UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF IOWA

Monitoring Team Report
Dates of Onsite: March 7-10, 2023
Date of Final Report: May 6, 2023

Submitted By: James M. Bailey, MCD-CCC-SLP
Court Appointed Lead Monitor

Teri Towe, B.S.
Alan Harchik, Ph.D., BCBA-D
Assistant Lead Monitors

Monitoring Team: Wayne Zwick, M.D
Daphne Glindmeyer, M.D.
Teka Harris, M.A., BCBA
Melanie Reeves-Miller, B.S.
Bonnie Wallington, RN, CCM
Jane Wiemerslage, B.A.

Table of Contents

Methodology
To assess the Center's compliance with the Settlement Agreement, the Monitoring Team undertook a number of activities.

a. Selection of individuals: The Monitoring Team requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Team then chose the individuals to be included in the monitoring review. This non-random selection process is necessary for the Monitoring Team to address a Center's compliance with all provisions of the Settlement Agreement.
b. Onsite review: The Monitoring Team was present onsite at the Center.
c. Review of documents: Prior to the onsite review, the Monitoring Team requested several documents regarding the individuals selected for review, as well as some Center-wide documents. During the week of the review, the Monitoring Team requested and reviewed additional documents.
d. Observations: The Monitoring Team observed individuals in their homes, day/work sites, and other locations at GRC during regularly occurring activities. Specific activities were also scheduled and observed, such as administration of medication, implementation of skill acquisition plans, and mealtimes.
e. Interviews: The Monitoring Team interviewed several staff, individuals, clinicians, and managers.
f. Monitoring Report: The monitoring report details each of the various outcomes and indicators that comprise each section of the Settlement Agreement. A summary paragraph is provided for each section. In this paragraph, the Monitor provides some details about the provisions that comprise the section.

Organization of Report
The report is organized to provide an overall summary of Glenwood Resource Center's baseline status as it relates to the Settlement Agreement. Specifically, for each of the lettered sections of the Settlement Agreement, the report includes the following sub-sections:

a. The Monitor has provided a summary of the Center's performance on the indicators in the lettered section. Some of the indicators were not able to be measured appropriately due to this being a baseline review. Additionally, some indicators reflect a roll up of scores which will be determined and measured during the next review.
b. Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to assigned numbers.

Executive Summary
The Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Glenwood Resource Center for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Team during the review. The Center Superintendent supported the work of the Monitoring Team and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Team; their time and efforts are much appreciated.

SECTION A	Research

Summary of Monitor's Assessment:

Research (41-47)

Individuals were not subjected to any form of research based upon the review of policies, procedures, documentation, and interview. (41)

The Research policy dated 5/23/22 stated that for an individual to participate in research there must be clear informed consent and the identified research must be reviewed to ensure risks are reviewed and all methods of mitigation are implemented. If the individual was unable to provide such consent, then the legal guardian may provide consent on their behalf. Any research-related proposals were to be presented to and approved by the Human Rights Committee. (42-44, 47)

The Office of Research Integrity within HHS appeared to monitor annually for research misconduct as noted on 1/4/22 and 1/9/23. Policies, certification, and any related research activities were part of this review. (43, 46)

Based upon training records provided by GRC, training in the Research Policy had been completed for staff and was providing ongoing for new hires. Per the report by the Superintendent, there was no research being conducted at GRC and there was no intent to initiate any research. (45)

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

1. Ensure policy shows review and approval by HHS. This may be accomplished via HHS staff signature or by HHS stamp on the document/policy. Per report from GRC, the research policy

2. The policy currently lists the Leadership Team as being responsible for monitoring compliance but did not state the frequency of the monitoring or what will be monitored (46).

Completion of the above recommendations should move Section A to compliance. Per report, GRC's Research policy has been updated to reflect the review and approval by the Iowa Department of Health and Human Services (HHS) with the signature obtained from the State-Operated Facilities Division Director (HHS Central Office). The policy has also been updated to reflect that the GRC Superintendent will monitor policy compliance by confirming with GRC Leadership and Department Heads, on a quarterly basis, as to whether research has been conducted at GRC. Documentation of confirmation will be kept by the Superintendent's Secretary. An HHS Central Office designee will review if research has been conducted at GRC on an annual basis, consistent with federal reporting requirements. These documents will be reviewed during the next visit.

SECTION B	Integrated Interdisciplinary Care and Services

Summary of Monitor's Assessment:

Integrated Interdisciplinary Care and Services (48-57)

The GRC policy related to Individual Support Plans stated that ISPs should be developed using a person-centered approach, however, there were no guidelines for how that might be accomplished or what that entailed so it was not evident that person-centered planning would be in line with generally accepted profession standards of care. (48)

The Center attempted to involve individuals and their guardians in the ISP process by inviting them to attend annual ISP meetings, other IDT meetings, and monthly review meetings. It was not documented in the ISP if/how the individual participated in the meeting and whether the individual had opportunities to provide input into each of their service plans and/or revision of that plan. There was no evidence that individuals were provided with support, education or training to support meaningful participation and self-advocacy. (49)

During the week of the review, the Monitoring Team observed two ISP meetings, for Individual #57 and Individual #105. Additionally, to review this section of the Settlement Agreement, a sample of ISPs was requested. It was not evident that individuals and their guardians routinely participated in the development of the ISP.

- Individual #105 attended her meeting and the IDT attempted to include her in the discussion by asking for her agreement as plans were reviewed.
- Individual #57 did not attend his annual meeting nor did his guardian.
- A small sample of signature sheets were reviewed to determine if individuals and their guardians attended annual ISP meetings. This included Individual #99, Individual #45, Individual #46, Individual #1, Individual #48, and Individual #82. One of the six individuals attended their annual meeting. None of the guardians were in attendance.

Person-centered planning should be used as part of a discovery process to identify individual's preferences in areas, such as recreation, relationship, housing, vocational preferences, and/or other meaningful day activities. That discovery process should drive the development of an ISP that outlines supports, services, and training focused on helping the individual achieve their vision for what their life might look like in a less restrictive setting. GRC's ISP process was centered around activities available at the Center and identification of living options that might be available to support the individual's needs without consideration of other important parts of the individual's life. (50)

The ISP documented various assessment findings and recommendations, but that information was not integrated into one comprehensive plan that was based on the individual's vision and goals for the future, including preferences for living options, working, daily routines, opportunities for community integration, and building relationships. Details regarding the ISP process will be further discussed under Section Hi. The adequacy of discipline-specific assessments and treatment plans used to develop the ISP/discharge plan were also commented on in detail in the provisions of Section C. (51-52)

In general, assessments were brief without a focused look at how support could be provided in a less restricted setting or how support needs may vary in a different environment. Without establishing long-term goals for the individual based on their preferences, disciplines were not able to address barriers or determine support needs that supported goal achievement. (52)

For the most part, IDT presence at annual meetings by relevant disciplines was good and each discipline submitted assessments prior to the development of the ISP. The exceptions were attendance by the PCP and psychiatrist. Additionally, medical and pharmacy assessments were often not submitted on time for review by the IDT. Input from PCPs and psychiatry is critical to ensuring that there is a smooth transition and individuals are not at risk because IDTs did not identify supports to reduce risks. Active participation at the ISP meetings varied with the primary discipline often being a member of Habilitation Therapy or the physical and nutritional management team (PNMT). (51-52)

GRC had a process in place for a monthly integrated review (MIR) by the IDT of all supports and services. The individual and guardian were invited to attend IDT monthly reviews, as were other relevant IDT members. The last six months of MIR minutes were reviewed for Individual #45, Individual #99, and Individual #82. When individuals and/or their guardians did not attend the meeting, there was no documentation that other avenues of participation occurred or that they were informed of the meeting and any recommendations or revisions to supports. (53-55)

- Individual #45's MIR minutes did not document his attendance at meetings.
- Individual #82's attendance was documented for two of the six months.
- Individual #99's MIR minutes documented her attendance at meetings.
- There was no evidence of guardian attendance or participation in the monthly review process for the three individuals.

Data related to behavioral objectives and skill acquisition programs were reviewed for evidence of progress and effectiveness of treatment at MIR meetings. When an individual was not making progress, their IDT recommended revisions. PCP and psychiatrist did not attend monthly meetings and for the most part, data related to risks, medical issues, and psychiatric issues were inserted into the document with no summary or comment. Thus, it was not possible to determine if all supports and services were reviewed and modified when not effective or if there was a change in status. (55-56)

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

1. IDTs need to make additional effort to include individuals and their guardians in developing ISPs and transition plans. Consideration should be given to supports that the individual may need to meaningfully participate in team meetings, such as communication support and advocacy training.

2. ISPs should include an overall vision for what the individual wants their future to look like, not just where they want to live, but also how they want to spend their day, including leisure activities, relationships, engagement in the community, and work/day/retirement programs. To determine preferences in these areas, many individuals will need greater exposure to options available in the community.

3. Rather than being a list of all discipline assessments and recommendations, ISPs should be an integrated plan where treatments and supports are integrated and individualized based on the individual's overall vision.

SECTION C	**Clinical Care**

Summary of Monitor's Assessment:
Indicators 58-67 reflect general clinical principles to be offered to the residents at GRC. These indicators are reflected in the review of Section C.i through C.vii. These indicators will be more fully assessed during the subsequent review but based upon the limited data reviewed below, these indicators are not being fully met.

Ci. Supervision and Management of Clinical Services (68-72)
GRC appeared to have sufficient medical staffing to ensure proper management of the individuals, The Medical Director and two NPs were the primary care team for approximately 100 individuals at the time of the review. The case load was acceptable to provide quality care management of the individuals. Each provider cross-covered as clinically indicated to ensure there was no gap in clinical services. The NPs took on call responsibility for approximately one week on and one week off. (68)

While there appeared to be sufficient medical staffing, psychiatry staffing lacked in its onsite presence. The facility currently has two psychiatrists contracted to provide clinical services. One psychiatrist was board certified. The other psychiatrist was reported as board eligible, however, this did not appear to be accurate. Each psychiatrist carried their own caseload and cross-covered as clinically indicated, but the two psychiatrists only accounted for 1.5 days per week of onsite attendance. This impacted their ability to be an active participant in the ISP and transition processes. (69-70)

The current Medical Director was new and had recently started his role in February 2023. The Medical Director was board certified in internal medicine with over 30 years of clinical experience as well as over 20 years of administrative experience as a Medical Director. There were two physician extenders (NPs); one was a licensed Nurse Practitioner with a major as Family Nurse Practitioner and the other had a Doctor of Nursing Practice. (71)

All medical staff were current in their State medical/APN professional licensure. One NP had accumulated 50 hrs. of continuing medical education since 10/7/22. The other had CMEs totaling 48.56 hrs. from 3/25/22. The CMEs completed since February 2022 were also requested for the Medical Director but were not provided. Per GRC report, Dr. Angel has completed 13 CMEs since February 2023 and GRC will develop a process to collect and track CME information for the medical providers. (71)

The Center confirmed there were no external reviews of clinical care by the PCPs during January and February 2023. The Medical Director indicated there was a monthly call to the University of Iowa Medical Center and a case was reviewed by staff at that institution. However, there was no documentation of this external review process. (72)

The Mortality Review Committee report dated 1/17/23 reviewed the death of Individual #113. Attendance included the Center superintendent, assistant superintendent, Director of Quality Management, Medical Director of the Center, PCP of the deceased individual, AON, TPA, and a representative from the central office via phone. The date of the meeting was documented as 1/17/23 but was signed by the Director of Quality Management on 3/3/23. (72)

An external peer review was also completed for Individual #113 whose death occurred during the Monitoring Team's review period. The external peer review was completed on 2/23/23, which was 11 weeks after the death but within reason. An external independent physician mortality review occurred on 2/28/23, which was signed by the Director of Quality Management on 3/3/23. Attendance at this meeting included the superintendent of GRC, a Central Office representative, Director of Quality Management, the chief medical officer, psychiatrist, and the AON. The GRC PCP completing the internal mortality review was the PCP assigned to the individual. This practice did not meet the standard of the Settlement Agreement**.** For this one death, there was no recommendation made from the Center's mortality review or the Independent Mortality Review Committee. Prior to this death, the most recent death of an individual was on 5/16/22, out of range for the Monitoring Team's baseline database. (72)

Cii. Medical Services (73-76)

As stated previously, the Medical Director was new to the position, recently starting in February 2023. The Medical Director was board certified in internal medicine, with over 30 years of clinical experience, as well as over 20 years of administrative experience as Medical Director. (73)

For acute care requiring communication and transport to the ED and subsequent hospitalization, documentation of PCP notes indicated timely documentation if after hours transfer occurred (Individual #99 on 2/20/23), or a PCP note at the time of transfer (Individual #43 on 1/5/23 and 2/14/23, Individual #12 on 1/10/23). For these two individuals, transfers to the ED occurred when the PCP was onsite and there was documentation of communication between the PCP and the ED staff discussing the reason for the transfer to ensure continuity of care. (74)

External consult reports were reviewed for Individual #82, Individual #45, and Individual #99. Out of the 16 consultations completed from 10/14/22 to 1/26/23, Individual #99 was missing initials for the 2/24/23 general surgery consults as well as the PCP progress note. Individual #99 was also missing a PCP progress note for the eyecare consult completed on 11/15/22. Individual #45 was missing the accompanying PCP progress note for the 12/1/22 eyecare consult. (75)

Lab data were reviewed for the two months prior to recent hospitalization of individuals. Seventy-eight of the 81 (96%) labs had signatures and initials noted by the PCP, and 77 of 81 (95%) had the date of signature or initials. (76)

Ciii. Residents at Risk of Harm (77-81)

To help assess risk, the individuals' risk levels along with their supporting rationale were reviewed. The Center had developed uniform triggers and thresholds to assist in the proactive identification of risks. These triggers were present in the HSSP for the individual records reviewed. For vital signs, parameters were defined in each plan as warranting notification of the nurse, who notified the primary care physician for blood pressure greater than 150/100, or less than 90/60, pulse greater than 100, or less than 60, respirations greater than 22 or less than 12, oxygen saturation less than 92%, temperature >100.4 or <96. The risk levels were also reflected as included in the ISP meetings. (77)

Civ. Nursing Services (81-87)

Based upon the master tracking document, the nurses were maintaining the timeliness of completing annual assessments of each individual, according to their internal guideline of no more than five days prior to the ISP. Most of the records verified that the quarterly physical assessments were also completed by the end of each third month. (82)

The AON and RN Supervisor met on weekdays with medical providers (morning medical), including the PNMT to review the status of individuals displaying symptoms of illness, and/or had experienced significant changes to health involving ER, hospital admission or discharge, or planned surgery. While the condition of the individual was discussed, there was lack of clear takeaways assigned to attending members or related follow-up to help measure the effectiveness of provided supports. (84)

Assessments

Based on the limited review, the nurses did perform comprehensive nursing assessments routinely and as necessitated by a change in individual condition, but the assessment was missing key components and documentation of such, as well as documentation of appropriate communication. (81-84)

- For Individual #103, there was evidence that the nurse assessed the individual upon a change of health status (to ER at 4:48 am following a seizure on 2/23/23 and returned approximately 9:30 am).

- The individuals' HSSP risk triggers vital sign parameters were defined the same as in all other HSSPs reviewed as: blood pressure greater than 150/100, or less than 90/60, pulse greater than 100, or less than 60, respirations greater than 22 or less than 12, oxygen saturation less than 92%, temperature >100.4 or <96 warrants staff to report to nurse, who will notify the PCP.

- While the documentation for Individual #103 displayed that he was assessed, documentation was incomplete or inconsistent. This was noted in the 2/23/23 initial assessment where components were missing, such as bowel sounds, whether the individual was on supplemental oxygen or room air, and description of seizure type or presentation details. For the assessment that occurred on 2/23/23 for the return home, the assessment did not include vital signs (blank), last BM, and lack of communication of high respirations to primary care physician. Missing components in other assessments included the 2/25/23 1:12 am note that was missing the date of the last seizure and lack of clarity if the individual was on room air or supplemental oxygen on the 2/25/23 10:00 am note.

- The nursing assessment completed on 3/3/23 for the purpose of annual/monitoring included vital signs, but weight was not included. Additionally, there was no follow-up documented in the resulting SOAP note for the borderline blood pressure and low pulse, nor for the cerumen in the ears.

- For Individual #82, the annual nursing report dated 6/2/22 and the corresponding annual physical assessment dated 6/4/22 were reviewed. Pain (present) was included, however, the section asking if pain relief measures were effective was left blank. There was no weight recorded and there was no mention of her use of a CPAP. The physical also mentioned a new finding since the previous month of an inverted nipple but did not document reporting of the finding to the primary care physician. In the next assessment, dated 1/11/23 (which was not timely as it was more than 90 days late), a different nurse assessed with no pain, no mention of the CPAP use, and no abnormalities to the breasts as medically stable.

- For Individual #45, a review was completed of the physical assessment dated 3/2/22 and nursing report dated 4/3/22. No weight and temperature were noted in the vital signs section, indicating taken by staff. It appeared that one would have to reference a different document (DAR) to determine the individual's temperature. Best practice is for the nurse to personally take vital signs for any assessment they complete.

- For Individual #12, the nurse documented to standards an assessment dated 1/3/23 that included assessment of his abdomen and a description of his intermittent abdominal pain that he voiced to the nurse, as well as the resulting actions taken to relieve pain. The SOAP note adequately documented the procedure and the resulting outcome. The PCP was updated via notification log, offered no new orders, and continued plan of twice daily GI assessments.

- The assessment on 8/24/22 of Individual #91 was missing apical pulse/cardiac circulatory section (left blank). Cerumen was noted in ears, but no follow-up actions were documented in the SOAP note. The annual Nursing Report dated 6/14/22 did include some, but not all, needed details on the neuro/seizure risk as it stated he had been having multiple seizures monthly, the use of Diastat, and the frequency of his neurology consultations.

- Per morning medical observation, Individual #91 was hospitalized in serious condition (ICU) after being sent out for meal and fluid refusals with electrolyte imbalance and was pending placement of a feeding tube. During the clinical team discussions, long term staff that knew him well shared that over the years he had similar intermittent periods where he stopped eating. Staff expressed that they believed this was triggered by changes in his routine/residence. Recent assessments preceding his change of condition revealed that this staff knowledge was not in the last risk screening/nursing assessment, so he scored as not being at risk for being underweight or fluid imbalance. Therefore, there was no support plan for those areas developed as there should have been.

Infection Control and Skin Integrity

Based upon the January 2023 Infection Control Committee meeting notes provided, GRC had established an Infection Control committee and designated an Infection Control Nurse (who was relatively new to the Center) that met monthly to review infections, including UTIs; antibiotic, antifungal, and antiviral use; COVID-19 positive rates; vaccinations; and concluded with actions required. The list of the committee members did not indicate who was present and there was no summary of the team discussion. There were several missing key components to the current program: (85-87)

- No antibiotic stewardship.
- no current method to access expertise or guidelines for infection surveillance and prevention.

During interviews onsite, the designated Infection Control Nurse was not aware of McGeer criteria but did state that antibiotic stewardship was set up at her former long term care facilities.

During observations of medication administration on the residences, three of three CMAs did not properly sanitize hands during the observation until reminded by the RN Supervisor that accompanied the Monitoring Team.

To help with the prevention of skin issues, the Center had a designated nurse with experience in wound care that was assigned to track individuals with impaired skin integrity. Upon review of the data, there were nine pressure wounds. Of those, three were hospital acquired (stage II), four were Center acquired stage II pressure wounds, and one was a (stage I) Center acquired wound. There were no pressure wounds at Stage III or higher.

It was positive to see during a visit to the medical home, that many of the individuals were provided with special Stryker beds to reduce pressure points. (85-87)

Medication Variances

During the Medication Variance committee meeting observed onsite 3/9/23, the Administrator of Nursing (AON) led the meeting, which was attended by the new Medical Director, the ARNP, and program staff. The AON explained that the group used the time to ponder potential contributing factors and possible solutions for each reported medication variance. They reviewed the reported variance form, a photo of the unit dose bubble pack, and MAR if indicated. The AON explained that they typically carry over action plans from previous meetings through completion, such as retraining of staff/status. The meeting documentation resembled a worksheet used to make notes while reviewing each medication variance document and while likely helpful for the AON in understanding factors and trends, as an official document of minutes, it did not sufficiently record that follow up actions for each medication variance were planned, who was assigned to take action(s), or whether or not implemented or completed. (87, 102)

During interview onsite with the AON, the Monitoring Team was informed that a significant number of the previous months' variances were related to potential errors related to unit dose packaging by the contracted pharmacy, some of which were resolved and did not reach the individual. Medication variance tracking and the meeting documentation were insufficient to verify compliance with internal policies and procedures for reporting and trending.

While the policy included the nine GRC levels of medication variances, procedures to follow upon discovery of a variance that reached the individual (Level 3 or above) did not include where to document the actions/activities listed. The timelines in the medication variance policy dated 8/22/22 as to completion of related medication variance review and of "within 72 hours of discovery or upon receiving the action plan from the CMA" and "clinic review within seven days" were vague and/or inappropriately lengthy regarding response to medication variances that reach the individual. (87, 102)

Examples of medication variances reaching individuals were:

- On 11/3/22, five individuals (Individual #4, Individual #38, Individual #62, Individual #66, Individual #98) received a pneumococcal conjugate vaccine without consent by legal representative.
- On 11/14/22, Individual #58 received a peer's medications and was sent to the ED.
- On 12/8/22, Individual #31 received a peer's medications and was sent to the ED.
- On 12/24/22, Individual #32 received the wrong dose of medication.

- On 2/1/23, five individuals (Individual #23, Individual #53, Individual #54, Individual #79, Individual #24) did not receive their ordered medications.
- On 2/7/23, 26 variances were discovered for Individual #1 who received the wrong dose of his thyroid medication (Synthroid) for 26 days due to a transcription error of ordered increase to his dose that failed to discontinue the previous dose.

Participation in the committee was lacking as noted by:

- Medication variance minutes from 1/26/23 documented participation by two TPAs and two RNs, with most staff recorded as absent (no prescribing providers present, no representation from the pharmacy present).
- Minutes from 2/9/23 documented participation by one TPA and one RN, with most staff recorded as absent (no prescribing providers or representation from the pharmacy present).

Medication Administration

Observation of medication administration for Individual #99, Individual #45, Individual #82, Individual #15, and Individual #18 were completed during the onsite visit, with the RN Supervisor present. All observations were of Certified Medication Aides (CMA). There were no medication errors during the observations. The CMAs were familiar with the individuals and their preferences for medication administration. One pink pill was noted on the floor near the medication cart in one of the homes. Upon bringing this to the attention of the CMA, the nurse was contacted. (102)

Hand hygiene, as stated previously, was the primary gap noted in three of the observations, with staff needing to be reminded to sanitize their hands. (102)

Cv. Psychiatric Services (88-91)

The facility had two psychiatrists contracted to provide clinical services. One psychiatrist was board certified. The other psychiatrist was reported as board eligible, however, this did not appear accurate and should be confirmed. Per GRC report, they are seeking further clarification on Dr. Murthy's board eligibility. (88)

Facility policy and procedure titled Psychotropic Drugs was initiated 4/20/20 and reviewed 4/25/22. It required that "Psychotropic drug use must be based upon a psychiatric diagnosis or mental disorder that prevents the individual from meaningfully participating in their habilitation plan. It is recognized that a situation may arise in which a psychiatric diagnosis may not be possible. In such cases, a behavioral-pharmacologic hypothesis is formulated based upon diagnostic and functional assessments." While this policy designated the requirement for evaluation and diagnosis prior to medication administration, it did not delineate the components of a psychiatric evaluation. While it is not necessary for this to be outlined in policy, it is recognized that a comprehensive psychiatric evaluation is necessary to ensure accurate diagnoses, the development of a bio-psycho-social treatment formulation, and treatment recommendations. The components of a comprehensive evaluation are well accepted in psychiatry and the focus of clinical practice guidelines promulgated by the American Psychiatric Association. (88)

Review of documentation regarding three individuals (Individual #99, Individual #45, Individual #82) prescribed psychotropic medication revealed the need for improvement regarding diagnosis. Specifically, the symptoms an individual is exhibiting indicating they meet criteria for a specific diagnosis should be reviewed and a bio-psycho-social formulation must be developed for each individual inclusive of the behavioral-pharmacologic hypothesis as required by policy. Diagnostic criteria from either the Diagnostic and Statistical Manual of Mental Disorders 5th Edition [DSM 5] and/or the Diagnostic Manual-Intellectual Disability 2nd Edition [DM-ID 2] can be utilized. (88)

For example, the following was illustrative of the need for improvement in diagnostic formulation. In the psychiatric documentation regarding Individual #82, a diagnosis of borderline personality disorder was added with the following justification, "the addition of the diagnosis of borderline personality disorder fits this young woman quite neatly. Explains some of her mode [sic] variability and acting out and her interpersonal conflicts as well." This did not inform the team or future care providers of the clinician's rationale for the diagnosis, nor did it describe the specific difficulties this individual was experiencing. (88)

In another example, regarding Individual #99, a diagnosis of Bipolar Mood Disorder "related to a general medical condition with manic or hypomanic episodes" was noted. There was no description of the symptoms associated with these episodes. Again, this did not describe the specific difficulties this individual was experiencing. (88)

While individuals prescribed psychotropic medications had a documented behavioral treatment plan, there were issues with integration of psychiatric treatment with behavioral and other interventions. As noted above, there was a need for combined assessment and case formulation. (89)

There was reportedly a difference between psychiatrists in the format for psychiatric clinic. One psychiatrist performed an Interdisciplinary Team (IDT)-based clinic where members of the individual's treatment team attended clinic and participated in the clinical encounter. The team members included behavioral health, nursing, and direct support staff. The other psychiatrist reportedly did not perform an IDT based clinic. This was one area where integration can be improved. IDT-based clinical encounters are necessary with presentation of data and other clinical information to the psychiatrist and the rest of the IDT. It is then the responsibility of the psychiatrist to review the data presented with the IDT to make team-based data driven clinical decisions. (89)

The psychiatrists were not participating in treatment team meetings or in transition planning (outside of the psychiatric clinical encounters). This is an impediment to integration. For meaningful integration, it is necessary that psychiatry is engaged as an active member of both the treatment and transition teams. This would allow for improved continuity of care upon transfer from the facility. During interviews performed to author this report, it was reported that there is a paucity of psychiatric treatment providers in the community, as such, the facility clinical staff were concerned about the overall community clinical competence regarding ongoing treatment for the individuals on their caseload. (89). The participation of the facility psychiatrists would allow for the development of a transition plan that includes not only the current state of the individual's psychiatric treatment, but a description of the current treating psychiatrist's ideas for future interventions with a focus on what interventions have previously been successful, what has been tried without success, and what could be considered.

There was a need for improvement regarding the risk/benefit analysis for both routine and emergency treatment with psychotropic medication. The risk/benefit analysis for routine psychopharmacology was not documented in the case examples provided for review. (90)

Psychiatry reported that chemical restraint plans were developed and documented for individuals requiring them. Three plans, for Individual #1, Individual #14, and Individual #46, were submitted for review. While the plans included some detail regarding the individual's behavior and ultimately indicated what medication or medications should be used if a chemical restraint was necessary, the plans did not detail alternative interventions that could be utilized to either avoid or deescalate a crisis. Crisis intervention requires an integrated team approach. This was another example of the need to integrate psychiatry into the overall treatment planning at the Center. (90)

As noted above, there were deficits in the diagnostic review, bio-psycho-social formulation, and risk/benefit analysis when considering treatment with psychotropic medications. These deficits should be addressed, so that the least restrictive, positive interventions can be determined. In the absence of foundational assessment, it is not possible to determine treatment interventions. (91)

An individual's response to psychopharmacological and non-pharmacological interventions in this setting are typically monitored via a review of data from a variety of treatment team disciplines. At this time, behavioral health data were not symptom-specific and per interviews with psychiatry, there were concerns regarding the reliability and validity of data. Reliable data are necessary such that psychiatry can make data driven clinical decisions regarding medication/treatment efficacy or the lack thereof. To improve data reliability and validity, psychiatry and behavioral health must determine the specific symptoms for review and consider symptom rating scales normed for this population that have established reliability. (91)

Cvi. Medication (92-102)

There were numerous QDRRs submitted during and after the onsite review, but these were often not done quarterly. Individual #105 had no submitted QDRR. Many individuals had two or three for the year 2022. There appeared to be a gap in completion for those QDRRs in the third and/or fourth quarters of 2022. There was a total of 46 individuals who

had incomplete QDRRs. Examples included, but were not limited to, Individual #1, Individual #5, Individual #6, Individual #11, Individual #43, Individual #44, and Individuals #102. Additionally, QDRRs were completed on 03/20/23 for 13 individuals who had been discharged from the Center. The pharmacy might inadvertently be continuing to complete QDRRs on individuals already discharged. Additionally, for Individual #113 who died in December 2022, the pharmacy completed a QDRR on 3/13/23. There was not adequate communication with the external pharmacy when an individual was no longer residing at GRC. (94)

There were QDRRs provided at intervals, for most individuals at the Center, that provided pharmacy expertise in communicating identified concerns to the PCP. Monitoring should ensure QDRRs are completed quarterly. (94)

Minutes of the Pharmacy and Therapeutics (P&T) Committee were requested since 9/1/22, as well as the polypharmacy committee. Submitted information indicated that meetings occurred monthly through June 2022, following which the in-house pharmacist left in June 2022. The GRC Pharmacy closed on 6/17/22 and ongoing pharmacy services were provided by Precision Direct Rx. There have been no Pharmacy and Therapeutics Committee meetings since then. Additionally, there were no polypharmacy committee meetings since January 2022 to the time of this review. Per review of the P&T Committee minutes and interview, there were 78 individuals prescribed psychotropic medications and 59 were prescribed medications for neurological conditions. One cannot determine if this reflects over or under prescribing of psychiatric or neurologic medications as there are too many variables involved to provide such a comparison. The table below shows the number of individuals with psychotropic polypharmacy.

P&T Committee Minutes	
1/18/22	40 individuals had psychotropic polypharmacy (3 intraclass, 26 interclass, and 11 both (mixed). For antiepileptic medications, in December, 8 individuals were prescribed 3 AEDs, 2 were prescribed 4 AEDS, 3 were prescribed 5 AEDs, and 2 were prescribed 6 AEDs. One individual increased from 3 to 4 AEDs, and none had a decrease in AEDs.
2/15/22	37 individuals had psychotropic polypharmacy (3 intraclass, 24 interclass and 10 both (mixed). For antiepileptic medications, in January 2022, 8 individuals were prescribed 3 AEDs, 2 individuals were prescribed 4 AEDs, 3 Individuals were prescribed 5 AEDs, and 2 Individuals were prescribed 6 AEDs.
3/15/22	36 individuals had psychotropic polypharmacy (3 intraclass, 24 interclass, and 9 both (mixed). For antiepileptic medications, in February 2022, 8 Individuals were prescribed 3 AEDs, 2 individuals were prescribed 4 AEDS, 2 individuals were prescribed 5 AEDs, and 3 Individuals were prescribed 6 AEDs.
4/12/22	37 individuals had psychotropic polypharmacy (4 intraclass, 23 interclass, and 10 both (mixed). For antiepileptic medications, in March 2022, 8 individuals were prescribed 3 AEDs, 2 individuals were prescribed 4 AEDs, 2 individuals prescribed 5 AEDs, and 3 individuals were prescribed 6 AEDs.
5/27/22	39 individuals had psychotropic polypharmacy (4 intraclass, 26 interclass, and 9 both (mixed) For antiepileptic medications, in April 2022, 8 individuals were prescribed 3 AEDs, 2 individuals were prescribed 4 AEDs, 1 individual was prescribed 5 AEDs, and 4 individuals were prescribed 6 AEDs.
6/14/22	40 individuals had psychotropic polypharmacy (4 intraclass, 27 interclass, and 9 both (mixed). For antiepileptic medications, In May 2022, 8 individuals were prescribed 3 AEDs, 2 individuals were prescribed 4 AEDs, no individual was prescribed 5 AEDs, and 4 individuals were prescribed 6 AEDs.

The Center provided search results for individuals completing a MOSES (Monitoring of Side Effects Scale) evaluation and DISCUS (Dyskinesia Identification System Condensed User Scale) from 9/1/22 to 3/14/23. These were completed by the psychiatrist or RN. Scores ranged from 2 to 18. Most individuals had tests performed quarterly. Occasionally, six-month intervals were noted between evaluations (Individual #101, Individual #90, Individual #89, Individual #70, Individual #69, Individual #35, Individual #28). The Settlement Agreement requires quarterly assessments.

GRC did not fully meet the required content and purpose of drug utilization evaluations. No pharmacy drug utilization reports were submitted nor discussed in P&T Committee meetings. The Center documented that there were no dates

of meetings of psychiatry and neurology to discuss medications prescribed for dual purposes from 9/1/22 to the time of the Monitoring Team visit.

- The 1/18/22 P&T Committee minutes documented that, in December 2021, there were six individuals with dual purpose medication for seizures and psychotropic use. There were also five individuals on primidone or phenobarbital.
- The 2/15/22 P&T Committee minutes documented that, in January 2022, there were five individuals with dual purpose medication for seizures and psychotropic use. There were also five individuals on primidone or phenobarbital.
- The 3/15/22 P&T Committee minutes documented that, in February 2022, there were four individuals with dual purpose medication for seizures and psychotropic use. There were also five individuals on primidone or phenobarbital.
- The 4/12/22 P&T Committee minutes documented that, in March 2022, there were four individuals with dual purpose medication for seizures and psychotropic use. There were also five individuals on primidone or phenobarbital.
- The 5/27/22 P&T Committee minutes documented that, in April 2022, there were five individuals with dual purpose medication for seizures and psychotropic use. There were also five individuals on primidone or phenobarbital.
- The 6/14/22 P&T Committee minutes documented that, in May 2022, there were five individuals with dual purpose medication for seizures and psychotropic use.
- At the time of the Monitoring Team visit, the Center reported one individual with dual purpose medications for neurological and psychiatric diagnoses. There were also five individuals on primidone or phenobarbital.

The Settlement Agreement stated that as of 4/11/23, an external clinical review was to be completed for individuals with specific prescribed medications. Per report, this was being completed by the University of Iowa. The Center provided an updated list of names of individuals on medications listed in the Settlement Agreement. This included the following data:

- Dilantin - two individuals
- Valproic acid/Divalproex sodium -33 individuals
- Thorazine - three individuals
- Loxapine - two individuals
- Haldol - four individuals
- Phenobarbital - three individuals

Additionally, there were three individuals prescribed alendronate (an oral bisphosphonate) at the time of the Monitoring Team visit (Individual #7, Individual #100, Individual#102). Zero of the three individuals had GERD. The Center provided a current list of individuals categorized by the following: sit unsupported, sit supported, stand unsupported, stand supported. This was from a query entitled Sit.Stand.30 minutes.

Zero of three had a diagnosis of esophageal motility disorder. Individual #7 could sit unsupported but could not stand unsupported. The Medical Director indicated the low number of bisphosphonate orders occurred when he reviewed the medication usage and had discontinued several as they were eligible for a drug holiday. However, the data appeared incomplete. According to the QDRR of 3/6/23, Individual #9 was on bisphosphonate and had a diagnosis of dysphagia, suggesting the database may be incomplete, and was documented to not be able to sit unsupported and could not stand unsupported. As stated previously, since June 2022, there had been no ongoing monitoring of individuals on these medications.

Per review of the medication variance minutes from 9/1/22 to 1/26/23, there was no representation by a member of the medical department at any of the meetings. Additionally, there was not a member of the quality management department present at all meetings as required in the Settlement Agreement.

The medication variance meeting minutes did not trend data over the year as to any change in medication variance numbers or severity with a parallel timeline of action steps taken to reduce the frequency of medication variances. There were no graphs nor tables to indicate a systemic approach was taken to resolve repeat issues (e.g., administering medication to wrong individual).

The GRC Pharmacy and Therapeutics Committee Meeting minutes also tracked medication variances, with the following numbers recorded at each meeting:

- 1/18/22 P&T Committee: seven total medication variances in December 2021
- 2/15/22 P&T Committee: 174 total medication variances in January 2022
- 3/15/22 P&T Committee: 108 total medication variances in February 2022
- 4/12/22 P&T Committee: 50 total medication variances in March 2022
- 5/27/22 P&T Committee: 47 total medication variances in April 2022
- 6/14/22 P&T Committee: 427 total medication variances in May 2022

Cvii. Psychological Services (103-122)

Comprehensive Psychological Assessments were required to include information about medical, psychiatric, environmental, diagnostic, or other reasons for target behaviors. The assessments were also required to be trauma-informed and identify psychological and mental health needs that required intervention. To evaluate this provision of the Settlement Agreement, a sample of assessments, along with the assessment template were reviewed. Technical guidance on development of the assessment, as found in the assessment's template, included instructions to describe the individual's strengths, communication abilities, and medical, social, and family history in a way that was relevant to their behaviors of concern.

In general, assessments did summarize strengths, communication skills, and medical, social, and family histories, though the summaries did not always correlate with the individual's target behaviors. For example:

- Individual #45: the strengths section of the assessment described his ability to complete tasks independently, his memory, work ethic, and his sense of humor. The summary did not connect his strengths to his behaviors of concern.
- Individual #82: the strengths section of the assessment documented her reading and writing skills, her ability to follow her schedule, her understanding of her medication regimen, and some of her personality characteristics. The section did not describe how her strengths could reduce behaviors of concern and lead to a successful transition to a less restrictive and more integrated setting.
- Individual #82: the medical, social, and family history section of the assessment documented her premature birth and delayed developmental milestones, corrective eye surgery at a young age, social history, and contact with her family. The summary did not describe her history relative to her behaviors of concern. (103)

The functional behavioral assessment was a component of the psychological assessment that outlined diagnostic information, behaviors of concern, behavioral functions, and strategies to promote generalization and maintenance. Assessments defined target behaviors using operational terms and identified their respective functions. While assessments did identify psychiatric indicators, they did not adequately document the mental health needs and challenges of the individuals. None of the assessments provided insight into the individuals' trauma histories, or recommendations for trauma-based interventions. Findings included:

- Individual #1 was removed from his family home and taken into protective custody when he was a child. Abuse and neglect were suspected, and his parents' rights were subsequently terminated. The psychological assessment did not reference the trauma history and did not include trauma-informed recommendations to support his current services and supports.
- Individual #82's psychiatric consult note dated 4/25/22 documented her report of auditory hallucinations. Monthly integrated review (MIR) documentation dated 10/13/22 indicated that she had social anxiety that often led to behavioral issues. The psychological assessment did not identify any mental health need and did not describe how her psychiatric challenges contributed to her behavior. (103)

The suicide assessment protocol provided guided responses to suicide threats and attempts made by individuals at the Glenwood Resource Center. According to the protocol, following any suicide threat or attempt made by an individual, the psychologist assigned to the individual (or a registered nurse) completed a suicide risk screen to determine the level of risk and next steps. The risk screen determined whether a suicide watch order that consisted of 1:1 supervision, removal of sharp objects, a room and clothing search, and other safety precautions and restrictions was necessary. The suicide watch protocol also identified points of contact for reporting and documentation purposes. The risk screen provided a multiple-choice selection of reasons for an individual's suicide threat or attempt. This meant the

risk screen was not individualized. The risk screen did include a section for the assessor to identify the individual's level of risk and provide comments, though the comments were not detailed and did not provide much information about the threat or attempt. It was good to hear of the Center's plan to revise the suicide assessment protocol and suicide risk screen to include more evidence-based guidance on response and action steps. (103)

Comprehensive Psychological Assessments included current clinical and behavioral data. It was good to see that assessments included graphed behavioral data that allowed for a visual analysis of trends. Updates and modifications to an individual's behavioral programming were tracked in a detailed and thorough summary of previous treatment. While behavioral trends were clearly displayed, graphs showed data only from a one to two-year period. The efficacy of the interventions was not clear because there was no reference to the individual's baseline level of functioning, and the behavioral impact of previous treatment and interventions was not documented. (106)

Functional behavioral assessments should incorporate data from indirect and direct observation assessment tools. Findings should reflect the individual's current behavioral status and be the basis for the development of a hypothesis about behavioral functions. While it was good to see that, in most cases, multiple assessment tools were used to determine the functions that maintained an individual's behaviors, it was not clear that direct observations had been conducted. Assessments credited indirect tools that gleaned information from staff or others who were interviewed about the individual. (106)

To further evaluate this provision of the Settlement Agreement, behavior support plans for five individuals were reviewed. Findings included:

Individual #	Date of Psychological Assessment	Behavior Support Plan Written	Behavior Support Plan Implemented
1	5/21/18	12/26/21	2/8/23
45	4/13/22	1/27/22	2/15/22
46	11/2/22	11/1/22	12/1/22
82	6/6/22	6/21/22	11/3/22
99	12/1/22	No date	1/2/23

- Individual #1: It was not evident that the psychological assessment had been updated following his return to the Center after a failed community placement. An undated psychology report offered detailed plans for assessment and program development. For Individual #1, the behavior plan that had been in place prior to his transition to the community was re-implemented. The current behavior plan was not informed by post-transitional assessments or data because behavioral assessments were used to evaluate him after readmission had been completed after his behavior plan was implemented.
- Individual #45: The psychological assessment was written after the behavior plan had been implemented.
- Individual #46: The psychological assessment was written after the behavior plan had been developed.
- Individual #82: The behavior plan was implemented more than four months after it was developed.
- Individual #99: It was not clear when the behavior plan had been developed or updated.

Behavior plan formatting and content were not consistent. For some individuals, the medical issues section of their plan had been omitted. For others, the safety and supervision section had been omitted or left blank. Thus, it was not clear if the individual had needs in those areas or if the areas were not applicable. In some cases, goals and objectives were missing. None of the behavior plans contained information about trauma histories, and it was not evident that trauma screenings or assessments had been completed for any of the individuals. (107)

There were two full-time BCBAs employed by the Center who managed caseloads of approximately 25 individuals each. One BCBA was assigned to support individuals who had behavioral health needs that did not pose a significant risk to health and safety. The other BCBA managed a caseload of individuals who had more severe behavioral challenges that did pose a risk to health and safety. The two BCBAs reported directly to the Director of Psychology who was also a BCBA. The Center was in the process of hiring a fourth BCBA who was scheduled to begin her employment in June 2023. (108-110)

Functional behavioral assessments and behavior support plans should be written by staff who have been trained in Applied Behavior Analysis. The credentials of staff who authored the Center's functional behavioral assessments and behavior support plans were not completely clear. All staff with graduate and postgraduate degrees, despite their academic fields, who were directly supervised by the Director of Psychology, were referred to as psychologists. It was not clear that the functional behavioral assessments and behavior support plans had been written, reviewed, or approved by staff who were trained in Applied Behavior Analysis. It was good to hear of the Center's plans to ensure all behavior plans are reviewed and approved by a BCBA. (108-110)

Behavior plans were not trauma-informed and did not reference the individual's mental health needs. Behavior plans provided guidance and support to prevent and respond to instances of problematic behaviors. The plans did not adequately define replacement behaviors or describe how they would be trained or reinforced. In general, behavior plans did not teach replacement behaviors that were function-based. For example:

- Individual #45 often engaged in self-injurious behaviors when demands were placed on him. The behavior plan did not identify replacement behaviors or include strategies to teach him how to appropriately escape demands.
- Individual #46 engaged in aggression. According to his functional behavioral assessment, aggression was maintained by access to attention and tangible items. The behavior plan did not include replacement behaviors that were function-based, or that taught him to use prosocial behaviors to access attention and tangibles.
- Individual #99 would hit her thighs and make loud vocalizations whenever she wanted to escape an aversive situation or be brought to a quieter location. Although there was a skill-acquisition program to teach her to indicate her preference to be relocated, the behavior plan did not include the replacement behavior.
- Behavior plans did not adequately describe how or how often an individual was to receive reinforcement for desired behaviors. Guidance to staff was vague and did not include specific examples of desired behaviors to reinforce. For example:
    - Staff were guided to look for examples of when Individual #46 was being respectful to staff and peers. The plan did not provide examples of specific behaviors to reinforce.
    - Staff were instructed to reinforce appropriate phone use before Individual #46 had the chance to use the phone inappropriately. Appropriate phone use was not defined, and it was not clear what staff would specifically measure and reinforce.
    - Individual #82's behavior plan described a reward schedule staff were to follow if she completed her programming and managed her responses to feelings and urges. It was not clear which behaviors were to be rewarded or how staff would know criterion had been met.

As written, behavior plans did not promote growth, development, or independence because they were not function-based and because they did not teach functionally equivalent alternatives to problematic behaviors. Individuals were not afforded opportunities to learn prosocial skills and behaviors, and staff were not provided adequate support to implement antecedent strategies, and recognize, teach, and reinforce desired behaviors. (111)

The Director of Psychology did not meet the requirement of five years working with the IDD population. He was hired one year ago with prior experience with the childhood forensic population. (112)

The Center's policy required psychologists to complete at least six program implementation monitoring reviews (PIMs) of behavior plans, skill-acquisition programs, and data per month, and to review their entire caseloads every six months. If any program or intervention was found to be ineffective, then the psychologist was to document findings in the comment section of the monitoring tool, then review their concerns with the IDT, and discuss plans for improvement. Psychology assistants were also able to complete monitoring reviews. To evaluate this provision of the Settlement Agreement, reliability data were requested, and the Center provided access to behavior support plan monitoring reports. Based on review of the reports, the Monitoring Team could not find evidence that reliability checks were being performed according to policy. The reports for Individual #1 and Individual #46 were reviewed. Monitoring by the psychologist and psychology assistant was infrequent or had not occurred. Findings were not documented, and it was not clear how concerns were addressed.

Behavioral and skill-acquisition data were collected on each home using accountability sheets. At the end of each shift, staff entered the data into the electronic system to be reviewed by the psychology assistant who converted behavioral data into graphs and shared it with the psychologist and psychiatrist. Behavioral and skill-acquisition data were discussed at monthly integrated review (MIR) meetings that the individuals were able to attend.

Individual #99 consistently attended her monthly review meetings. For the other four individuals in the review group, attendance was infrequent. Data reviewed at monthly integrated review meetings was clear and allowed for monitoring of progress and effectiveness of treatment. Documentation also permitted clinical review of medical conditions, psychiatric treatment, and use of psychotropic medications. When an individual was not making progress, their IDT recommended revisions. It was good to see that (regarding behavioral and skill-acquisition programs) IDTs responded promptly to recommendations made the previous month. It was good to hear of the Center's plans to examine the data collection and review process to determine if improvements could be made to facilitate a more immediate response to an individual's lack of progress or the need to modify a behavioral or skill-acquisition program. (114-115)

For the most part, behavior plans used clear and concise language that could be easily understood. The plans described precursor behaviors, target behaviors of concern, what data to record, and how to avoid and address target behaviors. The plans also included guidance on reinforcement of behaviors targeted for increase. In some cases, jargon terminology was used to describe interventions and coping strategies. The terminology was not described in a way that could be easily understood by new or pulled staff who were unfamiliar with the individuals. For example:

- Individual #82's behavior plan guided staff to prompt her to utilize unhooking skills that were described as independent coping strategies. The skills were not well defined. When direct care staff at the home were asked to describe the skills, they deferred to the psychology assistant.
- Individual #46's behavior plan included guidance for staff to refer to "good bus" and "bad bus" behaviors. The behavior plan did not adequately describe what the behaviors were. The plan did not provide enough examples for staff to utilize the intervention appropriately. (116)

The Monitoring Team was unable to find evidence of a formalized process for addressing staff deviations from an individual's behavior plan or skill-acquisition program. The Center indicated that there were several safeguards in place to ensure procedural fidelity and reliability, including reliability checks by the psychologist and supervisor rounds. In response to the Monitoring Team's request for documentation of reliability checks, the Center submitted a behavior plan monitoring report. The report did not clearly indicate how reliability checks were performed, outcomes, or the IDT's response to unreliable data. (117)

According to the Center's training rosters, all staff were required to complete Applied Behavior Analysis training. Staff were also required to complete the Mandt Training System that was a two-day training on the following topics:

- Building healthy relationships.
- Healthy communication.
- Healthy conflict resolution.
- Trauma-informed services.
- Positive Behavioral Supports.
- Intervention and restraint during emotionally escalated situations.

According to Center staff, the Mandt training included the topic of trauma, though it was not trauma-based. The Monitoring Team could not find evidence that staff had received training in the areas of severe behavioral needs or regarding the co-occurrence of mental health needs and IDD. Staff on the homes reported that they had been trained by the psychology assistants to understand behavioral programs, skill-acquisition programs, and data collection systems. The Monitoring Team could not find evidence of formalized training that was specific to the individuals at the home. It was not clear what had been trained or the training format was utilized. (118-120)

The Monitoring Team could not find evidence of competency-based behavioral and skill-acquisition trainings for staff on the homes. It was also not evident that staff were regularly assessed for their knowledge and skills with respect to individual-specific behavior plans, behavioral programs, or skill-acquisition programs. (121)

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

Ci. Supervision and Management of Clinical Services

1. The process for an external peer review process at periodic intervals (monthly/quarterly, etc.) should be formalized by appropriate documentation. The results are an opportunity to be discussed at a medical staff meeting as the information would be helpful to all PCPs.

2. According to the Settlement Agreement, the internal mortality review should not be completed by the PCP assigned to care for the individual.

Cii. Medical Services

3. It is imperative that the PCP or designee be represented at the ISP meetings and Transition meetings to ensure a successful transition to the community.

4. Immunization records needed further review to ensure recommended vaccinations were current.

5. An antibiotic stewardship program was lacking, which would impact successful treatment of infections to ensure minimal antibiotic resistance occurs. Community hospital and laboratory antibiograms should be incorporated into the decision for choice of antibiotics. The Medical Director should ensure that the post hospital antibiotic treatment plan reflects culture results when available and recommended duration of treatment. Tracking all use of antibiotics will allow monitoring for appropriate selection and duration of antibiotics at GRC.

6. For those individuals with repeated hospitalizations for the same acute illness, a root cause type of analysis was indicated to address the ongoing clinical instability of the individual. This was especially noted for those individuals with repeated hospitalizations for aspiration pneumonia/pneumonia and bowel obstructions. As an example, for those with repeated aspiration pneumonia, evaluation of the upper gastrointestinal tract to determine severity of GERD as a contributor to aspiration, as well as the degree of gastroparesis, is important. For those individuals with these problems, aspiration pneumonia will continue unless the gastrointestinal issue is resolved. The medical team needs to ensure aggressive medical and surgical treatment was offered to the individual.

7. The Medical Director needs to create a monitoring tool to ensure there is a PCP note providing critical information leading to the hospitalization.

   It would be beneficial to create a monitoring system to ensure all off-site consultation reports are addressed in a PCP progress note.

8. It would be beneficial to create a monitoring system to ensure all significant labs are reviewed by the PCP and documented in a progress note. Although many of the lab forms included a brief entry, the plan should be recorded in a PCP progress note. As a documentation standard, the PCP should document all clinical decision-making activity routinely, including review and response to consult reports; section f specifically includes the content of such a document. This includes agreement or not with the consultant, and the actions taken in response to the consultation. It would be important for the PCP to document any actions that the PCP has decided upon. If other departments also have recommendations from the specialist, ie., PT, OT, speech, nursing, etc., a similar note by that department is expected. The PCP should not rely on an IDT document or other department to include the PCPs action steps. Unless there is documentation by the PCP, the PCP has no ability to provide evidence the PCP analyzed and implemented consult recommendations or documented rationale for not following the consultant's recommendations.

Ciii. Residents at Risk of Harm

9. Risk assessment tools should be completed as part of the annual medical review for each high and moderate rated risk, as well as preventive steps for at-risk clinical areas. Some of the risk tools required a knowledge of family medical history for accurate completion. Family medical history should be included in every annual medical assessment. The family medical history should be updated annually in the annual medical assessment by contacting family with date of contact (or attempt of contact) recorded in the annual medical assessment.

Monitoring by the Medical Director would be important to ensure this aspect is completed. Family history is a routine component of a complete history and physical. Especially when reviewing the risks of the GRC population, which may include genetic disorders, and diagnoses that are common to other family members, this provides guidance in ensuring such illnesses are ruled out or tracked, or highlighting the individual is at increased risk of a diagnosis. Family history would be included under provision 61 Clinicians shall conduct direct assessments consistent with current, generally accepted professional standards of care.

Civ. Nursing Services

10. Nurses/direct health care staff must advocate for the individual's well-being during times of change. This large body of knowledge about the individual must be incorporated into documentation (ISP, HSSP, and Transition Plan) and discussed further during new care staff orientations and interactions with potential new providers in other residential settings. To accomplish this, nursing should enhance documentation to identify signs and symptoms that the individual is known to display and approaches that the individual prefers/responds well to. Examples include when a non-verbal individual is not sleeping well, up and pacing, and appears uncomfortable, caregivers should take vital signs/temperature prior to any PRN acetaminophen, check on elimination pattern, assist in encouraging to use the restroom, and observe results as it is known he has exhibited similar clues in the past and was later confirmed to be constipated.

11. All individuals should have their regular pattern of bowel elimination documented by nursing in the assessments, including (Bristol stool chart) type, size of BM, any other known information, and the steps to follow/bowel regimen clearly identified.

12. For individuals that are at risk for falls, injury, aspiration, and inadequate oxygenation related to seizures, nursing documentation within the assessments, HSSP, and transition plans should include more individualized detail. A seizure log should be maintained ongoing and taken to neurology consults to assist with proper management of anti-epileptic drugs.

13. Assessments should include type of seizures, date of last seizure or seizure like activity, and any history of status epilepticus (even if more than two years ago).

14. Staff should be trained to report the circumstances in as much detail as possible, including what was observed/happening prior to the seizure, and any environmental factors, such as bright flashing lights or loud sounds.

15. Continue diligence to maintain timeliness of nursing assessments and increase focus on quality of the documentation through education and reminders, as well as consideration of the importance of including details about individual's preferences and signs/symptoms in the Transition Plans. Include height and weight in the nursing assessments. It is likely being stored/recorded elsewhere but is an important component of a thorough nursing assessment. In addition, ensure that the nurse is measuring vital signs for the assessments, rather than recording those taken by residence staff.

16. The Medical Director voiced his plan to facilitate ongoing communication, which is key. It is positive that the clinical team meets each morning Monday through Friday, however, the resulting meeting minutes provided by the assistant did not fully capture clinical aspects of the discussions. Develop a more formal structure to utilize the time to document outcomes/plans during the meeting (e.g., physician orders, action plans). This would maximize the efficiency of the meetings and reflect the team's accomplishments.

17. GRC should use of the "other" risk category to capture any situations that are not fully defined/required in the current risk process and remind nurses that an HSSP for "other" is an option to utilize when indicated.

18. The e Infection Control Committee should include the Medical Director (who has connections with hospital systems) and explore/implement State and/or national expertise in meeting long term care infection surveillance standards of care, such as but not limited to UHIC.org, AHRQ, CDC, and McGeer criterion for LTC facilities.

19. GRC should continue to track and trend pressure injuries and focus on early detection and treatment.

20. GRC should continue with the practice of good skin care that consists of frequent repositioning, inspection of DME to identify pressure points, and keeping the skin clean and dry.

21. Combine the P & T committee and the Medication Variance committee into one meeting to accomplish objectives for both.

22. Review the Medication Variance and Remediation policy version 8/22/22, especially timelines and documentation. Consider creating a flow diagram to clearly display steps, and timelines for reference by nursing and medical.

23. Complete Sections I and II of the Medication Variance Reporting form, prior to the committee meeting, with completion of Section III as designated for committee review, at the meeting. at the committee meeting, to ensure all steps of the process are clearly accounted for.

24. As the census decreases, residences are condensed and closed, and ongoing staffing changes, it would be beneficial to increase RN presence on the residences with a focus on safe medication administration. More frequent involvement, including the actual administration of medication by RNs should occur. Nursing should also be involved in the reconciliation of the unit dose exchanges with outside contract pharmacy, random inspection of the medication areas, and real time observations and support of CMA/LPNs to ensure the individuals preferences as to receiving their medications is incorporated and documented into the transition plan.

25. Calculate medication error rate for the Center and number of actual medication variances by Level 3-9 as listed in the policy.

26. Calculate the resulting % of medication variance rate (i.e., number of doses ordered to be given versus number of variances including omissions that reached the individuals).

27. Include pharmacist (or at least pharmacist technician from the community contracted pharmacy) to address dispensing and or other pharmacy related issues, to increase the vendor's knowledge of the practices and needs of the individuals and staff in reducing errors. If this is not possible in person, do a remote meeting and document the details/include in medication variance recordkeeping and provide a (HIPAA compliant) copy to the pharmacist/pharmacy contractor for their records.

28. For individuals at high risk for aspiration/choking, include photos on the PNMP of the individual's optimal positioning. This will allow for a quick and accurate reference for staff that are unfamiliar with the individuals due to changing assignments and coverage during the closure activities. CMA did state this would be extremely helpful to have to save time and ensure properly upright.

29. Provide frequent refresher training and reminders regarding infection control practices during medication administration encounters.

<u>Cv. Psychiatry</u>

30. Determine the board certification status of the board eligible physician.

31. Designate the components of psychiatric evaluations (e.g., initial, annual, and quarterly) to ensure comprehensive evaluation as well as appropriate documentation.

32. Ensure each individual prescribed psychotropic medication has a bio-psycho-social formulation justifying each psychiatric diagnosis and the plan for intervention that integrates both pharmacological and non-pharmacological interventions as needed.

33. Ensure team-based psychiatric clinics with team-based data driven decision making.

34. Psychiatry must attend treatment team and treatment/transition planning meetings for individuals on their caseload. This should include documentation of the psychiatric component of the transition plan.

35. Ensure documentation of the risk/benefit analysis regarding treatment with psychotropic medication.

36. In lieu of chemical restraint plans, ensure the development of crisis intervention plans integrating alternative interventions to avoid or deescalate behavioral health crises. This should include a stepwise progression through non-pharmacological interventions prior to the consideration of chemical agents. This would ideally be a living document that could be modified based on an individual's response to interventions.

37. Both pharmacological and non-pharmacological interventions should be considered. Review an individual's symptom response to interventions via the use of reliable data. Reliable data could be obtained by using symptom rating scales normed for this population.

38. Given the increased psychiatric responsibilities noted above, the facility must review the current psychiatric resources and determine future needs. Per the GRC report, they will begin the recruitment of an additional psychiatrist.

Cvi. Medication

39. The Medical Director should ensure the clinical pharmacist completes a QDRR each quarter for each individual. The facility needs to ensure accuracy of the date of QDRR completion when printed for review.

40. Ongoing Monthly P&T Committee meetings are expected. As there was no longer a pharmacist onsite, providing an internet team meeting to include a clinical pharmacist with access to the needed information would be one way to provide the needed review by the clinical pharmacist.

41. Monitoring to ensure quarterly evaluation of side effects needs to be implemented, as required by the Settlement Agreement.

42. A clinical pharmacist with training in drug utilization evaluation is needed. Reports should be at least quarterly and are usually reviewed at a P&T Committee meeting.

43. There needs to be documented collaboration between neurology and psychiatry concerning individuals with prescribed medications for dual purposes of neurological and psychiatric conditions.

44. Quality management needs to assist the medical department to ensure the quality of database management.

45. Monitoring for adverse drug reactions should continue among the medical team with input from a clinical pharmacist. When an adverse reaction occurs, if determined to be a drug allergy or significant adverse reaction, the medical team should ensure it is appropriately entered into the medical record.

46. As required in the Settlement Agreement, the Center should ensure a member of the quality management department attends all medication variance committee meetings.

47. The medication variance and P&T committees should track the numbers and categories of errors on an ongoing basis to ensure there was a trend of improvement, with continuous quality improvement strategies to ensure minimal medication variance occurrences. This area appeared to need collaboration between the medical and nursing departments, along with expertise from a clinical pharmacist.

Cvii. Psychological Services (103-122)

48. The Center should ensure that psychological assessments are trauma informed. This will help with the development of behavior plans and strategies to address behaviors for which an individual's trauma history serves as a setting event.

49. The Center should ensure that baseline data on behaviors targeted for decrease, replacement behaviors, and other behaviors targeted for increase are included or referenced in psychological assessments to allow for a comparative analysis and to show the efficacy/inefficacy of treatment/intervention.

50. The Center should consider including phase change lines in graphs to show the impact of updates or modifications to behavioral programming.

51. All sections of the behavior plan should be completed. If a section of the plan does not pertain to the individual, then there should be a notation that the section is not applicable. Leaving the section blank can appear to be an omission of information.

52. Behavior plans should be developed from findings and recommendations of behavioral assessments that are trauma informed. This will support the development and implementation of trauma-based interventions to teach coping strategies and other ways to navigate distressing situations.

53. Behavior support plans should be trauma-informed and include trauma-based interventions to support the individual to develop effective coping strategies needed to respond to antecedents and setting events that might otherwise provoke a trauma response.

54. Behavior plans should be based on outcomes of functional behavioral assessments and should identify replacement behaviors that are functionally equivalent alternatives to the behavior of concern.

55. Behavior plans should be clearly written, using language the staff can understand, and should describe behavioral targets in observable, measurable terms so that the staff is clear on what they are measuring and tracking.

56. The Center should ensure that reliability checks are occurring according to policy, and that findings are clearly documented.

57. Monthly integrated review meetings should be scheduled at a time of day the individual is likely able to attend. Some of the individuals refused to attend their monthly integrated review meeting because it conflicted with their work schedules or other activities. The Center should ensure all individuals are able to attend the meeting and should attempt to reschedule meetings that conflict with obligations the individual has.

58. Assessments, behavior plans, and skill acquisition programs should use language that can be easily understood by staff at the Center, and by potential providers who are unfamiliar with the individual, considering them for post-transition placement, and looking for guidance to develop post-transition supports.

SECTION D	**Restrictive Interventions**

Summary of Monitor's Assessment:

Di. Restraints: (128-143)

The restraint policy was updated since the Effective Date. It included and addressed the components in Settlement Agreement paragraphs 128-140. This was the fourth update to the policy since 6/30/20. The previous policies were not reviewed by the Monitoring Team, but it was likely that this version was written to correspond with the requirements of the Settlement Agreement.

The State submitted a list of all restraints from 9/1/22 through 2/23/23. There were 48. During the review week, the Monitoring Team learned about any additional restraints from 2/24/23 to date. There were three for a total of 51. In some instances, two or three restraints were implemented in succession, indicating that this was likely a single incident with multiple restraints. It was good that GRC was recording each instance of restraint even if more than one occurred in a single incident. There were 10 of these multiple-restraint incidents. Eight of the 10 were an incident with a physical restraint followed by a chemical restraint. Overall, 28 of the 51 restraints (55%) were chemical restraints. Three of the restraints were for implementation of medical protocol (suture removal [for two minutes], COVID test [for 15 seconds], and an unnamed medical test [for 27 minutes]).

The frequency of use of restraint showed a marked decrease as reported in the State's list below. During this time, the census was also decreasing. If the frequency increases in March and going forward, it then might make sense to also track with a calculated census-based rate.

- September: 20
- October: 18
- November: 2
- December: 1
- January: 3
- February: 4

The Monitoring Team reviewed all documentation for three of the 51 restraints (3/5/23 chemical and physical, 11/22/22 physical, and 9/14/22 chemical). The 3/5/23 incident was listed as having two restraints, however, the documentation (Three-Day Restraint Debriefing) said that the recording of it including a physical restraint was an error. That is, there was no physical restraint implemented, only chemical restraint.

GRC restraint documentation consisted of three parts: (a) Restraint Documentation and Initial Debriefing Report, completed by the staff directly involved in the incident, (b) Three Day Restraint Debriefing, nine items completed by a group of direct support and clinical staff, and (c) various nursing documentations of monitoring and application of chemical restraint. Overall, the documentation provided a description of the circumstances surrounding application of the restraint, its implementation, and post-restraint monitoring. The Center will want to update its documentation to ensure it explicitly and saliently provides all the information required by paragraphs 129-139 (139). Much of this was already in the documentation but would benefit from re-organization and alignment with the Settlement Agreement. For instance, explicitly indicating that restraints were only used when there was an immediate and serious risk of harm (129a), as a last resort after other less restrictive interventions were tried (129b), and in the least restrictive form and duration (129c).

At GRC, restraints were not used for punishment or for the convenience of staff, however, without a more thorough understanding of these three individuals' programs, the Monitoring Team did not determine whether BSPs and other supports were in place (130). Prone restraints and mechanical restraints were not used (131, 137, 138). There was, however, no explicit statement regarding whether the restraint was prohibited by medical orders or contraindicated by any condition (133).

The 11/22/22 physical restraint was implemented for two minutes, but the Monitoring Team could not determine if it was terminated because the situation was no longer dangerous or if there was some predetermined type of calm criteria (e.g., calm for 30 seconds) (132).

Staff checks of the individual within 15 minutes of implementation were not evident in the two chemical restraints but was reported in the physical restraint documents. It occurred at 20 minutes rather than 15 minutes as required. In addition, the Monitoring Team could not determine if the staff doing the check met the criteria for annual certification (135). Restraints were well-monitored by nursing and medical. They conducted face to face examination within 30 minutes of implementation and conducted post-restraint monitoring of vital signs and mental status (134, 136).

Since the Effective Date, there were no occurrences of an individual receiving restraint three or more times in any 30-day period, or an indication of an increasing trend in restraint usage for any individual over a three-month period. Therefore, paragraph 140 was not, and did not need to be, implemented because it did not apply to any individual.

The Monitoring Team did not review the requirements of paragraphs 141-143 during this baseline review. Paragraphs 141 and 142 are about staff training and professional management of the chosen restraint protocol, which was the Mandt system. Also, their implementation was required within three months of the Effective Date (i.e., not yet). Paragraph 143 refers to the creation and implementation of BSPs. This paragraph requires completion six months after the Effective Date (i.e., not yet) and it overlaps with other sections of the Settlement Agreement.

Dii. Seclusion: (144-149)
Seclusion was not being implemented and there were no plans to implement seclusion. Therefore, GRC was meeting the intent of paragraph 144. And thus, paragraphs 145-149 did not need to be implemented because they were not applicable to any individual.

Diii. Other Restrictive Interventions: (150-154)
GRC was guided by their Human Rights Committee policy, written in April 2022 (i.e., before the Effective Date). The Settlement Agreement does not require a policy, however, GRC's policy addressed much, though not all, of what is in paragraphs 150-154.

There was no summary of the number of individuals with restrictive procedures (programmatic or emergency) and what those restrictive procedures were. Eleven of the items in pre-review document 22 noted that HRC consent was obtained for the supportive equipment. It was not clear if these were considered programmatic restrictive procedures or if HRC consent was obtained for other reasons.

The Monitoring Team attended HRC during the review week and received the agenda and handouts. The Committee reviewed the annual BSP update and associate medications for four individuals, the two restraints that occurred the previous week, and the proposed removal of 1:1 staffing for one individual. No other restrictive interventions were reviewed or discussed, and it remained unknown how many programmatic restrictive interventions were in place during the review week, and how many emergency restrictive interventions were implemented over the past months (not including BSPs).

No determination was made by the Monitoring Team as to whether the Center was following its own policy. The Director of Quality Management reported that the occasional use of emergency restrictive procedures was, for the most part, regarding suicidal actions, were for 24 hours, and were mostly about supervision of the individual.

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

1. Update restraint documentation templates to fully correspond with the requirements of paragraphs 129-139.

2. The Center should examine the use of chemical restraint to determine if it is applying chemical restraint too often or only when absolutely needed.

3. Implement a regular check to ensure seclusion is not being used in any plan, or in any informal manner.

4. Update the HRC policy to be fully in line with the Settlement Agreement.

5. Implement a quality check that all Settlement Agreement requirements are being followed for any restrictive interventions as per paragraphs 150-154.

SECTION E	Engagement and Skill Acquisition Programs

Summary of Monitor's Assessment:
Engagement and Skill Acquisition Programs (155-163)
Habilitation and skill-acquisition programs did not tend to focus on the development of meaningful skills that could enhance an individual's overall independence. Programs also did not promote the development of skills the individuals could utilize after transitioning to the community. Some programs taught compliance with demands instead of the development and learning of functional skills. For example:

- Individual #1: will independently wear his eyeglasses.
- Individual #45: will bring sleepwear to the laundry room.
- Individual #99: will remain dry.

Other programs had potential to teach functional skills, however, there were no corresponding steps to teach the task or activity. For example, Individual #46 had skill-acquisition programs for laundry, toothbrushing, and showering. His functional skills assessment identified the need for support in those areas. The training programs, however, did not

include teaching steps. Without a task analysis or teaching strategy, it was not clear how he would complete the tasks and how staff would support the development of the skills.

During the week of the review, the Monitoring Team visited the day program located in Building #102. The program offered a wide array of options for engagement, learning, and skill-development. It also offered opportunities for unique and meaningful recreational and leisure activities. During one visit, the Monitoring Team observed six individuals in attendance. It was reported that due to staffing shortages, the day program could not accommodate full attendance. Five of the six individuals observed, who appeared to have significant expressive language deficits, were passively engaged in a Jeopardy video game operated by one of the two staff who were present. None of the individuals were actively engaged in the activity. The sixth individual was in the sensory room manipulating objects on the floor as his assigned 1:1 staff sat nearby. The individual, who often engaged in pica behavior and wore tear resistant clothing, was seated on the floor manipulating and mouthing a variety of sensory items. He was also picking carpet fibers from the floor and placing them into his mouth. It was not apparent that the 1:1 staff person was aware of what the individual was doing, or the risk the individual's behavior posed. It was evident, based on his answers to questions about the individual, that the staff person was not adequately trained on the individual's behavior plan and supervision guidelines.

Individuals who attended vocational programs had potential to develop meaningful skills that could transfer to community-based, competitive employment. Vocational goals, however, did not focus on the development of such skills. In general, habilitation, vocational, and skill-acquisition training did not point to the development of long-term skill development that could lead to independence for living and working successfully in the community. (155-157)

Comprehensive functional assessments were current for each of the individuals in the review group. Assessments identified the individual's strengths and deficits in self-help, domestic, eating, hygiene, communication, social skills, and other life areas. Preference assessments were included in the individual's psychological assessment.

Transition plans contained recommendations to support community living, however, barriers to community integration were not clearly identified, and there was no evidence of a community integration plan to minimize and/or overcome behavioral barriers as required by the Settlement Agreement. It was, therefore, not clear if goals or skill acquisition programs were designed to teach skills the individuals could utilize in the community. Behavioral and skill development programs were implemented at the Center and individuals were rarely offered opportunities for training in the community. (158)

In general, goals and skill acquisition programs were not observable or measurable, and they lacked guidance on implementation and review. Individuals were not provided adequate training, and for those with significant skill deficits, it was not clear how they were being supported to develop skills. It was also not evident that staff were provided adequate knowledge and training to implement programs effectively. Examples included:

- Individual #4: will say hi.
  - The Monitoring Team observed the plan being implemented. After giving an initial prompt, the staff waited for him to respond. When he did not respond, the staff terminated the session.
- Individual #1: will learn to communicate his wants and needs.
  - As written, it was not clear what he was expected to do.
- Individual #22: when asked what to do before standing up, he will touch the brakes of his wheelchair or tell staff to lock the brakes.
  - After providing an initial prompt, staff asked if he was supposed to touch the brakes on his wheelchair. He responded positively. He did not provide the desired response and the staff scored the trial as met.
- Individual #46: will express himself appropriately through daily situations.
  - As written, it was not clear what he was expected to do or how progress would be measured.
  - The goal was for him to complete a social skills worksheet independently. If he did not respond to prompting, staff were to continue to encourage him to complete the task. The plan did not outline steps for completing the worksheet. Staff were not trained to provide additional support.
  - The Monitoring Team observed the plan being implemented. Instead of supporting the individual to complete answers to questions outlined on the sheet, staff asked questions, he responded yes or no, and then staff completed the sheet themselves.
- Individual #46: will independently clean his bed and bedding.
  - As written, it was not clear what he was expected to do.

- Additional guidance was for him to take his bedding to the laundry room and get it started in the washing machine. If he did not complete the task, then the staff reminded him that he wanted his room to look nice and smell good. His functional skills assessment identified the need for training to make his bed and complete laundry. The plan was not supportive of skill development, because it did not include steps to train him to complete the task. (159)

The homes reported that they had been trained by the psychology assistants to understand behavioral programs, skill-acquisition programs, and data collection systems. The Monitoring Team could not find evidence of formalized training that was specific to the individuals at the home. It was not clear what had been trained or the training format was utilized. (160)

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

1. Plans and programs should focus on helping the individual to develop functional skills that can increase independence and be used once the individual transfers to the community.

2. Goals and objectives should be aspirational and not be used to teach compliance with demands and expectations.

3. Goals and objectives should be based on the outcomes of the functional skills assessment that identifies strengths and areas of support need.

4. The Center should work to ensure skill development objectives are clearly written and teach behaviors and skills that can be easily observed and measured by staff.

5. Skill development programs should be informed by the functional skills assessment, preference assessment, and vocational/recreational assessment to ensure the skill being taught is consistent with the individual's strengths, needs, and abilities, and that the skill is important to the individual.

6. Individuals should have the opportunity to practice skills in the community. To the extent possible, teaching trials should be run in a setting that the individual is likely to encounter post-transition. For example, ordering from a restaurant menu should occur at an actual restaurant in the community.

SECTION F	**Record Keeping**

Summary of Monitor's Assessment:

Recordkeeping (164-166)

This section will be examined in more depth during the six-month review. Per review of the three individuals, their assessment and treatment programs contained the needed signature by the assessment/document owner along with the corresponding date. Some issues were noted with the PCP signature upon consult return and review of labs. (164-166)

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

1. It would be beneficial to create a monitoring system to ensure all off-site consultation reports are addressed in a PCP progress note. (This is also a recommendation above in Section Cii. Medical Services).

2. It would be beneficial to create a monitoring system to ensure all significant labs are reviewed by the PCP and documented in a progress note. Although many of the lab forms submitted included a brief entry, the plan should be recorded in a PCP progress note (This is also a recommendation above in Section Cii. Medical Services).

SECTION G	Incident Management

Summary of Monitor's Assessment:

Incident Management (167-176)

The Settlement Agreement requires policy to set forth a variety of expectations and procedures to address all of Section G. This means that all the details and sub-components of each paragraph require salient presentation in policy. The Settlement Agreement also requires implementation of these policies and procedures.

To these ends, the Center needs to have a policy (or policies), maintain documentation that aligns with policy, and demonstrate that they are indeed correctly documenting implementation of procedures that are in line with policy.

The Center had one policy for this. It was titled Abuse and Incident Management. It was initiated on 4/28/20 and had three subsequent revision dates. The most recent was 3/28/22, almost one year prior to the Effective Date of the Settlement Agreement.

Much of what is required by the Settlement Agreement was in the Center's policy, however, there were various items that were not in the policy (e.g., semi-annual audits of injuries in paragraph 168.j).

For some of the other items, activities were reported to be occurring, but they were not documented at all, or as required by the Settlement Agreement (e.g., tracking and trending of incidents and investigations in paragraph 175).

The Monitoring Team requested and received a listing of Type 1 and Type 2 investigations from 9/1/22 to 3/10/23. There were 85 Type 1 investigations. There were 84 Type 2 that were mostly bruises, scratches, or other seemingly minor injuries. The Type 1 investigations were about the following:

- Deaths: 1
- Physical abuse: 11
- Neglect: 11
- Serious injury: 10
- Medication variance: 9
- Suicide attempt: 9
- Unauthorized restraint: 3
- Unknown injury: 9
- A label of incident assigned, with no further description or detail: 17
- Sexual abuse: 1
- Verbal abuse: 1
- Mental abuse: 1
- Peer to peer injury: 2

The Monitoring Team requested, and received, documentation for six of these Type 1 investigations and for three of the Type 2 investigations. For Type 1 investigations, the documentation consisted of the finalized report (3-21 pages), witness statements, guardian contacts, and other investigation-specific reference material, such as the BSP and CFA. For Type 2 investigations, a three-page document described the incident (e.g., fall, cut, bruise).

Investigations were conducted by the Center's investigators. They were employees of the Center, supervised by the Director of Quality Management. The findings of the investigations in the review group were unsubstantiated or inconclusive. The absence of substantiated findings does not reflect the quality of the investigations.

None of the investigations in the review group involved a sentinel event or contained a preliminary assessment component. The Center reported that no events had occurred that met the criteria for sentinel event during the review period.

For Type 1 investigations, there was a lot of relevant information in the reports and associated documents, which was good to see. The finalized report, however, was not in a format that included all the components required by sub-paragraphs of paragraph 169. There was much more information in the investigations from December 2022 onward than in November 2022. There were no recommendations in any of the investigations.

For Type 2 investigations, there was information describing the incident. There were no recommendations.
In a comment on the draft version of this report, the State pointed out that paragraph 169 calls for recommendations when appropriate. In other words, the Settlement Agreement does not require there to be one or more recommendations in every investigation. This review looked at just nine investigations, it was odd that there were no recommendations at all. For example, there were no recommendations for any staff training or retraining, assessment of environment(s), or follow-up of any kind. This may reflect an inadequate investigatory process. The State should take a close look at its investigatory process to ensure that recommendations are identified.

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

1. Update policy to be fully in line with the Settlement Agreement.
2. Fix investigation report format/template to include all required components.
3. Document the discussion re the quality of the investigation by staff who supervise investigations, as per paragraph 169.h.
4. Give more effort to generating recommendations and possible areas for improvement, even if an allegation is found to be unsubstantiated and especially if the investigator cannot make a strong determination (i.e., inconclusive).
5. Develop a quality check to ensure all required components of the investigation are included and done correctly.

SECTION H	**Individual Support Planning, Discharge Planning, and Transition from Resource Center**

Summary of Monitor's Assessment:

Hi. Individual Support Planning and Discharge Planning (179-188)

The GRC policy on Individual Support Plans (dated 4/22/20 and reviewed 3/28/22) required that every individual should have a current ISP. Current was defined as within 30 days of admission or readmission and within 365 days annually thereafter. A small sample of individuals were reviewed for current status with these paragraphs. All individuals had a current ISP. (179)

The Settlement Agreement contemplated that with sufficient supports and services, all residents could be supported to live in an integrated setting and required that discharge planning begin upon admission to the facility and continue throughout an individual's stay. The GRC policy on Discharge and Transition Planning (dated 5/24/21 and reviewed 4/25/22) required that ISPs include a discharge plan section in the ISP that identified barriers to a successful move to the community and the inclusion of strategies directed at removing those barriers. (180)

The Monitoring Team found that individual support plans (ISPs) did not fully integrate a component for discharge planning as contemplated in the Settlement Agreement. ISPs did note some barriers to living in the community but did not include a robust set of measurable action plans addressing barriers to living in a less restrictive setting. (180)

To review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, PNMPs, PBSPs, Integrated Health Care Plans and/or risk action plans, implementation plans, monthly reviews, and the individual's daily schedule.

Attendance at Meetings

During the week of the review, the Monitoring Team observed two ISP meetings, for Individual #57 and Individual #105. Individual #105 attended her meeting and the IDT attempted to include her in the discussion by obtaining her verbal agreement to proposed treatment plans. The IDT did not discuss her vision for what her life might look like in a

less restrictive setting or offer her choices in activities that she would like to participate in (other than where she might want to live). Individual #105 did not attend his meeting, nor did his guardian. (178, 183)

For the most part, IDT presence and participation at the meetings were observed by the Monitoring Team with each discipline submitting assessments prior to the development of the annual ISP. The QIDP was present at both meetings and facilitated the meetings. The exceptions were participation by the PCP and psychiatrist. Additionally, medical and pharmacy assessments were often not submitted on time for review by the IDT. Discussion focused more on physical issues and did not address a full review of life goals, etc. (181-183)

A sample of six ISP signature sheets was reviewed to determine if relevant staff attended the meetings. The following is a summary of that review.

IDT members NOT in attendance at the annual IDT meeting	
Individual #99	QIDP, PCP
Individual #45	PCP
Individual #82	PCP, psychiatry
Individual #1	Psychologist, Nurse, OT, PCP, direct support professional
Individual #46	Vocational staff, direct support professional, psychiatrist
Individual #48	QIDP, psychologist, PCP, OT, SLP, Psychiatrist

Assessments

GRC submitted the following regarding the submission of assessments prior to the IDT meeting for ISPs developed in the first quarter of 2023. None of the individuals had all relevant assessments completed within five days of the annual ISP meeting as directed by GRC policy.

Relevant assessments NOT submitted prior to the annual ISP meeting	
Individual #105	OT, Medical, and Pharmacy
Individual #24	OT, Medical and Pharmacy
Individual #30	Medical and Pharmacy
Individual #89	PT, Medical and Pharmacy
Individual #16	Pharmacy
Individual #13	Pharmacy
Individual #84	Medical

Assessments were often brief and did not include data or a comparative analysis of the individual's status to determine if the support was effective or needed to be revised. Without determining what the individual's long-term goals might be, support needs and treatment plans overwhelmingly focused on what the individual was already engaged in at GRC. (180, 181, 183)

Outcomes and Action Plans

ISPs did not provide opportunities for individuals to explore new activities, particularly related to work and day programming. None of the action plans offered opportunities to explore community-based activities or engage in integrated activities in the community, such as banking, going to church, participating in retirement programs, joining community groups, attending classes, volunteering, etc., so that individuals were better able to make informed choices regarding what they wanted to do during the day and where they wanted to live. (180, 183, 184)

All ISPs included some general activities/outings that the individual enjoyed in the community, however, there were no outcomes developed to ensure that individuals had regular opportunities to participate in community activities based on their preferences or to receive supports and services in the community. (181)

There were a variety of day and vocational programs at the Center that could have provided opportunities for individuals to learn skills that might lead towards meaningful leisure and work opportunities in a less restricted environment. IDTs did not consider how day activities could be provided in the community or develop training plans related to day/vocational programming. It was noted during observations that many individuals were working at the

vocational sites and had work skills that could have transferred into meaningful community jobs. ISPs stated what the person was currently doing during the day but did not document exposure to other opportunities or education on jobs/activities available in the community, so it was not possible to determine if individuals were able to make informed choices about what they wanted to do during the day.

The day program area was well equipped to provide individuals with opportunities to explore new recreational and educational opportunities. Participation in the day program, however, was limited due to staffing shortages. Day program staff reported that they notified residential staff when there would be staff available to provide support at the day program daily. On two days of observations at the day program, there was a small group of five to six individuals participating in one room of the day program. Other rooms were not being used and staff reported that there were not staff available for additional activities. (180-181)

Outcomes tended to focus on training to address skills identified through the assessment process and were generally basic skills that would be needed in the community; however, they were not prioritized based on long term outcomes that the individual wanted to achieve, and specific training strategies were not developed to implement training in the community. The community was considered a possible training site, though guidance was not included for staff to implement plans in the community. (181, 182, 184) For example:

- Individual #1 had an implementation plan for budgeting his money. In general, this was a skill needed in the community, however, the individualized implementation plan did not include strategies for practicing this goal in the community. His communication outcome to communicate his wants and needs to his support staff was also a skill needed in the community, but the implementation plan did not include ways that he could practice this skill in the community.
- Individual #82 had an IIP to independently exercise. Strategies included offering her a variety of exercise opportunities (e.g., biking, swimming, walking, aerobics). Her plan did not include guidance for offering these activities in the community. Her IDT missed an opportunity to expose her to available activities in the community and support community integration by not considering implementing training at community gyms, walking groups/events, dance classes, etc. Her employment section indicated that work was important to her and noted that she would need a job if she moved into the community, but the IDT stopped short of exploring jobs that she might like and then identifying job skill training specific to those jobs.

Outcomes were generally not worded in a way that was observable or measurable, so that the IDTs could measure progress and determine when an outcome had been achieved. Expectations for goal achievement were not clear. Examples of outcomes that were not measurable included (183-184):

- Individual #1: will independently wear his glasses, develop budget skills, increase communication skills by learning to communicate to his support people what his wants and needs are.
- Individual #46: independently clear his bed and bedding and express himself appropriately through daily situations.
- Individual #48: teach appropriate social skills associated with telephone usage, provide a more socially appropriate response, will improve his social skills.
- Individual #81: increase self-help skills by building positive relationships through structure conversation.

<u>Discharge Planning</u>

The ISP template included a vision for the future section (a picture of a happy and safe life in the community). ISPs did not describe what that might look like for each individual. The ISP template further directed for a description of challenges and strategies to overcome barriers to the identified picture of a happy and safe life in the community, but these were mainly generally stated barriers to various support categories with little to no specifically identified strategies and actions. (184)

There were some barriers to living in the community noted (typically behaviors and/or guardian objection to moving) and broadly stated strategies to overcome barriers such as will continue training opportunities but plans lacked detail to help the IDT develop measurable plans for addressing barriers. (184)

ISPs did not include individualized plans to provide opportunities for individuals and their guardians to learn more about living options, such as by visiting providers and/or visiting with individuals and their families that were living in

the community. For guardians who expressed concern or objections regarding community transition, specific plans to address those concerns were not included in the ISP. (184)

The ISP included a table titled discharge planning efforts. In this table, QIDPs documented contact with families regarding transition over several years, however, statements were often not dated and were general in nature. They did not include specific information to educate the individual and/or guardian. ISPs did not include measurable action plans for moving forward to educate the individual and guardian/family about living options. (186-188) For example:

- For Individual #45, the ISP documented yearly contact with the guardian from 2014 through 2017, then two more contacts (undated). The last contact included a general statement (the option to consider alternative living arrangements was brought up again with the guardian to discuss transition options). There was no indication that individual specific information was shared with the guardian or that more details were shared regarding available living options that might support his needs. His ISP noted that the guardian was not in favor of Individual #45 moving from GRC. There was no further information regarding what Individual #45's living option preferences were or what his level of understanding regarding living options might be. The IDT did not develop measurable action plans for moving forward to educate the individual and his guardian or to address specific concerns.

- For Individual #99 actions taken by the IDT included that it was announced that GRC will close in 2024. The outcome of those efforts noted that none is known. Another entry noted that they mailed a flyer to the guardian inviting her to a presentation being held at GRC about the MFTP program that assists people who want to transition. The outcome of those efforts was that the guardian did not attend. A third contact noted that they sent a survey to guardian asking how she would feel about moving into the community if all her needs were met. The outcome of those efforts was that guardian felt very strongly against moving from GRC. There was no indication that individualized contact and education about community living options had occurred.

- For Individual #82, action taken to move forward with transition was documented and the guardian was informed of action taken, however, it was not documented that the IDT had developed written action plans for moving forward or that the individual and/or guardian were informed and offered input prior to action taken. For example, the discharge planning grid noted that on 6/7/22 a referral was sent to REM Iowa. The outcome of those efforts was that on 6/30/22 the recorder of the note met with REM to do an introductory meeting. Individual #82 did not attend because there was no one to bring her to the meeting. Another entry noted that an ITSP meeting was held on 6/30/22. Individual #82 was accepted to Lakes Life Skills and her sister had set up a meeting with REM in Davenport. The outcome of those efforts noted that Individual #82's mother did not want her to go to Lakes Life Skills because it was too far away. This should have been known before GRC moved forward with a referral to Lakes Life Skills.

There was some confusion and lack of coordination regarding which IDT member was working with individuals and their family on exploring community options and ensuring that they were able to make an informed choice regarding options. While the QIDP had the overall responsibility to coordinate all services, the social worker was tasked with transition activities.

Hii. In-Reach and Community Engagement (189-192)

GRC indicated they had no specific policy or training related to sharing information with the individual and guardian regarding community options in a way that enabled them to make an informed decision about community transition.

Although some individuals had visited with providers in the community, there was no written plan to ensure that individuals had consistent opportunities for quarterly (or more frequent) visits to community-based residential and vocational settings and opportunities to meet with other individuals with IDD who were living, working, and receiving services in integrated settings.

The expectation of these paragraphs is a process by which a fully informed individual and/or legal guardian has decided about where and how they want to live, based on several elements: nature and parameters of the decision; reasonable alternatives; and relevant risks, benefits and uncertainties related to each alternative. For these elements

to be present, substantive discussions with the guardian and individual regarding the benefits of community living should have been documented as part of the individual support and discharge plans. (189-191)

A small sample of ISPs, IDT meeting minutes, and monthly reviews were reviewed for documentation regarding educational activities provided to individuals and their guardians about community living and day programming options. None indicated that the required related activities were consistently occurring. (189-190)

- Individual #45's ISP did not include action plans related to educating him or his guardian about living options. There were no IDT meetings to discuss living options and his monthly reviews simply noted monthly that he was transitioning to Community Options. Monthly reviews did not summarize transition activities provided by Community Options. His social services annual report indicated that his guardian was provided with educational materials related to community-based providers. The guardian was invited to a video presentation hosted by providers that spotlighted individuals who had successfully transitioned to the community. Notes did not document the guardian's participation or response to these activities. Overall, this reflected a dual process whereby interdisciplinary teams (IDTs) developed an individual support plan that directed the supports and services the individual would receive at the facility without integration with the social workers or transition facilitators who were charged with development of discharge and transition plans.

- Individual #82's ISP did not include action plans related to providing information to the individual or guardian regarding living options. There were no meeting minutes indicating that the IDT had met to discuss living options. The monthly reviews included a list of providers that referral had been submitted to and the status of those referrals. Participation by Individual #82 and her guardian in the referral/transition process was not documented.

- Individual #99's ISP did not include action plans related to providing information to the individual or guardian regarding living options. There were no meeting minutes indicating that the IDT had met to discuss living options. The monthly reviews noted that her guardian wanted placement at Glen Haven Nursing home but was open to other options. It was noted that other referrals had been made. There was no documentation of discussion with the guardian about options that might meet her support needs and no documentation of visits to providers in the community.

ISPs did not provide guidance for individuals to be offered opportunities to fully engage in community activities consistent with their identified needs and preferences. Without consistent exposure to activities in the community, it was unlikely that individuals could make informed decisions regarding preferences related to recreation, relationships, day/work activities, or living options. None of the individuals were meaningfully participating or integrated into the community. (192)

H.iii. Transition Planning

Transition planning for individuals residing at Glenwood Resource Center is defined by facility policy (dated 5/24/21, reviewed 4/25/22) as "When the most integrated setting is identified to meet the individual's needs and the individual is accepted for and agrees to service in a new setting, the IDT including the individual, provider(s), guardian, family, MFP transition specialist and/or MCO case manager as applicable, promptly develops and implements a transition plan."

The responsibility for development of discharge and transition planning, along with facilitation of education with guardians and individuals regarding least restrictive, most integrated setting and informed decision making appeared to have been delegated to the social workers, while the QIDP had the overall responsibility to coordinate the individual's services and supports at the facility. This dual process whereby interdisciplinary teams (IDTs) developed an individual support plan that directed the supports and services the individual would receive at the facility without incorporation of an adequate discharge plan was contrary to the requirements of the Settlement Agreement.

Based on a review of ISPs for three individuals, the Monitoring Team found the following descriptions of the IDT evaluation of the type of setting most likely to ensure a successful transition (e.g., number of roommates, urban or rural, preferred geographic location, proximity to family) based on the individual's strengths, preferences, and needs:

- Individual #45: Individual #45 will need assistance finding housing that meets his needs. He will need assistance setting up utilities and paying for services monthly. Individual #45 would like to live in a house in a small town. Somewhere that has some land with a rocker out front that he could sit in and enjoy the day while rocking. He would also love to have a garden with many plants as he loves watching the flowers and is very proud to show them off to people. He also enjoys sitting and watching the birds eating from the bird feeder. Individual #45 would like to live with less than four other people. He would prefer it to be males. He would prefer that they were active and wanted to be out and about. He would prefer it if they did not mess with his stuff and were not overly loud for long periods of time. Individual #45 would enjoy being roommates with individuals who are rambunctious and energetic from time to time but did not want a roommate who does not enjoy relaxing as well. Individual #45 would not like any pets in the house but might like having animals outside that he could watch. He would need someone to take care of the pets as he would not be able to do so himself. Individual #45 would need assistance with transportation in community activities. Individual #45 would not be able to find anywhere by himself and will need assistance from staff in all parts of the activity.

- Individual #82: Individual #82 says that she would like to live closer to her family in Davenport, IA, so that she may visit them more often. She does not have a preference between city or country, apartment, or home. Individual #82 would be appropriate for a single or multi-level home with two to four peers around her age. Individual #82 would prefer to live with women but does not have a preference of activity level. It would be beneficial for Individual #82 to live with people that she does not feel the need to "mother," so that good boundaries remain in place.

- Individual #99: Individual #99 does not state where she would like to live, but people who know her best believe that if she were to move from GRC it would be to a smaller house in a small community. She would not like too many other housemates as this place would be quieter with less people as she is easily annoyed with noisy areas. She would have to have a room with a recliner where she could sit and relax, whether that is in her bedroom or a living area within the house. She would need the same basic care that she currently receives to include, but not limited to meals, medications, appointments, transportation, and any of her other needs.

These descriptions are person-centered and focus on the individuals' preferences which in the most basic sense satisfies the Agreement. However, the descriptions do not provide sufficient detail as to the type of services and supports the individual would need for a successful transition to the community (e.g., behavioral, PT/OT, medical focus, etc.).

The process whereby GRC interdisciplinary teams developed an individual support plan that directed the supports and services the individual would receive at the facility without incorporation of an adequate discharge plan was contrary to the requirements of the Settlement Agreement. Given the decision to close the facility, each individual should have a discharge plan that provides for options of community living consistent with their identified needs and preferences along with actions for guardians and individuals to make a choice of provider, consistent with Sections H.i. and H.ii. of the Settlement Agreement. (193)

According to documentation provided by the facility, there were currently 104 individuals in various stages of the transition process, 14 of whom had targeted move dates between 3/16/23 and the end of April 2023. The remaining were classified as follows:

Status	# of Individuals
Awaiting Med Resolution	1
House Completed in July	1
Awaiting Completion of Renovations	1
Awaiting Funding	1
Awaiting Guardian Decision	4
Awaiting Guardian Signature	1
Awaiting Home Build	3
Awaiting Home Renovations	1
Awaiting House	1
Awaiting New Build	2

Awaiting Open Bed	5
Awaiting Process	2
Awaiting Sister's Recovery from Surgery	1
Awaiting Recovery from Surgery	1
Guardian Exploring Options	1
Guardian Interested in HH, Waitlisted	1
In Process	7
Move Date Set for April/May 2023	1
No Move Date Set	1
No Provider Acceptance	38
Provider Acceptance	4
Provider Acceptance, Guardian Looking at Providers	1
Provider Acceptance, Awaiting House	1
Provider Acceptance, Waitlisted	1
Provider Accepted	1
Starting Process	1
Touring Provider, Guardian Will Make Decision	1
Waitlisted	6

- Documentation did not provide information as to how the IDTs supported the individual and Authorized Representative in choosing a provider, nor did documentation reflect anticipated dates for resolution to barriers, such as those classified as awaiting open bed or waitlisted. The Monitoring Team reviewed the transition plans for Individual #45 who was noted as being waitlisted with Community Option, Individual #82 who was noted as having no provider acceptance, and Individual #99 who was noted as having no provider acceptance. The transition plans for all three individuals were incomplete and the individual support plans for two of the individuals contained no comprehensive discharge planning efforts (193-194 Individual #45's ISP indicated that the option to consider alternative living arrangement was brought up again with the guardian who responded in writing that GRC is where he belonged, all his needs were met, and where she wanted him to continue to reside (at GRC) and benefit from the programs offered to him.
- Individual #99's ISP indicated that a list of community providers from Eastern Iowa was provided to the guardian by mail and was instructed to let the social worker know if the guardian would like Individual #99 referred to any of them. The guardian did not respond.
- Individual #82 had a more detailed summary in her ISP but did not meet the criteria for a discharge plan. Most recently the social worker noted that Individual #82 was accepted to Lakes Life Skills and there was a meeting set with REM in Davenport as her family would prefer to have her in the Davenport area. The social worker noted that REM will accept Individual #82 if she can go six months with no IM chemical restraints. No further actions or strategies were developed.

The IDTs should develop action plans for aggressive education for guardians to make an informed decision as to the best possible community placement given the facility will be closing. These actions should include specific providers and/or group homes selected based on individuals' needs for guardians to visit and have opportunities to ask questions about services and supports. If the guardian refuses, there is a question as to whether the State can choose an appropriate community provider and move forward with the transition. For Individual #182 as an example, the question to be posed is whether the individual was not in a stable behavioral/psychiatric condition for transition and what the facility was doing in that regard. If IM chemical restraint is the required practice for behavioral intervention for Individual #182, the provider may not have been the most appropriate option and the individual would be at risk of future institutionalization due to the IM chemical restraint intervention and instability. There was no indication the facility had developed a plan with the provider for ongoing transition activities.

The Monitoring Team found no clear guidance or expectation that discharge plans contain strategies for individuals to visit the selected home, have overnight stays, or for provider staff to spend quality time at the facility with the individual. (195)

The Monitoring Team found no clear policy regarding development of a right to return agreement, and this was not a standard component of the individual discharge plan. Data requested by the Monitoring Team revealed that while some individuals were noted to have a right to return agreement, this was not standard or consistent. The Monitoring Team reviewed three individuals who had transitioned from GRC (Individual #110, Individual #111, Individual #112) and none had a right to return agreement. (196)

The Monitoring Team found that paragraph 197 was not being met because the individual support and discharge plans and the transition plans did not include a referral date. Additionally, requested reports regarding transitions did not provide data points of a referral date and a transition date to ensure individuals move within a six-week period as contemplated in the Agreement (197)

The Monitoring Team found that the IDTs did not sufficiently identify desired outcomes for incorporation into transition plans to ensure consistency for a successful transition. For three individuals who were reviewed in their community homes, the transition plans were devoid of clearly identified outcomes and training that would support them in continuing to work on skill acquisition they had been working on at the facility. (199)

The Monitoring Team requested data about individuals who had transitioned from Glenwood Resource Center to the community or to another facility (e.g., hospice home, nursing home, Woodward RC) including (a) date of transition, (b) where the individual transitioned (e.g., group home, another facility), and (c) identification of and details related to any negative events since transition. According to information provided in response to this request:

- 49 individuals moved from Glenwood Resource Center between August 2022 and December 2022. Of these, four individuals died less than four months after their transition. Two of these four individuals were transferred to large, congregate facilities.
    - One was discharged to a skilled nursing facility on 9/12/22 and passed away on 1/5/23.
    - One was discharged to a 75-bed skilled nursing facility on 11/18/22 and passed away 11/29/22; documentation reflected this placement was for hospice care.
- 13 individuals transferred to Woodward Resource Center (10 in August 2022, one in October 2022, one in November 2022, and one in December 2022).
- One individual was discharged to a HCBS Waiver group home on 7/25/22, but after experiencing multiple arrests, returned to Glenwood Resource Center on 1/11/23:
    - 8/8/22: arrested for assault causing bodily injury.
    - 9/19/22: arrested for assault.
    - 9/24/22: arrested for assault on person in certain occupations.

The data provided by the State reflected one meeting held on 9/30/22: "the team discussed what had taken place, and what could be done in the future to prevent the same outcomes. After much discussion, the teams came up with some solutions that they felt could help the individual going forward. It discussed getting the person more involved independently with chores, getting more staff training on what to do when they got upset, looking for some outside resources, and even possible restraint training for the Ameriserve staffing. At the end of the meeting, the teams made dates for regular meetings to be held in the next several weeks so they could monitor the behavior, and to make sure he's staying on task."

<u>H.iv. Community Integration Management</u>

A Community Integration Manager (CIM) position was created as required by paragraph 201 of the Settlement Agreement and the position was filled approximately six weeks prior to the Monitoring Team's baseline onsite visit. The CIM was still in the process of developing her role of transition activity oversight and there was no specific documentation or evidence available (yet) related to identification of needed actions to address shortcomings of the discharge and transition planning process at Glenwood Resource Center. (201-202)

Based on documentation requested by the Monitoring Team, the Community Integration Manager had identified several issues of concern:

- Community Integration Manager met with several provider agencies regarding barriers to clear communication from GRC. Specifically noted was that GRC often made referrals and then follow-ups were

confused or not followed up on. CIM noted that since this meeting, the process had improved and the CIM was planning to meet with more agencies at the Vendor Fair scheduled for 3/29/23 at GRC.
- Many GRC guardians continued to act as if the facility was not closing.
- GRC staff, individuals, guardians, and providers did not understand the role of MFP. CIM suggested follow-up/refresher training to be scheduled for 3/27/23 and in April 2023.
- There was also a lack of understanding regarding HCBS rights restrictions.
- More training was needed for both GRC/WRC, MFP, and case management regarding person-centered planning and clarification pertaining to rights restrictions suggested by CIM.

The Community Integration Manager had also identified areas for corrective action:

- Revisit with GRC team and community providers of person-centered supports and services (where individual wants and needs drive services, not what providers are willing to do/accept). Revisit focusing on what will support success for an individual's transition, including cross-training, visits to the new home, an opportunity to truly get to know potential roommates prior to setting a move date, are supports in the community in place, and what does the individual feel are the most important things to them in their community setting.
- Require training for facilities, HCBS providers, and case managers on person-centered processes and alignment with Federal expectations.
- Expectations for community providers to work collaboratively with supports available. Create an expectation that providers use objective data to support decisions, and that when outside supports are involved, data will be recorded and shared as outlined in the individual's individualized plan/behavior support plan.
- Providers overall continued to struggle to be able to support individuals with multiple complex needs. Bolster community supports such as psychiatry, crisis supports, and mental health therapy as they aren't sufficient across the state to consistently support people remaining in their homes.

For individuals where the IDT recommended maintaining placement at Glenwood RC or placed in a congregate setting with five or more individuals, the discharge plan did not include clear justification for the decision, the barriers to placement in a more integrated setting, and actions the IDT would take to address the barriers. Additionally, there was no evidence that the CIM had reviewed the instances where an individual was placed with five or more individuals or in another congregate setting. (203-204)

At the time of the Monitoring Team's review, 13 individuals had transferred to Woodward Resource Center. There was no documentation provided to identify how many of the individuals remaining at GRC and their Authorized Representatives were contemplating such a transfer. (205)

The data provided by the State did not include information regarding whether the individual and/or guardian was offered a meaningful choice of community providers prior to choice of placement at a SRC. The Monitoring Team did not have access to all ISPs and transition plans for these individuals. Nor did the Monitoring Team have access to or review ISPs and transition plans for all individuals who had moved from Glenwood.

Settlement Agreement paragraph 206 required the State to produce routine public reports or maintain current public data dashboards regarding the status of Glenwood RC's community integration efforts, including historical data reflecting by month: the proportion of residents in each stage of transition planning, the number of transitions accomplished, and the types of placements, and recommendations that individuals remain at Glenwood RC. The Monitoring Team requested these reports and was provided the following link:
https://hhs.iowa.gov/dashboard_facilities

Settlement Agreement paragraph 207 requires the State to ensure that information about barriers to discharge from involved providers, IDT members, and individuals' ISPs was collected from Glenwood RC and aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services. The Monitoring Team requested documentation to assess this and was provided the following link: Building the Community 2020: Community Integration Strategic Plan | Iowa Department of Health and Human Services

Per Settlement Agreement paragraph 208, "The State shall develop and implement quality assurance processes to ensure that ISPs, discharge plans, and transition plans are developed and implemented, in a documented manner,

consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being advanced. Whenever problems are identified, the State shall develop and implement plans to remedy the problems." The Monitoring Team requested these quality assurance process and documents, but none were provided.

Per Settlement Agreement paragraph 209, "a GRC staff member shall conduct monitoring visits within each of four (4) intervals (approximately seven, 30, 60, and 90 days) following an individual's transition." This paragraph of the Agreement further requires that "Documentation of the monitoring visit will be made using a standard checklist that encompasses all areas of the transition plan and addresses whether all supports and services are in place according to the timeframes in Paragraph 200. This review shall include ensuring that the new provider has a current person-centered individual support plan in place, consistent with the requirements in Paragraph 183. The State shall ensure staff conducting this monitoring are adequately trained and shall assess a reasonable sample of monitoring visits to ensure the reliability of the process."

The Monitoring Team found no documentation to suggest the State was planning to do a reliability assessment of post-transition monitoring.

To assess, the Monitoring Team requested a policy and other documentation to reflect implementation of a post-transition process including a standardized monitoring tool. In response, the Center provided a Post-Transition Checklist with verification of training with the social work department and transition facilitators on the topics of:

- accepted discharge planning process follow-up (conducted 2/1/23)
- transition follow-up process (conducted 2/7/23)
- documentation of significant events, transition meetings, transition activities and discharge notes (conducted 2/28/23)

Therefore, all individuals who transitioned from GRC prior to implementation of this checklist and process did not have comprehensive follow-up reports based on the required elements of the Settlement Agreement. The Monitoring Team conducted post-transition visits to three individuals. All three individuals appeared to be doing well in their new homes and had received visits by the responsible Glenwood Resource Center staff at the required intervals. However, as noted above, formal and consistent documentation was lacking for any visits that occurred prior to 3/1/23. (209) Examples included:

Individual #110 transitioned to a HCBS group home on 11/7/22. Accomplishments and/or issues noted from the monitoring visits included:

- psychiatry appointment 2/22/23, discontinued Risperidone 1 mg BID, continued Lorazepam 1 mg daily PRN for anxiety/agitation, prescribed Olanzapine 5 mg BID.
- lost her job at GRC due to layoffs of all Family Support and Outreach clients from their jobs on the GRC campus.
- her family took her home for her birthday on 2/23/23.
- Family Support and Outreach plans to help her learn new ways to communicate without resorting to self-injury and aggression.
- was able to go home with her parents for a day visit.
- communication device was erased and needed to be reprogrammed.
- was working independently at the GRC Laundry and Paper Recycling.
- has tried to open the basement door (to the outside) but could not.

Individual #112 transitioned to a HCBS host home on 11/4/22. Accomplishments and/or issues noted from the monitoring visits included:

- was excited to show his new puppy.
- was started on Trazadone 50 mg at night on 3/1/23 to help with sleep.
- had one major incident with behaviors this past month where he didn't like something that the psychiatrist said during his consult, and he ran out of her office stating that he was going to kill her and punch her in the face; host provider was able to calm him down.

- has been going to the Eagles Club to play Bingo on Tuesday nights, poker on Friday nights, and to play pool; calls his mom and aunt once a week.
- does not have a job.
- went to the Home & Garden show this past month.
- was able to go on vacation without behaviors.
- has chores to take out the garbage, vacuum, and sweep.
- working on his laundry and saving money.
- will learn to take care of his puppy.
- stated he feels like he is part of a family in his new home.
- was seen at UNMC Adult Dentistry 1/19/23 to get impression mold for partial dentures and again on 1/23/23 to have cavities filled and again on 2/6/23 to receive his partial dentures.
- was at Olive Garden with host family and housemate when he raised his voice and threatened to bite his host provider and run away; the host provider was able to deescalate the behavior outside the restaurant.
- went to Great Wolf Lodge in Kansas City and Muscatine for Christmas with his host family and housemate.

Individual #111 transitioned to a HCBS group home on 2/23/23. Accomplishments and/or issues noted from the monitoring visits included:

- Metformin was discontinued 3/9/23 due to stable blood sugar results.
- beginning to see his community physicians.
- has been participating in Meals on Wheels two days per week and exploring his neighborhood and community on a regular basis.

All three individuals had been assigned a community-based case manager. The Monitoring Team requested visit, contact, and monitoring notes from the assigned Managed Care Organization (MCO) case manager. Notes reflected at least monthly contact with the individual after transition. However, the case note format did not provide comprehensive prompts to gather substantive information based on review of documents and interview of provider staff and the individual to identify potential or emerging problems with the transition or to identify areas of needed follow-up with development of adequate correction actions.

All three individuals were receiving Money Follows the Person (MFP) services and case management. The MFP case manager had developed a Partnership for Community Integration Transition and Service Plan to complement the transition plan from Glenwood Resource Center. The Monitoring Team requested visit and monitoring notes from the MFP case manager, but none were provided. (210)

The Monitoring Team found the multi-agency case management approach was not clearly defined. The State of Iowa defined the role of the case manager as: Case Managers work with individuals and their families to coordinate medical social, educational, housing needs, transportation, vocational and other necessary services and supports into an integrated plan of care. Responsibilities included:

- Assistance with navigating the service system and gaining access to services.
- Coordination of services using multiple serve providers/agencies; establishing crisis plans to meet the health and safety needs of the consumers served.
- Securing/managing funding for services
- Working with the individual, their parent(s)/guardian; other members of the service team to develop an individualized integrated care plan.
- Coordination and monitoring of ongoing services; monitoring progress towards goals in the care plan as well as the health and safety of each consumer served.
- Monitoring the individual to assess the health, safety, and wellbeing of the individual.

The lack of a lead representative responsible for coordinating and monitoring of services, progress, and general well-being was noted as a critical component of the transition process that needed immediate correction. This was also noted in the Department of Justice Investigation of Glenwood and Woodward Resource Centers 12/8/21:

A lack of role clarity regarding key aspects of transition planning further impedes the process. Social workers, MCO case managers, and, in some instances, MFP staff share responsibility for engaging with residents and guardians about community services, identifying options, and planning for transition. State officials acknowledge

that the responsibilities of each remain unclear. The lack of coordination contributes to deficient information sharing and support planning.

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

1. ISPs should include measurable outcomes that address all areas of individual's lives, including recreation/leisure, relationships, independence, work/day/retirement, and living options based on the vision for what they want their life to look like.

2. An additional effort should be made to include medical and psychiatry staff at IDT meetings to guide the team in developing the needed support to address medical and behavioral risks both at the Center and in the community.

3. ISPs/transition plans should include measurable action plans to address identified barriers to living in the community. These action plans should be reviewed at least monthly by the IDT and revised as needed.

4. ISPs should include training in the community that would offer opportunities to practice skills in a less restrictive environment.

5. Individuals and their guardians should be included in all decisions regarding community transition to the greatest extent possible.

6. IDTs should develop an individualized set of action plans related to educating individuals and their guardians about community living options. Action plans should include what action will be completed, who will provide the information/support and by when.

7. The IDT should meet frequently to discuss the response to information/exposure and determine what the next step (if any) should be.

8. Transition decisions should be based not only on where the individual wants to live, but also include consideration of what relationships are important to the individual, their preferences for work, volunteering, education, or retirement programs, and preferences related to recreation and leisure activities.

9. Develop individual specific training that could occur during day programming related to individual's preferences for working, volunteering, or engaging in retirement activities in the community.

10. Develop measurable outcomes for increased exposure to new activities in the community based on individual preferences to increase their awareness of options available in the community.

11. Given the decision to close the facility, each individual should have a discharge plan that provides for options of community living consistent with their identified needs and preferences along with actions for guardians and individuals to make a choice of provider.

12. Ensure all individuals at Glenwood Resource Center have an individualized transition plan that clearly identifies the supports and services needed to successfully serve the individual in the community.

13. Transition plans should include measurable action plans to address identified barriers to living in the community. These action plans should be reviewed at least monthly by the IDT and revised as needed.

14. Develop strategic actions for educating individuals and their guardians about community living options and documentation of informed decision making.

15. Documentation should reflect information as to how the IDTs supported the individual and Authorized Representative in choosing a provider and anticipated dates for resolution to barriers, such as those classified in the table above.

16. As the census decreases, convert QIDP and social work positions to the office of the Community Integration Manager for more controlled and coordinated post transition monitoring.

17. Ensure that a clear and streamlined case management service is provided by the Managed Care Organization to coordinate and monitor all services and supports provided to individuals who transition from GRC.

SECTION I	**State Staff**

Summary of Monitor's Assessment:

State Staff (212-215)

Like many employers, Glenwood RC was facing multiple challenges in recruiting and maintaining staffing. The issue of closure further complicated the challenge that must be addressed to ensure individuals living at GRC continue to have their needs met as the transition process continues.

As of this review, Glenwood RC had 146 filled Resident Treatment Workers (RTWs, with an additional 20 RTWs that were filled by a Maxim contract). GRC was budgeted for 246 RTWs and had 100 openings. The current RTW relief factor was 1.5, including the temporary RTWs. This fell short of the 1.8 relief factor identified in the Settlement Agreement. A relief factor multiplier formula of 1.8 (meaning there will be 1.8 residential treatment workers filled and budgeted for every residential treatment worker needed on shift) or more if necessary to account for staff vacancies and leave.

Glenwood RC continued to advertise openings and was looking into possible expansion of contract services as needed. To reach a relief factor of 1.8, GRC would need to have a staff of 198 RTWs, which reflects an increase of 32 RTWs from current levels. In addition to the hiring of staff, GRC reported that they were reviewing opportunities to consolidate and improve care as the census is reduced.

A Performance Planning and Evaluation policy guided the ongoing review of staff to ensure continued competency. The policy did not have an origination or review date. The policy provided information regarding the purpose of the evaluation and the responsibilities and tasks. The accompanying administrative rule "Chapter 62-Performance review," included the minimum requirements of the performance evaluation and the sharing of information. (213)

The Center was asked to provide a policy for the training of staff on how to report concerns as well as the methods in which staff can report such concerns, but no documentation was provided.

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

1. GRC should ensure that staff have multiple methods in which to report the concerns of fellow staff. Of these methods, one should be anonymous. Policies should clearly indicate that the individual filing the complaint will be free from retaliation.

SECTION J	Organizational Accountability

Summary of Monitor's Assessment:

Organization Accountability (216-228)

Glenwood Resource Center had a full leadership team that consisted of the below professionals. In addition, GRC was supported by Kelly Garcia-Director of Iowa Health and Human Services and Cory Turner-Division Administrator of Iowa Human Services. (216)

Cory Turner was currently serving as the Director for all State-Operated Facilities and reported directly to the HHS Director. Per his position description, he was directly responsible for the oversight of the six HHS 24/7 facilities. His role was to ensure the superintendent in charge of GRC developed and implemented strategic and effective operational plans. (216)

NAME	TITLE
Angel, Jose	CHIEF MEDICAL OFFICER
Baggett, Karen	TREATMENT PROGRAM ADMINISTRATOR - AREA 2
Darrow, Charles	PSYCHOLOGY ADMINISTRATOR
Edgington, Marsha	SUPERINTENDENT
Heiman, Cara	ADMINISTRATOR OF NURSING
Hunter, Daniel	DAY SERVICES DIRECTOR
Iversen, Cade	ASSISTANT SUPERINTENDENT OF INTEGRATED SERVICES
Konfrst, Scott	INFORMATION TECHNOLOGY ADMINISTRATOR
Landeen, Dax	ASSISTANT SUPERINTENDENT OF TREATMENT SUPPORT SERVICES
Lovato, Darlene	QUALITY MANAGEMENT DIRECTOR
Mayhew, Diane	TREATMENT THERAPY SERVICES DIRECTOR
Robinson, Kelly	SOCIAL WORK ADMINISTRATOR
Sayers, Heath	ASSISTANT SUPERINTENDENT OF TREATMENT PROGRAM SERVICES
Wade, John	TREATMENT PROGRAM ADMINISTRATOR - AREA 1

Per report, the State currently engaged with stakeholders (including staff, parents, guardians, non-governmental entities with oversight responsibilities for GRC, and other stakeholders) to identify their goals, concerns, and recommendations regarding implementation of this Agreement, however, there was not a clear consistent cadence to the meetings. Additionally, the meetings were combined with the other State Resource Center, which was not in the same transition/closing status. It was reported that having these meetings together resulted, at times, in GRC topics using most of the meeting and leaving little time for WRC stakeholders. Also, the stakeholders from GRC had very different concerns than those at WRC. (218)

There was no Resident Council in place that enabled GRC individuals to make recommendations regarding topics of interest to the Superintendent and HHS Central Office. (225)

GRC policies had been, and continued to be, updated, and reviewed, but lacked evidence of review and approval by HHS prior to implementation. (227-228)

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

1. See recommendation above regarding the need to have an anonymous method in which staff can report concerns. Methods to report concern should be clearly marked on the homes, so that they are readily readable and accessible to staff and the individuals living at GRC.

2. The State should separate the GRC and WRC stakeholders to allow the guardians, etc., the ability to focus on issues that are more relevant to the respective parties.

3. Ensure policy shows review and approval by HHS. This may be accomplished via HHS staff signature or by HHS stamp on the document/policy.

SECTION K	Effective Quality Management

Summary of Monitor's Assessment:

Effective Quality Management (229-235)

GRC had a quality management staff that included a director, two investigators, and a quality assurance coordinator (who was also a Qualified Intellectual Disability Professional (QIDP) for one building). The trainer also reported to quality management. (229-230)

The quality management staff, in conjunction with GRC leadership, had identified over 200 quality indicators, including outcomes and performance measures that were defined and data that were reported monthly. Responsibility for providing monthly data was assigned to department heads/designated staff and was to be submitted by the 5th of each month. Quality management staff compiled the data into a report by the 10th of each month. A subset of the quality indicators was reviewed during monthly meetings of the Quality Council, comprised of leadership from GRC and representatives of HHS Central Office (who participated via conference call rather than in person). (229-230)

It was reported at an interview during the monitoring visit that the quality management department, QIDPs, and others that an incident report was generated in the electronic system for any incidents included in Quality Council data. Any missing incident reports were then completed. If inaccuracies of information reported on incident reports were discovered, the correct information was documented on another incident report because the original could not be corrected in the electronic system once finalized. (229-230)

GRC identified thresholds/triggers for certain incident types or frequencies of specified incidents that required additional review. The policy Abuse and Incident Management, last reviewed on 3/28/22, outlined incidents that required additional review by trained investigators, clinical and/or interdisciplinary teams (IDT), and QIDPs. When thresholds were met, incidents were flagged in the reporting software to prompt responsible individuals to conduct those reviews. Incidents that met thresholds were also reviewed during Quality Council meetings, per policy. (229-230)

The following observations were made after a review of minutes from four Quality Council meetings, on 10/18/22, 11/15/22, 12/20/22, and 1/17/23:

- The discussion section of the minutes included some analysis of the data, including limited efforts to confirm the data were accurate, possible causes for changes, trends, etc. The frequency of these analyses increased as the months progressed.
- In many cases, the discussion cited the month-over-month change in frequency for certain data, but no indication of thoughts about what might be driving this change and/or what GRC planned to do about it.
- The minutes had columns for Action Needed, Responsible Party, Date Due, and Date Resolved, but these were not completed for any of these four months.
- Discussion among Quality Council members was often documented verbatim (e.g., X person said this; Y person said this, etc.).
- Trends, patterns, strengths, problems, and resulting actions taken/planned, if noted in the minutes, were presented on an individual or possibly area level. The minutes did not include information about assessing at systemic levels.
- The Pharmacy Quality Council Report was not made available for all Quality Council meetings.

It was reported that certain types of incidents (e.g., falls, medication variances) had separate meetings for more detailed discussion on those topics. It was also reported that any identified issues and resulting corrective action may be discussed and documented in the minutes of those meetings rather than the Quality Council meeting minutes. Incident review meetings included a review of whether follow-up actions identified during previous meetings were completed, including required submission of evidence of completion (training, program modification, etc.). The appropriateness of those corrective actions and services will be further explored during the next monitoring review. (229-230)

During monthly meetings, the Quality Council did not review each of the 200+ indicators, however, a separate report titled Glenwood Resource Center Quality Indicator Report was completed monthly and designed to include data on all indicators. A review of a report that was generated 3/3/23 for the months of February 2022 through January 2023 revealed that data for indicators numbers 28 (# persons with Axis I diagnosis) through 36 (# of persons receiving an older generation anti-psychotic medication) was missing for the months of June 2022 through January 2023. Monthly data for indicators 64 and 64.1 (neurology consults for persons with a seizure disorder required and received) were not present for any months of the report. In most cases, the indicators in this report referred to "persons," but a few of them include the outdated terminology of "client" (e.g., 105 - # staff injuries resulting from client aggression, 174 – total # allegations of staff-to-client abuse or neglect). (229-230)

Based on a review of reports provided and interviews completed during the onsite review, it could not be confirmed that GRC maintained data required to satisfy para. 231. It was reported that data was collected for each domain; however, some data were not as detailed or fully developed. (231, 211) For example:

- It was verbally reported that data on engagement and skill acquisition (d.), choice and self-determination (e.) individual service plans (ISPs), inclusion in planning process, and individualized goals, and risk management (g.) were collected monthly through a review completed by the Quality Assurance Coordinator, of a sample of ISPs. It was reported that these data were presented on an individual per-record basis and not aggregated in any way. (Documentation of these reviews and follow-up communication was requested, but not received.)
- Data on the total numbers of community outings (f. community inclusion) and total number of people who participated were included in the Quality Council report, but there was no analysis of the types of activities offered. It was reported in an interview that GRC planned to add this type of information during the March 2023 Quality Council meeting.
- GRC Superintendent reported regularly reviewing data on vacancies and caseloads (h. staff capacity). Two examples of reports (QIDP RTS Numbers and GRC Direct Care Vacancies) were requested and provided. The reports contained numbers of required and actual staff by position, but did not include information about trends, analysis of causes for turnover, etc. Data on the status of training for staff was not generated proactively. It was available in the learning management system and could be queried. It was reported that supervisors received lists of staff by training topic who were due and past due, but data on training were not aggregated. Data on completion of new employee orientation were tracked on an individual staff basis, but also not aggregated.
- There was no length of stay data (item j.) reported regularly. Admission date was recorded on each individual's face sheet, but data were not aggregated for the GRC population.

Systems were in place to monitor individuals in the Target Population who transition from Glenwood Resource Center. Calls and in-person visits were made at specified intervals for individuals who transitioned from GRC. The expectation was that these contacts are completed within two days, 14 days, 30 days, and every 30 days thereafter until one year has passed since the individual discharged. When possible, these discussions occurred with individuals, but also included input from representatives of the new provider. Discussions were documented on the Glenwood Resource Center Event Log and included who the interviewer talked with and response to questions. The schedule for follow-up and the questions were supplied to the provider and individual ahead of time. A review of a sample of documentation of these calls indicated the areas outlined in the Settlement Agreement were included. (231, 211)

Five HHS Central Office employees, including the State Operated Facilities Director, received the monthly Quality Council data and report prior to each meeting and the minutes following. All were invited to attend the meeting and often did so via conference call. They occasionally attended in person. As evidenced by emails sent by the State Operated Facilities Director to the GRC Superintendent, the Executive Officer for State Resource Centers and the Consent Decree Manager, the State Operated Facilities Director reviewed the data and provided questions/comments in advance of the meeting. Many of these questions/comments were observations of incident trends and suggestions of possible cause for consideration. (233-234)

The Division Administrator received detailed data about discharges and transitions for all individuals who had transferred out of GRC. In addition to the discharge date and new provider of services for the individual, the tracker included the dates by which follow-up communication following transfer were required and the dates they occurred.

Included for each of these timelines (two days, 14 days, 30 days, etc.) was an assessment of whether the actual date of contact complied with the required date. (233-234)

GRC also maintained a Transition and Discharge Monitoring report that was updated regularly (monthly) and included data about:

- Current Census
- Number of Active Six Month Return Agreements
- Discharges Anticipated in the Next 30 days.
- Additional Discharges Anticipated within 60 days.
- Number Individuals Accepted Without Discharge Date Set
- Number of Individuals without Release of Information for Referrals

This report provided information about follow-up contact and summary comments obtained through that process, including reference to any medical concerns, activities, etc. and GRC's follow-up with any identified issues. This report was provided to previously identified HHS Central Office employees, including the Division Administrator. The Transition and Discharge Monitoring report indicated that HHS Central Office employees review a "psychology audit that tracks pre- and post-transition efforts" for "all individuals who transition from GRC" but did not include information about GRC or HHS examining trends across discharges and transition planning. The Transition and Discharge Monitoring report included summaries of information obtained during follow-up contacts but on an individual basis and not across the group of those discharged. There was no indication that system-level trends were evaluated nor were discharge planning process improvements identified. (233-234)

The State Operated Facilities Director and the Executive Officer for State Resource Centers indicated there had been discussion about expanding the process of discharge monitoring from GRC to HHS (external to GRC), especially after individuals had been discharged from the Center for a period of time.

At least four DHS employees who were regularly working with GRC were present for the monitoring review. When interviewed during the monitoring review, they described specific tasks and oversight they provided for GRC's day-to-day operations. During these same interviews, it was mentioned that the Executive Officer for State Resource Centers was onsite at GRC approximately 12-15 times per month and the State Operated Facilities Director and/or the Clinical Director from the Office of Facility Support were onsite at GRC at least monthly. These visits were documented on a spreadsheet. (235)

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

1. Reassign QIDP responsibilities currently completed by the quality assurance coordinator so this position can dedicate 100% of time to quality management activities.

2.
3. Add date of completion to each Quality Council Meeting report.

4. For the minutes from Quality Council meetings, indicate the months of data that were reviewed for the indicators.

5. Revise reports to exclude the term client.

6. Quality Council reviews should include greater analysis of patterns, trends, concerns, etc. and this should be reflected in the minutes.

7. Quality Council discussion and resulting minutes should include an analysis of the data and, if applicable, actions needed, responsibility, completion date, and date resolved should be documented in the corresponding section of the minutes for each meeting. If discussion of corrective action occurred during another meeting, include information in minutes for Quality Council and/or attach.

8. Track all planned (corrective) actions through to completion, including submitted evidence of completion. If adjustments are made to required follow-up actions, based on data-driven results, changes should also be documented.

9. Quality Council meeting discussions and resulting decisions should be summarized in minutes rather than citing exact words stated by team members.

1. Normalize the data for month-to-month comparison as census changes (rate vs. total number). Take into consideration that events, such as falls, SIB, etc. will likely go down as the census decreases, thereby skewing the data. GRC would benefit from additional HHS Central Office or external resources for setting up framework and completing data analysis.

2. Review paragraph 231 of the Settlement Agreement to verify that data are being collected, reported, and analyzed for items a. through j. Add or improve clarity of data for any items not fully represented in current data review practices.

3. Data from ISP and risk management review should be aggregated and reported for upper management/Quality Council review. Exceptions should be noted, and action taken as indicated.

4. The risk assessment used at GRC required placing a check before the listed items that apply to an individual rather than a yes/no type of response for each item, making it difficult to know whether the item was addressed. Consider modifying the document, so that a response is required for each item, so it is clear that each one is addressed.

5. There were systems in place to monitor accurate completion of individual service plans, but nothing in place to monitor overall trends for choice and self-determination.

6. Completion of corrective/improvement actions were documented, but there was limited evidence of follow-up to confirm actions produce desired result for included individuals.

7. GRC maintained a tracking system by individual for those who transitioned from GRC, including date follow-up contact was required and date completed. In addition to continuing this practice, develop a method to summarize these data, aggregated for the entire group of those who have discharged.

8. Maintain documentation of responses to Division Administrator's questions/comments about Quality Council data. This could be included in the minutes from each meeting if designated as such.

10. Develop a summary report for GRC discharges, including aggregate data, in addition to current methodology of narrative and tracking for each individual. This report should include an evaluation of system-level trends and any discharge planning process improvements resulting from this analysis.

9. Determine responsibility and process for HHS (external to GRC) to monitor individuals discharged from GRC. Continue to document this communication and any resulting actions taken.

10. DHS employees should continue to regularly review data and report on GRC and document these reviews.

11. DHS and other parties in the State should identify and implement specific methodology for monitoring implementation and effectiveness of corrective actions and performance improvement initiatives at GRC. This would include those actions designed by GRC and recommendations GRC determines to implement in response to the baseline monitoring report and recommendations.