Comprehensive Dental Care Policy, updated 2/13/12; Missed/Refused Appointments Policy, updated 2/13/12; Dental Desensitization Policy, updated 2/13/12; Criteria for Determining Usage of Enteral Sedation or Total Intravenous Anesthesia (TIVA), reviewed 1/4/12; and Annual Dental Assessment Policy, updated 2/13/12.

Section R

- Presentation Book for Section R; and
- Action Plans for Section R.

Section S

- Draft Policy: Habilitation, Training, Education, and Skill Acquisition Programs, dated 2/2/12;
- Skill Acquisition Plan template;
- Active Treatment Services submitted to the State for approval;
- List of individuals referred for Orientation and Mobility services;
- Orientation and Mobility Evaluation for Individual #369;
- Description of Relocation Approval Committee policies, procedures, and membership;
- Audit of delinquent Personal Support Plans;
- Spreadsheet used to track completion of Functional Skills Assessment and Vocational Assessment;
- List of Active Treatment Refusals – Behavioral Issues;
- ISP addenda related to work refusal for Individual #49;

- AUSSLC Daily Observations Form, revised 2/20/12 – accompanying instructions and training rosters for the month of February;
- Individual Resident 45-Minute Observation and Monitoring Form, revised 4/17/12;
- AUSSLC Active Treatment Monitoring – Coaching Guide, dated 3/26/12;
- Resident Attendance Procedures for Vocational and Day Programming, dated 2/16/12;
- The Activity Manual: A collection of meaningful activities supporting active treatment (The Columbus Organization);
- Environmental Checklist;
- Regulatory reports, dated 1/19/12, 1/20/12, 2/23/12, 3/16/12, 4/5/12, and 4/30/12;
- Proposed Directed Plan of Correction in response to regulatory reports from 1/19/12 through 3/16/12; and
- Letter from V. Benson to S. Fox, dated 2/27/12.

Section T

- CLDP, related assessments, previous ISP, BSP, Safety Plan, and 90-day post-move monitoring report for Individual #424;
- Community Placement Report, for period between 10/11/11 and 4/30/12;
- Post Move Monitoring Since Last Onsite Visit, from 10/11/11 to 4/30/12;
- Annual Report: Obstacles to Transition Austin State Supported Living Center, Fiscal Year 2011, data as of 8/31/11;
- Community Transition Process, undated; and
- Checklist for Community Transition Process, undated.

Section U

- Section U Presentation Book, including action plans;
- List of new Legally Authorized Representatives since 11/11; and
- Major Guardianship Accomplishments, dated 5/7/12.

Section V

- No documents reviewed.

Attachment C

Interviews and Observations

Section C

- Interview with Dr. George Zukotynski, DADS Psychological/Behavioral Services Coordinator, Jose Levy, AUSSLC Director of Behavioral Services, and Jamison Maris, AUSSLC Associate Psychologist.
- Observations of:
 - Incident Management Review Team meetings, on 5/7/12 and 5/8/12;
 - Behavior Support Committee meeting, on 5/8/12; and
 - Restraint episode for Individual #74, on 5/9/12.

Section D

- Interview with Jennifer Russell, Director of Risk Management and Incident Management.
- Observations of:
 - Self-Advocacy meeting, on 5/9/12;
 - Incident Management Review Team meetings, on 5/7/12 and 5/8/12; and
 - Observations in all residential areas (with the exception of 732 E and 779P), and in the vocational workshop, Graceland, and the Golden Years Program.

Section E

- Interview with Curtis Walters, Quality Assurance Director; and Cheri Gard, Program Compliance Monitor.

Section F

- Interviews with Holly Lindsey, QDDP Coordinator; Sarah Knowles, Director of Active Treatment; Keith Robinson, QDDP Educator; and Jim Sibley, State Consultant.
- Observations of ISP meeting for Individual #102, on 5/7/12; and ISP meeting for Individual #288 on 5/8/12.

Section G

- Interviews with Jammie Duggan, RN, Clinic Nurse; Dr. Lilani Muthali, State Office State Supported Living Center Medical Services Coordinator; Dr. Chrishanthi Perera, Director of Physician Services, AUSSLC; and Mary Gallo, RN, Medical Program Compliance Nurse.

Section H

- Interviews with Curtis Walters, QA Director; and Lilani Muthali, MD, State Office SSLC Medical Services Coordinator.

Section I

- No interviews with staff due to lead person not being assigned to Section I at the time; and
- Observation of ISP meeting for Individual #102, on 5/7/12.

Section J

- Interviews by telephone with Jose Levy, Director of Behavioral Services; Kenda Pittman, Director of Pharmacy Services, and Zach Corbell, Pharm. D.; and Drs. Scott Murry, Judi Stonedale, Lilani Muthali, and Bill Race.

Section K

- Interview with Jose Levy, BCBA, Director of Behavioral Services, and Jamison Maris, BCBA, Associate Psychologist, on 5/9/12;

- Interview with JoAnn Villasana, Human Rights Officer, and Nicole Hinajosa, Guardianship Coordinator, on 5/9/12;
- Observation of or participation in:
 - Unit Morning Meeting (Sunrise), on 5/8/12;
 - CLDP Discussion for Individual #424, on 5/8/12;
 - Behavior Support Committee Meeting, on 5/8/12;
 - ISP Meeting for Individual #288, on 5/8/12;
 - Human Rights Committee Meeting, on 5/9/12;
 - Residence 501, Residence 729, Residence 732 Dove, Residence 732 Falcon, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 795, Residence 796, and Residence 797;
 - Workshop 527, Workshop 544, and Workshop 503;
 - Activity/Day-Habilitation Center 510, Activity/Day-Habilitation Center 512, Activity/Day-Habilitation Center 532, and Activity/Day-Habilitation Center 772; and
 - Computer Lab 533.

Section L

- Interviews with Lilani Muthali, MD, Interim Medical Director for AUSSLC, and State Office SSLC Medical Services Coordinator; Chrishanthi Perera, Director of Physician Services, AUSSLC; all PCPs, including Archie Smith, MD, Alfredo Cisneros, MD, Tae Wong, MD, and Jodie Friedrich FNP; Mary Gallo, RN, Medical Program Compliance Nurse; and Curtis Walters, Director of QA.
- Observation of:
 - Individual #72, Individual #366, Individual #450, Individual #213, Individual #65, Individual #381, Individual #434, Individual #174, Individual #81, Individual #45, Individual #422, Individual #299, Individual #286, Individual #14, Individual #405, Individual #402, Individual #51, Individual #222, Individual #341, Individual #18, and Individual #287; and
 - Morning Medical Meetings, on 5/8/12, and 5/9/12.

Section M

- Interviews with Michelle Head-Blalack, RN, Chief Nurse Executive; Lori Z. Cordova, RN; Case Manager Supervisor; Debbie Carnico, RN, Hospital Nurse Liaison; Brittany LaBarreare, RN, Infirmery Nurse Manager; Mary LeFebvre, RN, Acting Nurse Operation Officer, and Nurse Manager, Sunrise; Michael J. Maynard, RN, Nurse Manager, Woodhollow; Cynthia Kiger Standley, RN, Nurse Manager Castner; Kathy Green, RN, BSN, Infection Control Nurse; Melissa Ann Klopf Sawyer, RN, Quality Assurance Nurse; Richard D. Sambrook, RN, BSN, Nurse Educator; Chrishanthi Perera, Medical Director; Kenda Pittman, PharmD Director of Pharmacy; Linda Fischier, FNP, State Consultant; Valeria Campbell, Environmental Specialist; Byron Swor, Director of Facility Supports Services; David Hoppe, Custodial Manager; Chris Ruddell, Assistant Plant Manager; Connie Horton, FNP, State Consultant; Karen Hardwick, Ph.D, State Office Coordinator for Specialized Services; Donna Jesse, State Office SSLC Director of Operations; and Sally Schultz, State Consultant;
- Observations of or participation in:
 - ISP meeting for Individual #102, on 5/7/12;

- Morning Medical Meeting, on 5/8/12;
- CLDP review meeting for Individual #424, on 5/8/12; and
- Walk-through of Building 797 with Assistant Plant Manager, Custodial Manager, Environmental Specialist, Chief Nurse Executive, Infection Control Nurse, and FNP State Consultant, on 5/8/12.

Section N

- Interviews with Kenda Pittman, Pharm D/Clinical Pharmacist, Director of Pharmacy; Zach Corbell, PharmD/Clinical Pharmacist; Guy Campbell, PharmD/Clinical Pharmacist; and Michelle Head-Blalock, RN, CNE;
- Observations of or participation in:
 - Pharmacy and Therapeutics Committee, on 5/9/12; and
 - Meeting with Pharmacy, Nursing, and Medical Departments, on 5/9/12.

Section O

- Interviews with Kim Ingram, Director of Habilitation Therapies; Karen Hardwick; State Coordinator for Specialized Services; Chris Strickland, OT; and Susan Hanson, PT.
- Observations in 732 Phoenix, 732 Dove, 732 Eagle, 792, 797, 779 Falcon, 795, 793, and 791.

Section P

- Interviews with Kim Ingram, Director of Habilitation Therapies; Karen Hardwick; State Coordinator for Specialized Services; Valeria Campbell, Environmental Specialist; Bryon Swor, Support Services; and David Hoppe, Custodial Manager.

Section Q

- Interview with Rhonda Stokley, DDS, Dental Director.

Section R

- Interview with Kim Ingram, Director of HT.

Section S

- Interview with Holly Lindsay, QDDP Coordinator; Sarah Knowles, Director of Education and Training; Keith Robinson, QDDP Educator; and Jim Sibley, State Office Consultant;
- Observations of or participation in:
 - Sunrise Unit Morning Meeting, on 5/8/12;
 - CLDP Review for Individual #424, on 5/8/12;
 - ISP Meeting for Individual #288, on 5/8/12;
 - Residence 501, Residence 729, Residence 732 Dove, Residence 732 Falcon, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 795, Residence 796, and Residence 797;
 - Workshop 527, Workshop 544, and Workshop 503;
 - Activity/Day-Habilitation Center 510, Activity/Day-Habilitation Center 512, Activity/Day-Habilitation Center 532, and Activity/Day-Habilitation Center 772; and
 - Computer Lab 533.

Section T

- Interviews with Debbie Burgett, State Office Continuity Services Consultant; Mary Birdsong, Admissions/Placement Coordinator; Mary Bishop, DADS State Office

Settlement Agreement Unit; Chris Adams, DADS Assistant Commissioner, State Supported Living Centers; and Donna Jessee, Director of Operations, DADS, State Supported Living Centers;

- Observation of or participation in:
 - ISP meeting for Individual #102, on 5/7/12;
 - ISP meeting for Individual #288 on 5/8/12; and
 - CLDP Review for Individual #424, on 5/8/12.

Section U

- Interview with JoAnn Villasana, Human Rights Officer; and Nicole Hinajosa, Guardianship Coordinator.

Section V

- Interview with Leann Boyd, Client Records Coordinator; and two Unified Record Clerks.