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Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
Washington, DC 20530

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BY ELECTRONIC AND U.S. MAIL

Gretchen W. Kraemer, Esq.
Assistant Attorney General
State of Iowa
Department of Justice
Hoover State Office Building, Second Floor
Des Moines, Iowa 50319

Re: United States v. State of Iowa, Case No. 04 cv 636; Woodwood Resource Center

Dear Ms. Kraemer:

As you are aware, on June 2-5, 2008, the United States toured the Woodwood Resource Center ("WRC") to assess WRC's and the State's compliance with the terms of the November 24, 2004, Settlement Agreement and the Iowa State Resource Plan ("SRC Plan"). We write now to transmit our assessment of WRC's implementation of the SRC Plan along with the determinations and technical assistance of our consultants.

We wish to thank you, Field Operations staff Sally Titus and Karalyn Kuhns, WRC Superintendent James Finch, the WRC staff, and staff from the Iowa Department of Human Services for the cooperation and courtesy extended us during our tour and in our subsequent exchanges.

Consistent with our pledge of transparency during this matter, during and at the conclusion of our tour, we provided ongoing feedback to various WRC staff and a detailed exit briefing. During this process, we congratulated WRC for its impressive work implementing the SRC Plan. In addition, we highlighted areas that WRC must address to achieve substantial compliance.

The attached chart sets forth our determination of WRC's implementation of each provision of the SRC Plan. We also have included (in the chart's middle column) our expert consultants' assessments and technical assistance. Please note that this is

primarily their work product, which we have copied into the chart simply for ease of reference.

Overview of Compliance with the SRC Plan

As we indicated during the exit briefing, WRC has made considerable progress and remains in substantial compliance with the majority of the SRC Plan regarding areas such as protection from harm; integrated protections, services, treatments and supports; clinical care; psychiatry; medical care; neurology; physical and occupational therapy; communication; serving institutionalized persons in the most integrated setting appropriate to their needs; and recordkeeping. Notably, since our last review, WRC moved significant provisions of the psychology and habilitation sections of the Settlement Agreement into compliance.

Protection from Harm - SRC Plan III

We note that WRC lapsed into non-compliance regarding some provisions in the abuse and neglect management section of the Settlement Agreement.

In particular, we found WRC noncompliant with SRC Plan III.A.3, regarding desensitization plans. While WRC has created such plans for residents undergoing dental procedures, we found that WRC only implemented the plans 16 percent of the time such plans should have been implemented. WRC must drastically improve its implementation percentage to achieve compliance.

We also identified concerns with WRC's mortality reviews (SRC Plan III.C.2e) and implementation of corresponding corrective actions (SRC Plan III.C.4). The mortality reviews should contain input from a disinterested physician and a nursing death review. To achieve compliance, WRC should write and implement a policy incorporating the above recommendation and creating quality control measures to ensure that mortality review recommendations are implemented in a timely manner. We note that when we discussed mortality reviews with facility staff, our concerns were not a surprise to Superintendent Finch, and we believe that WRC is actively working to correct the deficiencies.

In addition, we found noncompliance in quality assurance provisions of the SRC Plan regarding failure to include risk levels for individuals (SRC Plan III.D.2) and failure to convene interdisciplinary team meetings; WRC only convened 50 percent of such required meetings in response to individuals surpassing WRC's threshold of four incidents per month (SRC Plan II.D.3). We recommend that WRC add a screen to its current computerized

record in order to address individuals' risk levels, and we strongly urge WRC to improve its rate of convening necessary interdisciplinary team meetings.

Nursing - SRC Plan X

We found that while WRC developed a Nursing Protocol for Illness and Injury, the protocol is insufficient and must be reviewed to ensure that it is consistent with generally accepted professional standards (SRC Plan X.3). We also recommend that WRC's Medical Director and the State's nursing consultant review WRC's Basic Nursing Care curriculum to ensure that the information included is appropriate and consistent with WRC's policies and procedures.

Regarding WRC's system to modify nursing plans when necessary (SRC Plan X.5), we found that WRC has included indicators in its assessments but continues to lack an analysis component. In order to reach compliance, WRC must include a clinical analysis of implemented interventions and effects of such interventions on the individual.

Physical and Nutritional Management

WRC's main obstacle to substantial compliance centers on physical and nutritional management (SRC Plan XI.2-5, 7). In particular, WRC's mealtime positioning plans still do not include individualized triggers, its clinical justifications do not use objective measures for prescribed elevations or positioning interventions, its Daily Activity Records are missing data, its meal plans are not consistently implemented, and its interventions are not consistent or timely.

We cautioned the State regarding these issues in our December 12, 2007, compliance review letter. Given WRC's lack of progress regarding physical and nutritional management, we recommend that the State and WRC create a detailed plan to address this deficiency and prioritize compliance efforts regarding the issue. Again, we strongly urge WRC to concentrate its efforts to bring this area into compliance as soon as possible, and we are willing to work with the State and WRC to craft an appropriate plan.

Competency Based Training

Various sections of the SRC Plan require WRC to conduct competency based training (See SRC Plan III.A.8, SRC III.C.1d-g, SRC Plan IV.B.7, SRC Plan VII.10, and SRC Plan XIII.3). We found WRC noncompliant with each such provision because the facility

has not appropriately trained the required individuals in each discipline. We urge WRC to complete the required training as soon as possible.

Statewide Isses Regarding Serving Persons Having Moved from SRC to a More Integrated Setting Appropriate to Their Needs - SCR Plan XIV.B

There are significant issues regarding the State's quality assurance program concerning community providers. The system is still fragmented, and cannot yet ensure adequate reviews of provider agencies. During our latest review, the State provided us copies of a Notice of Intended Action to revise the State's regulations regarding incident reporting. Unfortunately, the revisions do not address concerns we had previously raised, such as the inadequacy of categories of incidents that need to be reported to State officials and delays in reporting incidents.

Also, it was unclear how the State is using information obtained through the incident management system to improve community services and to prevent the future recurrences of similar incidents. It does not appear that such information is systematically and regularly reviewed to identify and address any problematic trends. An adequate incident management system is key to identifying problems occurring on an individual, program, and systemic level, and most importantly, to identifying and correcting problematic areas and issues on a timely basis. The current quality assurance program for community providers does not have such a system.

Further, the efforts of WRC to assist people in moving to the community continue to be stymied by the lack of community capacity (SRC Plan - XIV.A.1). However, the State has applied for a grant from the Centers for Medicare and Medicaid Services that could assist the State in developing addition services and supports. As we have previously stated, without the State's help to expand community capacity and fill the gaps in services available in the community, individuals will continue to live in more restrictive settings than necessary and will be waiting for community options appropriate to meet their needs for much longer than they should.

Thank you for your prompt attention to this matter. We look forward to speaking with you soon to discuss the State's plan to address these outstanding issues and to schedule a WRC tour in early 2009. The lawyers assigned to this matter can be contacted as follows: Benjamin O. Tayloe, Jr. at (202) 514-8103;

Gregory Gonzalez at (202) 305-2941; and Verlin Deerinwater at (202) 514-6260.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

Attachment

#	Plan Requirements	Woodward Resource Center June 1-5, 2008 Tour Consultant Assessment	DOJ Assessment
	(Note that SRC paragraphs below are summarized and/or abbreviated to accommodate size of chart. No text in this chart is meant to augment or replace the actual language and requirements of the SRC Plan)		
III. PROTECTION FROM HARM			
A. RESTRAINTS			
1	Prohibit prone restraints	There has been no change in the policies of the Resource Center related to use of prone restraint. It is prohibited. In our review of 12 incidents of restraint, we found no instances where an individual was restrained in a prone position.	C
2	Restraints permitted only in emergency situations & not as a substitute for training	Information was sufficient in each of the 12 restraint forms to allow the reader to reasonably conclude that this was an emergency situation. Eleven of the 12 restraints were physical restraints that ended in less than three minutes.	C
3	Policies/staff training/desensitization programs as needed	In a sample of five individuals, all of whom were restrained for dental procedures and one of whom was also restrained during a medical exam, each had a desensitization program in place. However, review of the implementation of the plans revealed that in the time period February through April there were a total of 51 times when the program should have been implemented. Data indicated it was actually implemented on eight occasions --16% of the expected occurrences.	NC
4a	Identify persons restrained in last 12 mos	Each month Quality Management produces a report that identifies the individuals using restraints, the type of restraint, the date it was used, the duration, and whether the use was in an emergency situation or was part of a Behavior Support Plan. The March 08 graphs in the Outcomes and Analysis Report show that in the six-month period October 07--March 08 there were 158 physical restraints as compared with 384 in the previous 6 months. The number of individuals involved in physical restraints has shown similar variability in each of the 6-month periods. In April 07--Sept. 07 the number of persons using physical restraints in a month ranged from 10-20. Similarly, in the period October 07--March 08, the monthly number ranged from 10-21. The average duration of physical restraints in both time periods was 5 minutes. The data on mechanical restraints shows that the fewest number of these restraints (9) occurred in March 08. The nine restraints involved 7 individuals. In contrast, in December 07 there were 50 mechanical restraints involving 15 individuals, indicating that one or more individuals were restrained multiple times. January 08 saw the highest number of persons using mechanical restraints in the 12-month period, 17 individuals. The March 08 report stated that the average duration of mechanical restraints was 28 minutes, down from 38 minutes in February. The number of persons using chemical restraints has remained fairly stable with 26 individuals using these restraints in the period April--September 07 and 25 individuals using them in the period October 07-March 08. However, there was a decrease of 12 incidents of chemical restraint use in the latter period as compared with the earlier period—40 v 52.	C

		The April data presented in the Quality Indicator report shows that the number of physical restraints rose substantially from 15 in March to 38 in April and the number of mechanical restraints also rose from 9 in March to 13 in April. The 6 chemical restraints in April also exceeded the March incidence of 3. It is too early to tell if these findings are an aberration or the beginning of a trend.	
4b	Complete CFA on persons identified above	Functional Analyses are done for all behavior plans.	C
4c	Develop/implement BSPs for above persons; BSPs must contain min elements*	Requisite elements are present (see VII.8 below).	C
5a	No restraints when prohibited by ISP or medical orders	In a selected sample of 11 individuals that included two persons who were medically frail, one individual who used a walker and had a healed hip fracture, and several persons who had been restrained, the medical orders prohibited the use of restraint for the two medically frail individuals, (who had not been restrained), stated no restraint restrictions for eight individuals and specified five point restraint on the bed face up for one individual. The questionable order was the no restraint restriction for TC who had a hip fracture in February. It is unclear whether the physician reviewed and approved the order or whether it was merely carried forward without the physician taking notice. Given our sample of 11 individuals, we find WRC in compliance at this time. Durining our next tour, we expect to review a larger sample.	C
5b	Begin face to face observations by RN w/i 30 mins of restraint	We saw no instances in which nurses failed to observe individuals or where monitoring was inadequate.	C
5c-i	Person in restraint shall be monitored/examined/released in accordance with plan	Facility data indicate that in the period February through April 2008, monitoring of a restrained individual met policy requirements in approximately 75% of the cases reviewed. Our sample revealed that monitoring was appropriate in each of the 12 cases.	C
5j-l	Restraints will be documented according to plan	BSP format includes professional responsible, staff authorized and frequency/manner of data collection. The Peer Review Checklist monitors whether the BSP includes who is authorized (i.e., who should be trained) and frequency/manner of data collection.	C
6	BSP reviewed and/or revised when >3 restraints occur within 4 wks	Of individuals reviewed who met the criteria, all had evidence of an IDT meeting to consider the need for BSP revisions.	C
7	Each restraint reviewed w/i 3 busn days by IDT	An IDT meeting was held within three days for each of the 12 restraints reviewed.	C
8	Competency based restraint training for all staff	The facility's data indicates that the training of 104 of the 490 staff members who are required to have completed Mandt training and some who are also required to have Woodward restraint training is not current. This means 21.2% of the staff who require this training have yet to receive it. The overwhelming majority of these staff are direct support staff. We encourage WRC to complete this training as soon as possible.	NC
B. TIME OUT			
	Reduce/eliminate use of time-out; document justification for TO through BSP/ISP	The facility reports it does not use seclusion or time-out.	C
1-5	Review & revise time out policies & procedures to ensure consistency with SOC		C

C. ABUSE, NEGLECT & INCIDENT MANAGEMENT

1a	Zero tolerance	WRC policies stating a zero tolerance for abuse and neglect have not changed in the review period.	C
1b,c	Immediate reporting and protective actions	Each of the abuse/neglect investigations reviewed specifically identified the date and time the individual who alleged injury was examined by a nurse. Investigations further specifically the immediate actions taken with the alleged perpetrator and whether he/she was suspended. For example, the investigation report of an allegation of physical and psychological abuse of LE (poke on the chest leaving a red mark) on 3/20/08 states that the medical assessment occurred on 3/20/08 at 8:00 AM, 15 minutes after the incident occurred, the first interviews began within the hour, the alleged perpetrator was "relieved from the unit" and later suspended pending the completion of the investigation, which occurred on 3/27/08 with an addendum added on 3/31/08. The alleged perpetrator was terminated. Review of 15 randomly selected incident reports of minor injuries, (some requiring no treatment) showed that the individual was examined by a nurse within 30 minutes in nine of the incidents and within 2.5 hours in the remaining six.	C
1d-g	CBT of s/s of abuse/neglect, incl reporting requirements, posting individual rights	Review of the annual A/N training of 15 staff members revealed that five were not in compliance: JK and CD (11/1/05-date of last training), IN and IV (11/30/05), LM (10/27/05). Six of the 15 were due for annual training in May or June 2008. Recommendation: Additional work is necessary to ensure that staff members attend annual A/N training.	NC
1h	Procedures for referral to law enforcement	The state policies adequately address the responsibility to refer possible crimes to law enforcement.	C
1i	Reporting witness not subject to retaliation of any type	Since the last review there has been no change in the state incident policy that contains a prohibition against retaliation for reporting suspected abuse/neglect, noting that staff who engage in such activity will be subject to discipline.	C
1j	Timely/thorough investigation of unusual incidents	A review of 10 incident investigations revealed competent, thorough and timely investigations. For example, the investigation of a minor injury (reddened area) on SC following a restraint on 4/14/08 was completed the next day. The investigation of the choking incident involving LG on 4/26/08 was completed four days later. The investigation of the possible neglect involving ZM occurring on 4/9/08 was completed on 4/16/08. The exception to timely completion within 5 business days was the investigation of the allegation of nonconsensual sexual touch reported on 4/7/08. The delay in closing the investigation (5/21/08) is attributed to the victim first rescinding the allegation and later reinstating it. Several investigations were noteworthy for particular attention to an investigative function. Each investigation report reviewed addressed the names of all witnesses, the dates of all interviews, the date and time the investigator visited the site, documents reviewed, the question under review, a summary of the evidence, and a statement of the determination (substantiated or unfounded).	C
2a-d	Policy/proc ensuring investigator training & coord w/ police as appropriate	WRC remains in substantial compliance. Staff members conducting investigations have received investigations training.	C

2e	Investigations will be completed according to professional standards of practice	While the investigations referenced above met professional standards, the review of deaths at WRC does not conform to professional standards. The death reviews need to include: 1) a disinterested physician, and 2) a nursing death review. Review of Mortality Review Meeting minutes (physicians only) for two deaths indicates that recommendations made after the death of LV, that private rooms be provided to individuals with DNRs when demise is near and individual is at home and the need to anticipate the need for additional oxygen, were not brought forward to the Interdisciplinary Mortality Review Committee. Similarly, actions recommended in the minutes related to the death of KO addressing staff uneasiness in caring for a critically ill resident were not brought forward to the IMRC. Recommendation: Write and implement a death review policy that includes, but is not limited to, participation of a non-WRC physician in the review, directs the activities of the IMRC, ensures that all recommendations emanating from the various reviews of a death are discussed in the IMRC, tracked and monitored for implementation.	NC
3	All investigations to be reviewed by supervisor	The three FTE investigators, the Acting Director of Quality Management & Risk Management and the Acting Director of Program Services (supervisors) have been trained by Labor Relations Alternatives in the conduct of investigations. Completed investigations are reviewed by the supervisors cited above.	C
4	Corrective actions will be recommended and tracked for completion	Review of some corrective actions made as a result of incident and death investigations revealed variable implementation. For example, following the death of LL as the result of a van accident in 11/07, WRC determined the need to train all staff on van loading and unloading procedures. This was accomplished in a timely manner as was the revision of the van loading and unloading checklist. In contrast, WRC further determined the need to increase the number of staff certified in First Aid Training. It was reported that at the time of our tour, 362 staff members were not current in First Aid Training. LL's death also resulted in a recommendation that monitoring checks would be conducted on loading and unloading procedures. These were not begun until April 08. Quality Management Department tracks incident-related recommendations resulting from incident investigations and produces a list of cases open with recommendations pending and a list of corrective actions over-due.	NC

5,6	Investigation data will be collected, tracked and analyzed in accordance with plan	The Incident Review Committee meets weekly and gives careful consideration to individual focused and systemic issues that arise from incidents. Each month, as part of the Outcomes and Analysis Report, the number and type of incidents are presented. For example, the March report notes the increase in peer-to-peer aggression and the increase in the number of those incidents that resulted in an injury. The report also identifies the actions taken in response to these increases, e.g., separating victim from aggressor by moving one to another house, medication adjustments and changes in behavior support plans. A monthly incident report with wide distribution, including to Central Office, breaks down incidents by type in each house and identifies the individual involved. To illustrate, the April report shows FO in 101 Franklin engaged in 3 incidents of aggression, 2 incidents classified as unknown cause of injury, 2 classified as accidents, made 1 abuse allegation and had one incident classified as other. In two of those incidents there was no injury, in six incidents a nurse saw the injured individual, but no treatment was necessary and in one incident a nurse provided treatment. WRC also produces a monthly report on incidents by day of the week, by shift and by location. Recommendations: These last reports would be more useful if they contained totals.	C
7	Employment pre-screenings will be required to ensure client safety	Our review of the background checks of 13 staff members whose names we gathered in reviewing other documents revealed that the facility is meeting its obligations.	C
D. QUALITY ASSURANCE			
1	Data review/analysis will include minimum elements	WRC continues to collect data on 249 risk indicators. A scan of the report through April 08 indicates consistent performance on many indicators over the last 12 months. This is particularly the case in the physical health indicators. The data for April show a sharp increase in several areas that require additional scrutiny to determine the origin of the increase, as presented below. **Indicator / March / April** Incidents resulting in injury: 207 / 370 Individuals injured: 127 / 147 Incidents of peer aggression: 38 / 49 Persons aggressed upon by peer: 32 / 40 Aggressors: 24 / 35 Indiv. with 4+ incident/accident reports: 45 / 54 WRC plans to review the increase in peer aggression with greater specificity in June and succeeding months if necessary.	C

2	Corrective actions incl remedy/outcome/resp person & date	The Outcomes and Analysis Report produced monthly and reviewed by the Quality Council addresses outcomes, performance measures, contributing factors, actions taken and actions to be taken for five general topics: Physical Health, Physical Safety, Emotional Health, and Self Determination and Facility Practices. Risk Management and Incident Management fall under Physical Safety. The report for March notes the increase in peer-to-peer aggression and states that the 24 people who aggressed upon a peer each have a BSP in place. The Risk Management section states that all eight people who are at risk of bowel obstruction have a bowel management plan in place. Our review found that seven of the eight had a plan in place. Several other problems surfaced in the review of indicator data. For example, JQ had a decubitus ulcer at the time of the review but was not on the list of persons at risk for skin breakdown. LG was hospitalized for bowel impaction at the end of March but was listed as moderate risk for constipation because the nurse did not upgrade the risk level. Recommendation: The screen in the IPR from which staff make changes in risks identifies the individual and the risks, but not the risk level. Research the possibility of adding the risk level to this screen. We saw no instances of individuals unobserved by nurses or inadequate monitoring.	NC
3	C/A monitored for timeliness & efficacy & modified as needed	The review of implementation of corrective actions related to issues raised by the risk indicators is an area of work that requires further development. WRC's own review found that in only 50% of the cases, Interdisciplinary Team Meetings were convened in response to individuals involved in four or more incidents in a month.	NC

IV. INTEGRATED PROTECTIONS, SERVICES, TREATMENTS & SUPPORTS

A. INTERDISCIPLINARY TEAMS

1	IDT shall seek personal independence/choice/quality of life	The ELP / ISP does a good job of supporting personal independence, individual choice, and quality of life. There is good evidence of substantive and effective efforts to include individuals in their treatment planning. The improvement in the process and products of IDT meetings have persisted. Action plans are quite infrequently observed in MIRs and virtually none of the MIRs note whether previous action plans are completed. The action plan is a valuable tool that is being underutilized. Data from MIR observation checklists present a slightly different picture regarding action plans, suggesting that in most cases "action plans [were] created as applicable."	C
2	QMRP ensures assessments & services are adequately provided	Efforts to support team leaders in effective meeting facilitation have paid off. IDT meetings had good leadership and included very good team participation in monitoring, reviewing, and revising plans and programs.	C
3	IDT = Person, QMRP, guardian & others as needed	The MIRs observed generally included individuals or reported on why individuals were not present. An Annual Review meeting included the individual, a step-parent, and a parent by phone. The team generally did a good job of eliciting and responding to parent input in the process.	C
4	Assess when needed, to ID strengths, preferences, needs	Assessments are done routinely and as needed.	C
5	ISP, w/supports & protections, based on assessments	Assessment reports appear to contribute substantively to the plan.	C

B. INTEGRATED SUPPORT PLANS			
1	Policies/procedures requiring ISPs be consistent with standards of care	Appropriate policies and procedures appear to be in place.	C
2a, b	ISP quality will be consistent with professional standards of care	Woodward's ISPs do a good job of addressing strengths, needs, and preferences. The barriers included on ISPs are generally appropriate. Barriers are on the agenda in MIRs. We urge continued attention to the quality of the discussion of barriers. It may be useful to include monitoring of "substantive discussion of barriers and strategies to overcome barriers" in the MIR observation checklist.	C
2c	ISP to identify measurable beh goals, supports to attain, & barriers	The Habilitation Plan helps to summarize goals, intervention strategies, and necessary supports. Teams are making good progress on ensuring that goals are related to overcoming barriers.	C
2d	ISP will fully integrate all protections/svcs/supports/TX plans	The facility has made good progress on integration of protections, services, and supports. Good examples of interdisciplinary collaboration were noted during the tour.	C
2e	ISP will identify methods, time frames, pers responsible	The ISP Habilitation Plan format explicitly includes Strategies / Procedures and Supports.	C
2f	ISP will identify methods to implement in most integrated setting	The facility has done well at developing more community vocational settings as one means of providing services in the most integrated setting appropriate. Continued effort and vigilance is warranted but substantial progress has been made.	C
2g	ISP will identify data collection requirements, incl who collects & who reviews	The ISP Habilitation Plan format now explicitly includes Data To Be Collected, Persons Responsible for Implementation, Persons Responsible for Data Review, and frequency of data collection.	C
3	Goals, objectives, outcomes, services, supports, TX integrated into ISP	Woodward has made good progress on coordination of plans, services, and supports in the ISP.	C
4	ISP comprehensible for the capabilities of staff responsible for implementation	ISPs at Woodward are written in easily understood language.	C
5	Monthly progress reviewed by appropriate IDT member (one writing each program)	Monthly reviews demonstrate that staff respond to individuals' progress on training and behavior goals, and respond adequately to a lack of progress. There is improvement in keeping an appropriate threshold for a lack of progress on an objective; lack of progress judgments appear to be generally appropriate and program revisions are frequent in response to progress or lack thereof.	C
6	ISP and IEPs consistent with one another	ISPs reviewed included goals from individuals' IEPs. IEPs for individuals with challenging behaviors noted that behavior interventions were needed. A communication log is maintained between school and house. School staff have been completing monthly feedback forms that are integrated into MIRs, beginning in April '08. Psychology assistants train school staff on BSPs; documentation is kept at the houses.	C
7	CBT on individualized goals for staff implementing programs	Training on the development of ISPs is fairly well established and appears to be yielding generally good plans but is not well documented. The facility is using a paper-based system of competency based training for all individual programs. However, the system for tracking training on ISPs and individual programs does not ensure that those staff members who need training on programs receive it in a timely manner. There is no means to alert managers to ensure that all staff working with any individual have received adequate training on that individual's programs. Conversion to a computerized tracking system is underway. However, it will be important for management to clarify what are the anticipated functions of the system, to find a means to specify the urgency with which training on individual specific programs or classes of programs is required, to establish clear guidelines regarding time frames for training based on that urgency, and to design the reporting mechanism so that the system addresses the desired functions.	NC

8	1 trainer responsible for IDT training and oversight	Patti Handeland serves this function. The facility has put in place a system for monitoring ISPs and IDT meetings that is providing good quality improvement data and that should aid identification and remediation of problems.	C
9	Manageable caseloads for IDTs	Case loads appear to be manageable, allowing compliance with this section of the agreement.	C
10	Implement ISP QA system to ensure B1-9 occurs & is effective	The program implementation monitors whether the programs in individuals' ISPs are implemented in an appropriate manner. The monitoring program appears to function on a reasonable schedule to detect problems and lead to remediation.	C
V. CLINICAL CARE			
A. SUPERVISION AND MANAGEMENT			
1	Structure to ensure supv/mgmt & integration; establish clinical peer reviews	Nursing has as of November 2007 implemented a Nursing Peer Review that includes case reviews for LPN peer reviews. Although only nine reviews have been conducted from November through March 2008, the Nursing Peer Review process is very promising and the department has already identified areas of needed improvement: use of SOAP format, appropriate vitals documented, timely physician notification, and complete assessments. There needs to be plans of corrections attached to these reviews that indicate when interventions were implemented in response to findings from the reviews. In addition, the tool for nursing peer review needs to be expanded with criteria/instructions in alignment with WRC's nursing and medical policies. WRC has also initiated external peer reviews with GRC, especially in the review of cases regarding Physical Nutritional Management (PNM). These reviews have only been recently implemented and need to continue on a quarterly basis. Technical Assistance/ Recommendation: 1. Develop and implement plans of correction for findings on Nursing Peer Reviews. 2. Expand current Nursing Peer Review tool to include instructions/criteria for scoring compliance or noncompliance that are in alignment with WRC's policies and procedures.	C
2	Rev non-SRC consultants' recs- document SRC decision to implement/not implement	WRC remains in compliance with this provision. See earlier reports for more detail.	C
B. MINIMUM ELEMENTS			
1a	Timely assessment of clinical needs- regular and PRN	Technical Assistance/ Recommendation: Again, we recommend that documentation guidelines be developed and implemented for the Medical Department in alignment with generally accepted standards of practice.	C
1b, c	Diagnoses and TX consistent with current SOC of discipline	WRC remains in compliance with this provision. See earlier reports for more detail.	C
1d	Specific clinical indicators to measure efficacy	WRC remains in compliance with this provision. See earlier reports for more detail.	C
1e	System for measuring health status consistent with current SOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
1f	TX changes based on clinical indicators	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Policies/procedures requiring integration of clinical services	WRC remains in compliance with this provision. See earlier reports for more detail.	C
C. AT-RISK INDIVIDUALS			
	ID at-risk individuals as defined in V. C.	WRC remains in compliance with this provision. See earlier reports for more detail.	C
1	Implement risk assessment and mgmt system = SOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Regularly screen for at-risk status	WRC remains in compliance with this provision. See earlier reports for more detail.	C

3	Compl assmt w/i 5 busn days when new risk ID'd per est criterion	WRC remains in compliance with this provision. See earlier reports for more detail.	C
4	Develop care plan w/i 30days of assmt; incorporate plan into ISP	WRC remains in compliance with this provision. See earlier reports for more detail.	C

VI. PSYCHIATRY

1	Psychotropics only with evaluation & justified Axis I DX	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Psychotropic use must be consistent with SOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3a	Chem restraints req 60min on-site obs by nurse incl. notify MD of adverse effects	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3b	ChemRest = MD face-to-face obs w/i 24hrs; psychiatrist review next working day	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3c	Pre-meds routine med/dent exams to be doc in ISP w/desensitization prog in place	WRC remains in compliance with this provision. See earlier reports for more detail.	C
4	1 FTE psychiatrist per SRC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
5	Protocols for DX must be consistent with SOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
6	Full psych evals for all new admissions	WRC remains in compliance with this provision. See earlier reports for more detail.	C
7	Psych screening for all; psych evals for persons with possible MI DX	WRC remains in compliance with this provision. See earlier reports for more detail.	C
8	Pharmacological & psychological (meds and BSPs) coordinated	WRC remains in compliance with this provision. See earlier reports for more detail.	C
8a	W/med use, ISP must specify alternative TX to encourage med red	WRC remains in compliance with this provision. See earlier reports for more detail.	C
8b	Medication risk vs medication benefit analysis by entire IDT	WRC remains in compliance with this provision. See earlier reports for more detail.	C
8c	PsychMed TX plan incl: DX; symptoms to monitor; est time for results	WRC remains in compliance with this provision. See earlier reports for more detail.	C
9	Psych rev occurs at least quarterly and contain minimum elements	WRC remains in compliance with this provision. See earlier reports for more detail.	C
10	SRC monthly rev of persons on intra-class polypharm or 3+ psy med	WRC remains in compliance with this provision. See earlier reports for more detail.	C
11	System to monitor, ID, report & respond to med side effects. Qrtly rev	WRC remains in compliance with this provision. See earlier reports for more detail.	C
12	Informed consent for restrictive interventions, incl psych med use	WRC remains in compliance with this provision. See earlier reports for more detail.	C

VII. PSYCHOLOGY

1	Psychology Director responsible for psych services	Dr. Prickett has continued to provide good leadership for psychology services at WRC.	C
2	Psychology peer review system	The peer review system has continued to develop and serves to address professional development needs of psychology staff.	C
3a	Data protocols will incl info on target/replacement behs- when, where, freq, etc.	The data collection protocol includes the required elements.	C
3b	Monthly rev of data/progress by clinician - modify when no progress	IDR meetings contain monthly review of behavior data. There is evidence that teams pursue revision when they recognize a need. Team members' ability to recognize and respond to a lack of progress with respect to target behaviors and replacement behaviors is improved. Psychologists are encouraged to provide interpretation of data and data trends when reporting progress to the teams at MIRs and in their notes.	C
3c	Protocols for assessing/rectifying data integrity issues	Facility wide program integrity checks have been instituted for all programs, including BSPs. The checks address the issues of data reliability.	C
4	Psychological assmt protocols in place with minimum elements	There is a protocol in place that meets the requirement.	C
5	Assmts based on current, accurate & complete clinical & beh data	All psychological assessment reports reviewed on this tour had current data.	C

6	Complete psych assessment w/i 30 days of admission and annually thereafter	Psychology tracking system indicates that all new admissions this year were done within 30 days. 92% of 2008 annual psychological assessments were completed on time.	C
7	Psych svcs w/i 30days of being ID'd as needing svcs per above	There is an active group therapy service in place. A good number of groups are operating and there is a process for referral into groups that appears to be working. There is a proposal to pursue training in order to enhance Dialectical Behavior Therapy at WRC, to integrate it more completely into existing services, and to prepare to serve in a training and consultation role to community providers regarding DBT. The training appears to be a good next step for staff at the facility and a sound investment in developing community outreach services. Concern about capacity for individual therapy services appears to have been addressed. Individual psychotherapy appears to be available to individuals for whom it is indicated. Data from the system for referral to individual / group therapy services indicates that all referrals led to initiation of individual or group therapy services within 14 days.	C
8	BSP w/i 30days of assessment & containing minimum components	The required components of BSPs are present with the exception of specific attention to maintenance and generalization. However, the behavioral treatment packet includes the Comprehensive Psychological Assessment report which does address maintenance and generalization. This adequately addresses the intent of the agreement. The specificity of replacement behavior definition in BSPs is improved. Replacement behaviors are generally clearly stated behaviors that are operationally defined.	C
9	BSPs must be able to be understood & implemented by RTWs	BSPs continue to be written in easy-to-understand language.	C
10	CBT on individualized BSP for staff implementing programs	CBT for BSPs is in place. However, as above (B.7), the paper-based system for tracking training on BSPs is not ensuring that those staff members who need training on programs are receiving it in a timely manner. There are instances of revisions to BSPs that have apparently been in effect for months with only a small fraction of the house staff having received training on the revision. Although this portion of the agreement was judged to be in compliance on the last tour, there is no intent to suggest that the facility has regressed. Rather, a more complete audit of training records during the present tour indicates that training on BSPs is frequently delayed (i.e., longer than 30 days after the date on the BSP) and there is a substantial number of staff in some houses reviewed for whom there is no documentation of training on the BSPs.	NC
11	BSPs revised when needed	IDTs generally provide a good response to progress on a goal with revision of the program or addition of new programs. There is improved response to a lack of progress on training programs and evidence of frequent revisions to programs arising from judgments about progress.	C
12	Ratios of psychologists (1:30) & pscyh assts (1 asst: 1 psychologist)	All psychologist positions are filled and the requisite numbers are met.	C

VIII. MEDICAL			
1	Medical Director responsible for medical services	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Medical peer review system	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3	QA syst incl: clin indicators, trend analysis; corr actions & monitoring	WRC remains in compliance with this provision. See earlier reports for more detail.	C

4	Med error tracking system	WRC is in the process of adapting the use of a Medication Variance System rather than a Medication Error System for reporting, tracking, and analyzing medication variances. Some forms have been developed but were in the approval stage at the time of our review. WRC has a draft policy for Medication Variance and Remediation, a draft of a Medication Variance Report, and a draft of the Medication Variance Form Instruction Sheet.	C
5	Policies/procedures to ensure med svcs provided consistent with SOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
IX. NEUROLOGY			
1	Each admit w/sz disorder evaluated by neurologist w/i 30 days	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Standard seizure management plans in place	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3	Persons w/sz disorder examined by NeuroMD not less than annually	WRC remains in compliance with this provision. See earlier reports for more detail.	C
4	Neurological interventions must be in line with current PSOC	WRC remains in compliance with this provision. See earlier reports for more detail.	C
5	A/C meds monitored for side effects	WRC remains in compliance with this provision. See earlier reports for more detail.	C
6	Minimize older meds or document clinical justification for continued use	WRC remains in compliance with this provision. See earlier reports for more detail.	C
7	Persons on A/C meds & seizure-free for 2yrs evaluated for med reduction	WRC remains in compliance with this provision. See earlier reports for more detail.	C
8	Neurology & psychiatry coordinate med use when used for dual purposes	WRC remains in compliance with this provision. See earlier reports for more detail.	C
X. NURSING			
1		WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Nursing diagnoses and care plans updated no less than quarterly	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3	Establish nursing protocols for assessment & reporting of medical conditions	Since our last review, WRC has developed a Nursing Protocol for Illness and Injury. However, it needs to be reviewed for alignment with adequate standards of nursing practice. For example, the protocol indicated that clients with elevated temperatures of 101 oral or greater are to have their temperatures taken only once during waking hours for an 8 hour shift. Perhaps the protocol was meant to read "at a minimum," but as it is written, it is not appropriate. In addition, while the Nursing Education Department spend a great deal of time and effort developing the Basic Nursing Care curriculum for nursing orientation, we would also recommend that the State's Nursing Consultant and Medical Director review these documents to ensure that practices are appropriate and in alignment with the policies and procedures at WRC. We did not receive any information regarding an updated system for tracking staff training regarding individuals' health care plans. Technical Assistance/ Recommendations: 1. Review current nursing protocol and education curriculum for alignment with standards of practice and WRC's policies and procedures. 2. Develop and implement a protocol regarding the system to ensure staff are provided training regarding individuals' health care plans. 3. Ensure Code Blue Drills* are conducted at least once per quarter on every shift. 4. Develop a system to review drills to identify trends that include dates of corrective actions implemented. 5. Revise policy regarding emergency training to include all WRC staff. 6. Develop and implement a system to ensure that staff not current in First Aid/Emergency procedures receive the necessary training.	NC

		*We noted that there had been only two Code Blue Drills from 12/07 to 4/08 conducted 12/27/07 and 4/21/08 which is not in alignment with having Code Blue Drills once a quarter on every shift. We also did not find a review of trends, analyses, or corrective actions regarding the Code Blue Drills. In addition, the policy addressing staff requirements for having current certification in First Aid needs to be revised to include all staff at WRC. From our review of First Aid training rosters, the rosters indicate that 260 staff were not current with the training.	
4	Est clinical indicators w/plans of care, incl integrated team dialogue of the same	WRC remains in compliance with this provision. See earlier reports for more detail.	C
5	System to monitor/doc progress & modify nsg care plans when needed	Although the Nursing Department has included risk/clinical indicators in their assessments, the analysis piece has not been consistently implemented. Often, the assessments list raw data regarding skin issues or blood pressures, but there is not a clinical analysis of interventions implemented and effects on these issues compared to the last month or quarter. Technical Assistance/ Recommendation: Include an analysis of clinical indicators in the Monthly Integrated Reviews.	NC
6	Procedures for med admin, incl training, supervision, med error tracking	WRC remains in compliance with this provision. See earlier reports for more detail.	C

XI. PHYSICAL & NUTRITIONAL MANAGEMENT

A. COMMON ELEMENTS

	Team consisting of RN; PT; OT; RD; SLP; and MD (when needed)	WRC remains in compliance with this provision. See earlier reports for more detail.	C
1	Identify persons with PNM issues and causes for PNM issues	WRC has changed its risk levels to include High (including Critical), Moderate, Low and No Risk. Standardizing these risk levels should make transition to the community between WRC and GRC individuals less complicated and facilitate the development of a community Dysphagia system. At the time of our review, WRC had 24 individuals who were high risk and 14 individuals who were designated critical. Comprehensive care plans had been developed for all the critical and high risk individuals. WRC needs to complete these plans for the moderate, at risk and not at risk individuals.	C
2	Implement/maintain mealtime and positioning plans for those identified	We found most of the plans that we reviewed only consisted of general triggers and not individualized triggers. In addition, the clinical justifications have been identified for the critical and high risk individuals at the time of our review. However, a number of plans were not specific regarding the use of objective measures (O2 sats, vitals, lung sounds) for prescribed elevations or positioning interventions. Consequently, the team will have no baseline data for comparison if the individual's status changes. Also, during clinical case reviews that included the PNM core team as well as house staff and nurses, we noted that data was missing from the Daily Activity Records (DARs) such as weights, vitals, and intake data.	NC

		In addition, the house staff described episodes of coughing that were not documented on the DARs. From our observations at mealtime, we noted individuals experiencing triggers that were not documented on the DARs. The current practice at WRC is to leave the block blank if no trigger occurs. However, from the inconsistent data on the DARs, it is impossible to determine if staff forgot to document or if in fact, the individual did not have a trigger. During our observations and discussions with the PNM team, it was apparent that there was much emphasis placed on determining what symptoms were not triggers and did not need to be documented. Unfortunately, this has contributed to the unreliable data on the DARs and the common practice for house staff to make inappropriate interpretations regarding coughing episodes. In reviewing LV who had been hospitalized 3/5/08, 3/27/08, and at the time of this review, we found that there were few triggers documented on the DAR for an individual who was at critical risk. Consequently, most of the care he received from the PNM team was reactive in response to acute events. Tragically, after our review of LV's case, he died at the community hospital. We have recommended numerous times that the house staff need to document all coughing episodes, especially for the critical and high risk, and let the PNM team assess these episodes to determine the clinical relevance. What appears to have happened is that the house staff have picked up on the PNM teams' inconsistent practices regarding trigger data, which has resulted in unreliable data. This issue needs to be addressed promptly by the PNM team. Technical Assistance/ Recommendation: 1. Provide comprehensive assessments for moderate, at risk and not at risk individuals. 2. Revise justification plans to include specific clinical objective data to support interventions prescribed. 3. Ensure that data is complete and reliable on DARs. 4. Evaluate the need for staff to document both the presence and absence of triggers on the DARs. 5. Identify individual triggers and add these to PNM plans. 6. Ensure appropriate implementation of PNM plans.	
3	Ensure staff implement plans, incl positioning before, during & after meals	From our observations at meal time in 103 Franklin, we noted that the plans were not being followed by the staff for BC and CR. In addition, until we pointed this out, there were no interventions provided by the staff or clinicians observing with us. The competency-based training records indicated that staff were trained the day before on these individuals' PNM plans. WRC needs to focus on implementation of the PNM plans at the house level. WRC has implemented the use of suction toothbrushes for individuals who are NPO.	NC
4	Implement positioning plans for non-ambulatory persons w/PNM issues	See comments for #3 above.	NC
5	CBT for staff implementing plans, both general and individual-specific	At the time of our review WRC was in process of developing a system to ensure that all staff working with critical and high risk individuals have received CBT. Technical Assistance/ Recommendation: Continue to develop and implement a system to ensure that all staff who are working with individuals at high risk for aspiration are competency-based trained, including relief staff.	NC

6	Monitoring of program implementation to ensure appropriateness	WRC has implemented a monitoring system that includes clinical monitoring and compliance monitoring. Although they have a system for scheduling the monitoring, the data we saw regarding the monitoring were only in regards to when the person was monitored and how frequently.	C
7	System to monitor individual progress and modify interventions as needed	From our review of event logs, we noted that there were not consistent, timely interventions or documented reviews by the PNM team. In some cases it was difficult to determine if the PNM core team was actually following the individual's case. The minutes from the Core PNM Meeting from 3/08 to May 08 indicated that some individuals were being reviewed. However, there was no structure to the minutes regarding plan of corrections, date interventions implemented, and outcomes. Also, it appeared from some of the event logs that telephone assessments were being conducted for individuals who experienced a trigger rather than a face-to-face assessment. This is clinically unacceptable. The purpose of documenting triggers is to establish a proactive system which includes a timely assessment to identify potential issues that could be corrected and possibly prevent an acute event. In addition, the nursing assessments in response to triggers did not consistently include an assessment of the person's status or referrals to other disciplines documented in action plans. WRC needs to close a number of loops in its Dysphagia system in order to have a proactive system. In addition, issues regarding PNM and trigger data need to be integrated into the MIRs. The PNM core team and the facility have made some progress. However, there are still a number of critical issues described in previous cells that have not been adequately addressed and resolved. Once the system is running adequately, it needs to be reviewed for ease of transfer into the community. There were no clinical issues regarding trends or corrective actions aggregated from the monitoring data that we saw. From the issues noted above, WRC needs to validate the reliability of this data to ensure that issues related to individuals at risk are identified through the monitoring system. In addition, WRC policy allows 24 hours or next business day for observations by the PNM core team for a high risk individual. This is not an appropriate timeframe for this risk level. Technical Assistance/ Recommendation: 1. Ensure reliability of monitoring data. 2. Develop and implement a system to review clinical trends and outcomes from the monitoring data. 3. Revise timeframes for observations/reviews of critical and high risk indivduals. 4. Integrate PNM data into the MIRs. 5. Revise, simplify, and tighten the current system in order to facilitate its transfer into the community. 6. Ensure timely review and documentation of interventions by PNM core team. 7. Revise minutes of Core PNM Team Meeting to include plan of corrections, date interventions implemented, and outcomes. 8. Conduct face-to-face assessments for triggers for critical and high risk individuals. 9. Ensure nursing assessments include an assessment of the individual and interventions on an action plan.	NC

8	Eval medical necessity for g-tubes; return to oral feeding when appropriate	From our review of six individuals who warrant the use of tubes for nutrition (IA, KG, SJ, ZO, LR, RR), we found that all had documentation on their Comprehensive Care Plans addressing the need for enteral feeding. However, we did not see policies or procedures addressing the documentation or decisions and practices regarding therapeutic feedings during the review. Technical Assistance/ Recommendation: 1. Develop and implement policies and procedures regarding documentation of the medical necessity of G/J-tube use. 2. Develop and implement policies and procedures guiding the decisions and practices for therapeutic feedings.	C
B. PHYSICAL AND OCCUPATIONAL THERAPY			
1	Screening/comprehensive assessments will incl minimum elements	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Plans w/indiv interventions/outcomes/adapt equip & plan to minimize regression	WRC remains in compliance with this provision. See earlier reports for more detail.	C
3	CBT for staff implementing plans, both general and individual-specific	WRC remains in compliance with this provision. See earlier reports for more detail.	C
4	QA system to monitor individual status; equip avail/cond & TX efficacy	WRC remains in compliance with this provision. See earlier reports for more detail.	C
XII. COMMUNICATION			
1	SLP competent in augment/alter comm; assmts; prog dev/impl/monitoring & CBT	WRC speech language pathologists are well equipped to address this provision.	C
2	System to ID persons needing augment/alternative communication devices	The speech therapists have established a three-year rotation for re-screening individuals for communication needs. They are reportedly on track for completing the required screenings for this year.	C
3	Implement functional/adaptable comm plans for persons above; rev annually	Communication plans are reviewed and revised at least annually. There is a good emphasis on individuals' communication needs and communication programs appear to be in place for most individuals who need them. There is evidence of interdisciplinary collaboration in selecting communication goals and planning communication programs. Alternative / augmentative communication systems are in use with individuals who need them and the real-world functionality of those systems is improved. Teams are encouraged to continue to emphasize the importance of continually supporting individuals' communication abilities.	C
XIII. HABILITATION			
1	Ann assmts/qrtly rev of indiv strengths/pref/skills/needs/barriers to comm liv	Annual assessments and monthly reviews are held and include discussion of the identified areas.	C
2a-e	Develop training/education/skill acquisition progs from above & incl min elements	The habilitation plans demonstrate substantial compliance with this provision. Individuals' training programs do a better job of including "interventions, strategies and supports that effectively address the individual's needs for services and supports and that are practical and functional in the most integrated setting consistent with the individual's needs." Habilitation programs do a better job of including training opportunities in community settings; there have been good efforts at identifying vocational opportunities in community-based settings and soliciting or creating new work contracts that expand individuals' vocational options. Continued vigilance and effort is required to ensure that training opportunities in community settings continue to expand.	C

2f	Programs have explicit data reqs, incl what data, freq, who collects & who reviews	The ISP Habilitation Plan format now explicitly includes Data To Be Collected, Persons Responsible for Implementation, Persons Responsible for Data Review, and the frequency of data collection.	C
3	CBT for staff implementing plans, both general and individual-specific	As noted above (B.7), the system for CBT on habilitation programs has been implemented but is not yet assuring that staff members who need training on new or revised programs, as well as staff members who are working with new or unfamiliar residents, are receiving CBT in a timely manner.	NC
4	Monthly rev by IDT member on progress/status/prog efficacy, revising as needed	WRC has made good progress in the documentation of the results of training programs and establishing a tracking system to monitor progress. The system fosters more careful monitoring, and more accountability. The data from the training programs generally appear to be used to evaluate individuals' progress and to determine the need for program changes. Continued attention to judgments about progress is warranted to ensure that individuals' programs are revised when appropriate.	C
5	Ensure Habilitation QA process in place	The peer review system for ISPs is working to improve the appropriateness and scope of habilitation, training, education and skill acquisition programs. The system of implementation integrity checks on habilitation programs appears be adequate to meet the provision.	C

XIV. SERVING INSTITUTIONALIZED PERSONS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

A. PLANNING FOR MOVEMENT, TRANSITION, AND DISCHARGE

1	Encourage and assist people to move to community.	WRC continues to take proactive steps to encourage and assist individuals served and their guardians to access community services in the most integrated settings appropriate to their needs. For example, WRC has: 1) worked with community providers to hold a provider fair in the community; 2) continued to work on committees whose efforts help to build community capacity, such as the Polk County committees on services for people with criminal offense histories and improving community psychiatric care, and the State's Money Follows the Person Grant committee and sub-committees; and 3) worked extensively with providers such as Mosaic, REM and Comprehensive Systems to develop services for individuals with challenging barriers to community living. As individuals transition to the community, WRC appears to consistently take actions encourage and support their success. For example, Social Workers' documentation shows efforts on their part as well as other staff such as direct support staff and psychology staff to provide technical assistance to providers and follow-up with the individuals who have moved to ensure their successful transitions. On a systemic level, WRC has been offering providers opportunities for training to expand their capacity. For example, they have offered providers training on the APPLE program for people with histories of sexual offenses, and training on support strategies for people with autism. Another important component of what WRC continues to do is to work with the State on diverting people from admission to WRC. They do so by providing consultation and/or training to community providers, identifying funding such as Connor Grant monies to provide services to stabilize and maintain a person in the community, and offering time-limited assessments.	C

		When individuals are admitted to WRC, it appears that discharge planning continues to begin immediately. WRC Social Workers make efforts to identify community connections at the time of admission and maintain those connections. Individuals and their guardians are told from the beginning that WRC is not a permanent placement, but an option to provide intensive services to assist individuals to return to the most integrated community setting appropriate to meet their needs. Although WRC is not yet analyzing length of stay data, anecdotally, some individuals who have been admitted within the last two (2) years have received services and supports to address problematic behavior and have successfully returned to the community. However, the efforts of WRC to assist people in moving to the community continue to be stymied by the lack of community capacity. It is encouraging that the State has applied for a Money Follows the Person Grant from the Centers for Medicare and Medicaid Services (CMS). At the time of the review, the State was awaiting final approval from CMS. When and if approval is obtained, the State is encouraged to fully implement the plan outlined in the "Partnership for Community Integration: Operational Protocol for Iowa's Money Follows the Person Grant" dated February 26, 2008. This plan illustrates a commitment on the part of the State to provide additional resources to encourage community providers to develop protections, services and supports adequate to meet the needs of individuals who are currently residing in the Resource Centers, as opposed to more integrated community settings. As has been previously stated, without the State's help to expand community capacity and fill the gaps in services available in the community, individuals will continue to live in more restrictive settings than necessary and will be waiting for community options appropriate to meet their needs for much longer than necessary.	
1a	IDT annually identify/rev barriers to placement & strategies to overcome	Since the last review, it appears that WRC teams have continued to improve the way in which they identify barriers and the strategies to overcome them. Teams have been identifying more specific barriers as well as strategies that describe supports that the individual needs, but have not been identified in the community, in addition to programs that need to be implemented at WRC. However, these changes have not yet been consistently implemented in all individuals' ISPs. Some examples are provided below of barriers and strategies that are adequate, and some that continue to need improvement. The Social Work department is taking proactive steps to ensure that all ISPs include appropriate barriers and strategies. For example, the Social Work department has continued to implement and refine a peer review process for Future Vision/Discharge Plans during which all Social Workers review each others' plans in a team meeting and offer suggestions for improvement. The Director of Social Services and the Community Living Facilitator provide Social Workers who are not demonstrating an adequate level of competence with additional technical assistance. The Social Work department also has developed sample barriers and strategies that have been shared with all Social Workers, and begun an external peer review process of ISPs with GRC. We encourage WRC to continue these important initiatives.	C

As a matter of technical assistance, the following are examples of adequate and inadequate barriers and corresponding strategies found in some of the plans reviewed:

• Adequate: QJ's barrier section identifies specific staffing ratios and staff skills and competencies that the team perceives as current barriers to his movement to the community in a safe manner. These include having more than one staff present due to the need to provide QJ with needed attention when he engages in self-injurious behavior (wrist cutting) while still maintaining the safety of the others in the home; staff who are trained in Borderline Personality disorder; staff who are capable of providing non-physical and physical crisis intervention techniques; and staff who are trained to work with individuals with a history of sexually offending behaviors. Many of the strategies listed to overcome these barriers involve WRC staff training potential providers, and sharing methodologies that address QJ's behaviors. It appears from information in the discharge summary that the team has identified a provider who is willing to work with QJ once he is free of target behaviors for six (6) months.

• Inadequate: In IR's Future Vision, the following barrier is identified, "[IR] would need a specific staffing ratio to support her as her age and sight limitations are not representative of her activity level, and can be aggressive and hurt others if they are not respectful of her routines, boundaries and right to make her own decisions." The strategies to overcome this barrier include a behavioral support plan being implemented at WRC, a social program to assist her in socializing with her peers, and a description of actions WRC staff take to keep her safe from falls such as keeping walkways clear and furniture is not moved. Presumably, these programs and safety precautions will be an ongoing need for IR, but could be implemented in a community setting just as they are implemented at WRC. The only strategy that appears to be designed to overcome the perceived barrier to community placement states, "Continue to communicate with [IR's] county of legal settlement regarding the supports [IR] needs to live successfully in the community." Because the team has not specified the level of staffing that IR requires in various circumstances, it is difficult to determine if there are providers that have the needed staffing capacity or if funding is available to develop the capacity in a program designed to meet IR's other essential support needs. For example, the team should specify if IR needs a staff person within arms reach when she is in unfamiliar settings, outdoors, etc., or if it is necessary for her to have one-to-one staffing at all times. The barrier as it is currently written does not provide adequate information to determine what supports need to be located in the community. Likewise, the strategy with regard to working with the county is too vague, and does not identify the specific steps that will be taken to identify potential community supports that would meet IR's need for enhanced staffing.

		• Adequate: One of BA's barriers is listed as, It is essential that [BA] have staff who are familiar and consistent. [BA] has difficulty with changes, and would require a period of time to get to know direct-care staff prior to any move." The strategies to address this barrier include taking into consideration the longevity of staff as providers are identified, working with any new provider on a gradual transition process, making sure staff from the new provider visit BA at WRC, and having WRC staff spend time with BA at the proposed placement prior to the move and having ongoing contact after the move. • Inadequate: One of MO's barriers is listed as, "Supports to help reduce or deal with change. Changes can lead to minor aggression (pushing, hitting, slapping). She can get frustrated when she feels she is not in control. Consistent routine important; won't always listen to directions given from someone who takes over for her group leader or from relief staff. She has trouble switching group leaders during a shift." It is unclear what specifically the team believes is a barrier to movement to a community setting. The strategies to address this barrier include implementing her behavior plan, ensuring roommates are compatible, developing a crisis plan, training provider staff on behavior plan, and considering use of the Money the Follows the Person grant monies for behavioral support. However, it continues to be unclear what supports currently are unavailable to MO to address the items listed in the barrier section. Moreover, the notes in the discharge summary section indicate that in October 2007, MO experienced some health problems, and her guardian visited a Waiver home but did not approve due to the stairs in the home, the location, and MO's health. None of these items are identified as barriers. The discharge section also indicates that on 2/19/08 a session was conducted with Michael Smull to identify what an ideal life would look like for MO. It is unclear if any of the information gained from this process is being used in the discharge planning process. As noted above, WRC should continue its practices of peer review, and provide technical assistance to teams as necessary to continue to improve the way in which barriers and strategies are written. WRC continues to work with guardians and individuals who are reluctant about moving to the community. They have developed and have been implementing a plan that identifies a number of strategies to address this issue. From an outcome perspective, according to data provided by WRC, the number of guardians who are reluctant to consider community services has decreased from 129 in July 2007 to 113 in April 2008. Some of the strategies that WRC has employed include attendance at Family Council meetings by social work staff, inviting guardians to the provider fair, including articles in newsletters about people who have successfully transitioned to the community and showcasing specific community providers, and encouraging families to attend the WRC Home and Community-Based Waiver Services (HCBS) Open House.	
1b	ISP to specify protections, services/supports required for most integrated setting	It appears that WRC teams have continued to identify essential and non-essential protections, services and supports. Efforts have continued to improve the overall ISP development process. These efforts have resulted in positive outcomes, as the ISP has become a more integrated document, including the Future Vision. WRC continues to implement a quality/peer review process of a sample of ISPs. The review process evaluates team process as well as the resulting ISP document. WRC is encouraged to continue this valuable process.	C

1c	Trans plans will ID SRC/DHS actions, pers resp, compl date & solicit county CM role	It appears that WRC staff are developing detailed transition plans that are implemented. These plans include individualized action steps that facilitate individuals' safe and successful moves to community settings.	C
2	CBT for all persons developing/implementing ISPs, incl pol/procedures for same	Competency-based training continues to be provided on an annual basis. The Social Work department continues to update the training and materials used by Social Workers and teams based on lessons learned.	C
3	Rev assessments, trans plan & proposed supp with individ/guardian PRIOR to move	WRC remains in compliance with this provision. See earlier reports for more detail.	C
4	Current comprehensive assmt of needs and supports within 30 days of move	WRC remains in compliance with this provision. See earlier reports for more detail.	C
5	Identify essential/non essential supports; delay move if essentials are not in place	It appears that Social Workers are consistently monitoring the transition plan implementation, through on-site, face-to-face as well as telephone reviews of the services provided. When issues are identified, actions are taken to correct issues identified. In some cases, additional time has been requested to extend the final discharge date from WRC to allow for additional actions to be taken. In many instances, WRC staff have provided additional training or assistance to community providers to make transitions successful.	C
6	QA sys ensuring trans plans current w/ PSOP, & correct problems when identified	The Social Work Department continues to consistently conduct quality assurance of transition plans, as well as Future Visions and discharge plans. They are closing the loop by requiring and documenting follow-up to issues identified. They are consistently reviewing aggregate data, and making revisions as necessary. The Social Work department also has set goals for itself with regard to specific outcome measures.	C
7	Data mgmt system to analyze barriers w/ annual report to MH, MR, DD, and BIC	WRC, in conjunction with GRC, has continued to refine the system used to aggregate and analyze information about barriers to movement to community settings. WRC has automated this system, and Social Workers are now entering barrier information into a database. Efforts continue to be made to ensure that both Resource Centers are using the same definitions for barriers. In May 2008, the Resource Centers worked together to share the information gained from the 2007 aggregate barrier report with a variety of stakeholders, including the Mental Health, Mental Retardation, Developmental Disabilities and Brain Injury Commission, as well as the Area Education Association, and the Iowa Association of Community Providers. There are plans in July 2008 to share the information with the Olmstead Commission. Resource Center staff have asked the State what type of information would be helpful to the State and are currently working on developing a format that will describe scenarios in which barriers are preventing individuals from accessing community services. These will be shared with the State to assist in its planning process. In May 2008, the Social Work Department presented the results of the analysis to WRC's leadership team. The group decided that two action plans should be developed, to: 1) increase training opportunities offered to the community and continue to develop WRC to be a resource to community providers; and 2) increase the opportunities for individuals living at WRC to access the community (e.g., attend church, shop, work, etc.).	C

	It appears that the State is taking steps to address the barriers identified in the report through such commendable efforts as submitting the application for the Money Follows the Person Grant. Reportedly, the State also is considering submitting a request to CMS to modify the current MR/DD Waiver to include additional funding for behavioral supports. Given that the barrier report identifies behavioral services as a significant area of need, the State is strongly encouraged to pursue this option. However, the state has not provided any formal response to the barrier report to the Department of Justice for review.	
B. FOR SERVING PERSONS HAVING MOVED FROM SRC TO MORE INTEGRATED SETTINGS APPROPRIATE TO THEIR NEEDS		
Monitor placements w/i 60 days of move/post-move assmt to ensure plans in place ans implement effective quality assurance measures.	It appears that Social Work staff are consistently monitoring the provision of services and supports provided to individuals in their new placements for at least 60 days after the individuals move. In some cases, this period has been extended to ensure that services are fully in place and to ensure individuals' health and safety. In addition, documentation reviewed clearly showed Social Workers' efforts to confirm that essential and non-essential services were in place. The State's quality assurance (QA) system is an essential component to ensure that the protections, services and supports identified as being necessary are provided to individuals leaving the State Resource Centers (SRCs). It also is necessary to ensure that individuals are not unnecessarily admitted to the SRCs because of a lack of quality services in the community. According to State staff, the current QA system is in a transition phase and is undergoing a number of changes. Although many of these changes should help to improve the system, the system continues to be fragmented, and is not designed to ensure regular, rigorous, external review of provider agencies. The following discusses the various components of the State's QA system, including incident management, its oversight of provider agencies, and its case management system. The State's incident management system has been discussed in previous reports. In response to DOJ's document request, the State provided a copy of a Notice of Intended Action to revise the regulations related to incident reporting. The revisions do not address concerns raised in previous reports such as the inadequacy of the categories of incidents that need to be reported and the extensive length of time allowed between incident occurrence and the deadline to report incidents to the State. At a meeting on 6/5/08, State staff indicated that consideration is being given to further modify the regulations to include incident categories similar to those used by the SRCs, and to tighten the deadlines for reporting. The State is strongly encouraged to implement these changes. In addition, it continues to be unclear how the State is using information gained through the incident management system to improve the community services system and prevent future incidents from occurring. It appears that some aggregate information is analyzed when providers are certified through Chapter 24. However, it does not appear that such information is being systematically and regularly reviewed to identify and address problematic trends. As has been discussed in previous reports, an adequate incident management system is key to identifying problems occurring on an individual, program, provider, and systemic level, and, most importantly, identifying and implementing actions to address problem areas.	C (for WRC) NC (for State)

In the meeting on 6/5/08, the State described the work that has been completed to revise the current quality assurance system, particularly to comport with CMS's Quality Framework. The State's revised system will include a number of components, including:

• An annual provider self-assessment to be completed by all HCBS Waiver providers, the first to be submitted by 8/1/08. There are approximately 800 providers who will be submitting self-assessments. The 14 Regional Specialists will review the written self-assessments to ensure that providers have policies and procedures in place, and to ensure that each provider has a quality assurance system in place. If the self-assessment information indicates that adequate policies and procedures are not in place, then a plan of correction will be requested.
• Quarterly off-site audits with regard to a particular issue (e.g., staff training) will be conducted of a random selection of providers. Providers will be asked to send materials to the State office for review.
• Focused reviews will be completed based on issues or complaints about specific providers.
• Every five (5) years, providers will have an on-site audit to review providers' quality improvement and incident management systems. Staff indicated that this review also would involve a review of training documentation, completion of background checks, review of minutes of meetings, etc. When asked if there would be a look-behind component to ensure that the information provided was valid, staff indicated that the process has not been defined yet.
• Participant surveys will be conducted using the Medstat survey tool. Iowa is in the process of field-testing a tool that will allow for more dialogue.

There are a number of concerns regarding the State's system, including:
• Except for abuse/neglect or imminent safety issues, there are no additional triggers that require case managers to report issues being experienced by individuals served to State entities or staff (e.g., the HCBS Waiver Office). It is recommended that consideration be given to developing such a system. One of the factors that appears to result in individuals being admitted to the SRCs is that problems percolate in community settings until they become crisis issues. If they were reported at an earlier stage, there would be an opportunity to address them before they reached a crisis level. For example, behavioral issues could be addressed through staff training, development, or revision of a behavior plan, increased staffing, etc., before they become so intense that they require placement in an ICF/MR.
• Likewise, there is no current system for aggregating information collected from case management monitoring visits. Without this mechanism, the State is missing a key opportunity to help it identify problematic trends and correct them before they become larger issues. Each individual chooses his/her case manager, resulting in numerous case managers working with the same provider agency. The only way to determine if individual issues being identified by individual case managers are really larger provider or systemic issues would be to aggregate and analyze the information being collected by all case managers within the system. This also would allow meaningful information to be shared with those staff (e.g., Regional Specialists) who are responsible to work with providers on their quality improvement systems.

		Although Iowa has many components of a quality assurance system in place, continued efforts need to be made to ensure that the system is a rigorous and integrated one.	
XV. RECORDKEEPING AND GENERAL PLAN IMPLEMENTATION			
1	Review/revise all policies/procedures necessary to implement IA/DOJ Plan	WRC remains in compliance with this provision. See earlier reports for more detail.	C
2	Establish/maintain unified record, incl 15 audits/mo with corrective action PRN	WRC remains in compliance with this provision. See earlier reports for more detail.	C