#	Plan Requirements	Glenwood Resource Center May 19-23 Tour	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	Resource Center policies prohibit the use of prone restraint. Review of 12 restraint records showed no evidence of the use of prone restraint.	Compliance
2	Restraints permitted only in emergency situations & not as a substitute for training	The sample of 12 restraint episodes reviewed revealed that all were used in emergency situations. The facility is questioning whether all staff are aware of the imminent danger criterion for use of restraints and will be taking measures to review this element critically in all uses of restraint.	Compliance
3	Policies/staff training/desensitization programs as needed	In response to a request for information about the use of restraints during dental procedures, the Center responded that none had been used during February and March 2008. Further inquiry revealed that restraints are not used for dental procedures. If an individual would require restraint, he/she is sent out for the service and provided an appropriate level of sedation.	Compliance
4a	Identify persons restrained in last 12 mos	Our review of physical and chemical restraint data for the period April 07 through March 08 indicates the number of episodes of restraint markedly decreased in the first quarter of 2008. The average number of restraints in the prior three quarters was 456. In contrast, during the first quarter of 08, there were 262 episodes of restraint. The number of persons who have been restrained during the same 12-month period has shown a steady decline when reported on a quarterly basis. At the start of the review period, 45 persons were using restraints. This number steadily declined to 29 in the first quarter of 2008. The average duration of a physical restraint in the first quarter of 2008 was between three and four minutes. Review of chemical restraint data indicates that the use has remained relatively constant in the six-month period October 2007-March 2008. Highest usage occurred in January 08 with six instances and the lowest usage occurred in December 07 with no instances. Chemical restraints were used twice in February and three times in March 08.	Compliance
4b	Complete CFA on persons identified above	A functional analysis has been done for all individuals who have received restraints.	Compliance
4c	Develop/implement BSPs for above persons; BSPs must contain min elements*	A functional analysis has been done for all individuals who have received restraints.	Compliance

5a	No restraints when prohibited by ISP or medical orders	We reviewed the ISPs and medical orders of seven individuals, three chosen randomly and four chosen because of their frequent use of restraint . The review revealed the following: • The clinical records of the four individuals who frequently use restraints cited no restrictions on the use of GRC approved restraint techniques. The record of one randomly chosen individual also cited no restrictions. • The record of one randomly chosen individual cited the restriction that he was not to be restrained when he was having a seizure. • The record of one individual contained contradictory information. The monthly medication orders cited no prohibition while the Medical Evaluation for this individual completed on 10/9/07 stated FC "is not physically capable of being restrained for programming and emergency behavioral reasons." There is no evidence in the sample reviewed that restraint was used when it was prohibited in the ISP or medical orders. However, physicians should be advised to review the restraint statement on the monthly orders to ensure it accurately reflects the status of the individual.	Compliance Compliance
5b	Begin face to face observations by RN w/i 30 mins of restraint	Restraint observation forms revealed that the nurse observed the individual within the 30-minute window in all instances.	Compliance
5c-i	Person in restraint shall be monitored/examined/released in accordance with plan	The facility does not use mechanical restraints and the duration of the physical restraints is short.	Compliance
5j-l	Restraints will be documented according to plan	The standard format for BSPs identifies the person responsible for the plan and the staff authorized to implement the plan and includes a description of the frequency and manner of data collection required.	Compliance
6	BSP reviewed and/or revised when >3 restraints occur within 4 wks	Individuals who have had a restraint are generally reviewed by the TPM and others from the IDT according to policy. All restraints are reviewed weekly by the management team. BSPs of individuals who had restraints receive full review when they are scheduled to appear in weekly Data Reviews. It does not appear, however, that the threshold of three restraints in four weeks systematically triggers a review of the behavioral treatment the individual received (as reflected in the BSP). This appears to be in part an issue of incomplete documentation; in order to achieve compliance, the facility will have to demonstrate that, for each instance in which this trigger was met, there exists documentation that the team undertook as substantive discussion of the adequacy of the BSP and documentation of the results of that discussion. Currently, where there is documentation of team discussion, that documentation is usually simply to: "continue to follow BSP". This expression fails to convey that the team seriously considered the issue and identified that action was warranted.	Non-compliance

7	Each restraint reviewed w/i 3 busn days by IDT	Matching restraints of several persons frequently restrained with IDT reviews indicated that the IDT met as required.	Compliance
8	Competency based restraint training for all staff	Our review of the training records revealed that only 53% of GRC staff were compliant with annual MANDT training.	Non-compliance
B. TIME OUT			
	Reduce/eliminate use of time-out; document justification for TO through BSP/ISP	Review of facility data indicates that the use of time out had been decreasing as shown below. Even with the rise in use in April, the data indicates a significant decrease in the use of time-out since January 08 as compared with the monthly average of 30 episodes in May-December 07.	Compliance
1-5	Review & revise time out policies & procedures to ensure consistency with SOC	The policies governing time out meet professional standards. Whenever time was used it was not used capriciously and the individuals were removed as soon as was reasonable.	Compliance
C. ABUSE, NEGLECT & INCIDENT MANAGEMENT			
1a	Zero tolerance	The state of Iowa has developed policies governing the identification, investigation and review of incidents that govern both Woodward and Glenwood Resource Centers. The GRC Incident Management policy states: "No staff, volunteer, or contractor shall behave in an abusive or neglectful manner toward individuals." "Abuse shall not be tolerated."	Compliance
1b,c	Immediate reporting and protective actions	Our review of incident reports indicated reports were filed in a timely manner. GRC staff reported that, when there is an allegation of abuse/neglect and an injury, the staff is immediately removed from contact with individuals. Our review of investigation files confirmed that named employees are removed in these circumstances.	Compliance
1d-g	CBT of s/s of abuse/neglect, incl reporting requirements, posting individual rights	Our review of the training records showed several staff non-compliant with annual training requirements. Our review is not consistent with the facility's data in the March 08 Outcomes and Analysis Report, reporting 97% compliance with annual abuse training.	Non-compliance
1h	Procedures for referral to law enforcement	We noted that the Glenwood Police were notified as appropriate of potential abuse allegations.	Compliance
1i	Reporting witness not subject to retaliation of any type	State policies adequately address prohibiting retaliation for reporting suspected abuse/neglect, noting that staff who engage in such activity will be subject to discipline.	Compliance

	# time out episodes	# persons	Average length/minutes
December	22	3	19
January	21	4	19
February	5	3	20
March	5	2	10
April	11	3	18

1j	Timely/thorough investigation of unusual incidents	Our review of 20 investigations revealed that 19 were accurate, fair, thorough and timely. Each of the investigations listed the persons interviewed and the documents reviewed, presented clear documentation that the staff member and the alleged victim had been separated, review of the incident history of the victim and the discipline record of the staff member, and drew the determination from the facts obtained during the investigation. Serious incidents (Type 1) investigations are reviewed by the Incident Review Committee which meets weekly. We would recommend that the operation of this committee would be improved if each case were introduced and a brief description of the concerns it raised provided. GRC will begin using the same coding system presently used for systemic recommendations to code all recommendations. This should facilitate the identification of patterns. See below re: Mortality Reviews.	Compliance
2a-d	Policy/proc ensuring investigator training & coord w/ police as appropriate	All persons completing Level 1 investigations have completed professional investigator training provided by Labor Relations, Inc.	Compliance
2e	Investigations will be completed according to professional standards of practice	The quarterly Q&A report covering January through March indicates that all Type 1 investigations (those completed by trained investigators in the Quality Management Bureau) were completed within five workdays. In each investigation report reviewed the investigation was begun in a timely manner. The investigations included a listing of persons interviewed and documents reviewed. Recommendations were identified by the Incident Review Committee and tracked by the committee. The tracking of recommendations has improved with fuller documentation presented in the minutes. This is an excellent process. However, GRC's review of deaths do not yet meet professional standards. The facility finalized a death review policy in April 2008, although the interdisciplinary review process was initiated in December 2007. This policy states that a review of the medical record for the "past 12 months shall be made." All members of the new Death Review Committee receive a copy of the decedent's medical record for review prior to the meeting. However, the medical record is not reviewed by an independent physician. A peer physician at GRC completes the Physician Mortality Review form. However, these forms indicates that they contain minimal information. Further, the review forms are inconsistent with other GRC data. For example, the Physician Mortality Review forms completed following the deaths of JT and RW state the deaths were expected while the facility documents the deaths as unexpected. Also, neither report makes any suggestions for improvements to the "health care delivery system" nor "other services or systems" based on the case under consideration. We understand that revisions to this system were made	Non-compliance

		following our visit, and we look forward to assessing the revised procedures. Recommendation: Work with Woodward Resource Center to develop a single Mortality Review structure that provides a comprehensive and consistent review that meets current practice standards.	
3	All investigations to be reviewed by supervisor	All investigations are reviewed by the Director of Quality Management. This process has resulted in the good quality of the investigations.	Compliance
4	Corrective actions will be recommended and tracked for completion	The Resource Center has developed a database maintained by the Quality Management Department to track recommendations made by the Incident Review Committee in response to Type 1 investigations. Disciplines and Treatment Teams report the date the recommendation was completed with supporting documentation when required. Our review of the implementation of recommendations made during Type 1 investigations found that implementation had been completed in the significant majority of cases. The recommendations covered a variety of types of issues, including: • creation or revision of policies, • training for groups of staff members, • securing outside consultations, • environmental modifications, • communication between the Center's physician/nurse with the treating physician/nurse when the individual is in the hospital. Those recommendations that were not followed concerned the lack of documentation of a psychiatric consultation, the lack of documentation of communication between GRC and hospital staff who treated GRC individuals. Recommendation: Revise the accountability form for individuals on 1:1 to require a short description of the individual's activity at the half-hour intervals, e.g., sleeping, walking on grounds, listening to music, showering, rather than simply indicating the location of the individual.	Compliance

5,6	Investigation data will be collected, tracked and analyzed in accordance with plan	Incident data is presented monthly in the Outcomes and Analysis report for the Quality Council. For example, the data presented in the March 2008 report indicates injuries have fallen between October 2007 from the average rate of .8 injuries per individual to .6 injuries/individual in March. Most injuries are caused by accidents, followed by peer aggression. Cause of injury data is presented for the campus in total and for each Area and for each home. The monthly OVA reports provide the number of investigations by type (both Type 1 and Type 2). The quarterly Q&A report covering January through March indicates that all Type 1 investigations (those completed by trained investigators in the Quality Management Bureau) were completed within five business days. The facility is capable of producing incident data by type and shift, by type and location and by type and day of the week. GRC will begin providing these reports in the monthly Q&A report.	Compliance
7	Employment pre-screenings will be required to ensure client safety	The Management Policy addresses the need for pre-employment screening.	Compliance
D. QUALITY ASSURANCE			
1	Data review/analysis will include minimum elements	GRC has compiled 12 months of data on the 249 Quality Indicators. In addition to providing the numerical data, the Q&A report documents the context of selected items. For example, the March 2008 report notes that injuries increased slightly from February through March, but the number remains below the six-month average and while the number of injuries is decreasing, the number of injuries requiring physician treatment is increasing. However, the high compliance rating for some of the elements raise questions about the whether the monitoring tools and/or the monitors are applying sufficiently vigorous standards. For example, in 10 of the 12 months all observed medication passes have been in compliance according to GRC QA data.	Compliance
2	Corrective actions incl remedy/outcome/resp person & date	GRC's Quality Council is an interdisciplinary committee of executive-level managers and clinicians who "evaluate and monitor the systems and processes affecting individual and collective outcomes." The March minutes describe outcomes related to ten physical health areas: deaths, diagnoses of aspiration pneumonia, dehydration, bowel obstruction, skin breakdown, urinary tract infections, obesity, and persons on psychotropic medications and persons who visited an ER or were admitted to the GRC infirmary or community hospital. The outcome statements provide a context for the number provided. Following the outcome statements Actions to be Taken are enumerated which include the position of the staff members responsible. Other areas of review include Physical Safety (Incident Management and Risk Management), Emotional Wellness and Self Determination, Human Rights and Independence and Social Belonging.	Compliance

3	C/A monitored for timeliness & efficacy & modified as needed	Our review indicates that some monitoring of corrective actions is occurring. For example, the February 2008 report states that 40 of 162 Physical Nutritional Management Plan monitorings were found not to be compliant and that 30 had corrective actions that had been developed. Quality Management has plans to expand its monitoring to include not only collection of documentation that a corrective action has been implemented but also to include on-site monitoring of implementation on a sample basis.	Compliance

IV. INTEGRATED PROTECTIONS, SERVICES, TREATMENTS & SUPPORTS

A. INTERDISCIPLINARY TEAMS

1	IDT shall seek personal independence/choice/quality of life	Our review showed that Individual Service Plans (ISPs) are improved with respect to facilitating individual's choice, enhancing independence, and supporting self-determination. The peer review and team performance monitoring processes in place are having a positive effect.	Compliance
2	QMRP ensures assessments & services are adequately provided	While there have been good improvements in interdisciplinary team functioning, our review of Monthly Integrated Review (MIR) documents suggests that not all MIR processes have achieved adequate effectiveness. In particular, there are too frequently a lack of action plans and absence of documentation of ISP changes or updates based on data and team discussion. However, the monitoring and feedback system that the facility has designed and implemented has the potential to systematically address these concerns as well as improve the quality of interdisciplinary team functioning.	Non-compliance
3	IDT = Person, QMRP, guardian & others as needed	The ISPs appropriately document efforts to engage guardians in annual reviews. Individuals participated in the MIR observed during the tour.	Compliance
4	Assess when needed, to ID strengths, preferences, needs	Annual assessments are routinely included in the ISP and appear to address significant changes in the individual's life, strengths, preferences, and needs.	Compliance
5	ISP, w/supports & protections, based on assessments	As noted above (A.1) the peer review process should help to produce an ISP that outlines protections, services and supports that are consistent with the assessment.	Compliance

B. INTEGRATED SUPPORT PLANS

1	Policies/procedures requiring ISPs be consistent with standards of care	ISP policies are appropriate.	Compliance
2a, b	ISP quality will be consistent with professional standards of care	The person centered planning process appears to build into the development of the ISP support for choice, independence, and self-determination. There has been improved emphasis on addressing the big picture when it comes to integrating assessment data into a package that moves people toward their long-term goals. However, too many ISPs continue to lack an emphasis on prioritized needs, although the ISP peer review has been transformed into a tool that should be able to systematically address the remaining weaknesses in the ISP process.	Non-compliance
2c	ISP to identify measurable beh goals, supports to attain, & barriers	The habilitation plan includes goals and objectives and strategies to be employed. Needed supports are also identified.	Compliance
2d	ISP will fully integrate all protections/svcs/supports/TX plans	Integration of ISPs is improved, as is the peer review process.	Compliance

2e	ISP will identify methods, time frames, pers responsible	The habilitation plan identifies methods for implementation, time frames for completion, and the persons responsible.	Compliance
2f	ISP will identify methods to implement in most integrated setting	Interventions, strategies, and supports in the ISPs are increasingly, though not universally, practical, functional, or integrated. Further improvements in providing active treatment is needed. Some ISPs are still inadequate with respect to the amount of active treatment.	Non-compliance
2g	ISP will identify data collection requirements, incl who collects & who reviews	Individual program plans generally address these points.	Compliance
3	Goals, objectives, outcomes, services, supports, TX integrated into ISP	ISP goals, objectives, anticipated outcomes, services, supports and treatments are better coordinated in some ISPs, but this is not consistently the case, and further refinement is still required.	Non-compliance
4	ISP comprehensible for the capabilities of staff responsible for implementation	ISP language is generally accessible, comprehensible and appropriate for the capabilities of the staff responsible for implementing it.	Compliance
5	Monthly progress reviewed by appropriate IDT member (one writing each program)	The data analysis and characterization of progress occurring in the context of MIRs are improved. However, additional training and monitoring are recommended to ensure that the process by which the team analyzes program data is well established, and that the facility promotes consistent expectations for how progress shall be characterized.	Non-compliance
6	ISP and IEPs consistent with one another	The facility appears to have in place processes for making ISPs and IEPs for school-age individuals consistent and compatible. However, we found some discrepancies in this tour with respect to behavior goals; renewed vigilance is recommended to ensure that ISP and IEP behavior goals are consistent, that behavior plans are adequately trained and implemented at school, and that such training is well documented.	Compliance
7	CBT on individualized goals for staff implementing programs	Competency-based training on the development and implementation of ISPs is in place and annual updates are occurring.	Compliance
8	1 trainer responsible for IDT training and oversight	GRC has designated such a person.	Compliance
9	Manageable caseloads for IDTs	The caseload for IDTs appears to be reasonable.	Compliance
10	Implement ISP QA system to ensure B1-9 occurs & is effective	While a QA process is in place and appears to begun having positive effects, the system is not yet fully mature.	Non-compliance

V. CLINICAL CARE

A. SUPERVISION AND MANAGEMENT

1	Structure to ensure supv/mgmt & integration; establish clinical peer reviews	Since our last review, GRC has developed many new policies and procedures regarding clinical services. GRC had also appointed one of their primary care physicians as the Interim Medical Director. At the time of our May tour, a new Medical Director was hired and had just finished her orientation to the facility. An instrument had been developeded and implemented for physician peer review to be conducted monthly and discussed at the Medical Peer Review Committee quarterly. However, this system was only recently implemented at the time of our May tour. The physician peer reviews that we saw were brief and superficial. There was no indication that the issues identified by the peer reviews were actually being addressed. In addition, since this system is new, there have not been any trends identified or practices reviewed resulting from the peer reviews thus far. However, from our discussions with the Interim Medical Director and the Medical Director, GRC expects to be using the physician peer review process to analyze trends, develop plans of correction and implement clinically based corrections. We recommend that: 1) GRC continue to improve the quality of the physician peer reviews; 2) Ensure the peer reviewer tool is aligned with recently developed medical department policies and procedures; and 3) review, analyze and implement plans of corrections regarding physician peer review findings. The physical therapy (PT) and occupational therapy (OT) services have developed peer review processes. However, the current OT peer review tool is inadequate to provide meaningful data regarding individual-specific OT practices. The OT tool is a subjective review rather than a chart review of whether OT services provided meet GRC's policies and procedures. In addition, external peer reviews have been implemented for specialty therapies and Physical Nutritional Management. Again, this is a new system. From our review of Nursing Peer Review Checklists, we noted that very few items were found to "Not Meet" the audit criteria. However, nursing documentation reveals more gaps in nursing care that the Checklists were identifying. Although nursing has been conducting fairly regular peer reviews, they need to ensure that the review criteria are clear and that the nurses conducting the peer reviews understand the standards of nursing practice that they are reviewing. Further, it appeared that there has been no peer reviews conducted for Speech Therapy aside from the Physical Nutritional Management aspect. We recommend that GRC: 1) increase the number of OT/PT peer reviews per month; 2) revise the OT peer review tool to reflect data regarding specific practices for individuals in alignment with GRC's policies and procedures; 3) ensure nursing is conducting peer reviews using appropriate documentation criteria; and 4) implement peer review for Speech Therapy addressing assessments and services regarding communication.	Non-compliance

2	Rev non-SRC consultants' recs- document SRC decision to implement/not implement	Glenwood has developed and implemented the Medical Documentation Protocol (Revised April 4, 2008) addressing the process of Glenwood's physicians reviewing and documenting the accepting or rejecting of the recommendations from non-State Resource Center clinicians. However, our review of physician notes showed that this practice has not yet been consistently implemented thus far.	Non-compliance
B. MINIMUM ELEMENTS			
1a	Timely assessment of clinical needs- regular and PRN	Based on our May 2008 tour, nursing services at GRC has made little progress regarding the assessment of clinical needs. Nursing needs to develop and implement an effective system for critical review of timeliness of assessments and physician notification when there is a change in an individual's status. While there was improvement in the quality of many physician's notes, this improvements was not consistent. For example, there was inconsistent documentation by the physicians regarding assessments conducted prior to hospitalizations. Additionally, we noted some of the physicians' assessments upon an individual's return from the hospital focused too much on the treatments that were provided to the individual at the hospital, as opposed to an actual physical assessment of the individual's status at the time he/she returned to the facility.	Non-compliance
1b, c	Diagnoses and TX consistent with current SOC of discipline	At the time of our May tour, GRC was developing a system to address clinical indicators and to measure effectiveness of treatments. This process needs to continue. The GRC Infection Control Nurse has implemented a number of systems to regularly collect various surveillance data. However, GRC still needs to continue to develop its Infection Control program to include the analysis of these data for trends and use these data to impact the health outcomes on both an individual level and a systemic level.	
1d	Specific clinical indicators to measure efficacy	In addition, the minutes of the Infection Control Meeting needs to include how problematic issues were addressed and if the interventions used were effective. However, the Infection Control Nurse has begun addressing this issue. In addition, there needs to be a regular review of the treatment plans for individuals with infectious diseases to ensure that objectives and interventions are appropriate and are actually being implemented. Also, staff issues, such as illnesses and compliance with PPDs, need to be tracked as part of Infection Control. The facility needs to continue to use the external resources it has developed to assist it with further development of GRC's Infection Control program.	
1e	System for measuring health status consistent with current SOC	See above.	
1f	TX changes based on clinical indicators	See above.	
2	Policies/procedures requiring integration of clinical services	Although the Medical Department has developed and implemented a number of policies and procedures addressing this requirement, nursing has not yet addressed this. In addition, a number of Physician Nutritional Management policies/procedures have been recently developed. However, a number of these were in draft form and incomplete because the system has not yet been fully developed and implement. As the disciplines review and modify their practices, they need to update their policies and procedures to include integration of clinical services.	Non-compliance

C. AT-RISK INDIVIDUALS			
	ID at-risk individuals as defined in V. C.		
1	Implement risk assessment and mgmt system = SOC		Compliance
2	Regularly screen for at-risk status		Compliance
3	Compl assmt w/i 5 busn days when new risk ID'd per est criterion	Despite a number of nursing protocols being reviewed by GRC, there was no indication that this requirement was being addressed at the time of our May tour. We recommend that GRC: 1) develop and implement a system addressing this requirement; and 2) develop and implement a monitoring mechanism to verify compliance.	Non-compliance
4	Develop care plan w/i 30days of assmt; incorporate plan into ISP	During our May tour, we consistently found that nursing care plans did not have specific, proactive interventions related to the identified problems. Care plans were of poor quality and basically said that nursing "will monitor" or "will ensure" without actually identifying who will monitor or how the monitoring would occur.	Non-compliance

VI. PSYCHIATRY			
1	Psychotropics only with evaluation & justified Axis I DX	Psychiatric care and services at Glenwood continue to be in compliance with the requirements of this agreement. However, we did note that more than 70% of Glenwood's individuals are prescribed psychotropic medications. In comparison to similar facilities, this is a high percentage. We recommend that Glenwood continue to critically assess individuals' need for the use of psychotropic medications.	GRC remains in compliance with this provision. See earlier reports for more detail.
2	Psychotropic use must be consistent with SOC		GRC remains in compliance with this provision. See earlier reports for more detail.
3a	Chem restraints req 60min on-site obs by nurse incl. notify MD of adverse effects		GRC remains in compliance with this provision. See earlier reports for more detail.
3b	ChemRest = MD face-to-face obs w/i 24hrs; psychiatrist review next working day		GRC remains in compliance with this provision. See earlier reports for more detail.
3c	Pre-meds routine med/dent exams to be doc in ISP w/desensitization prog in place		GRC remains in compliance with this provision. See earlier reports for more detail.
4	1 FTE psychiatrist per SRC		GRC remains in compliance with this provision. See earlier reports for more detail.
5	Protocols for DX must be consistent with SOC		GRC remains in compliance with this provision. See earlier reports for more detail.

6	Full psych evals for all new admissions		GRC remains in compliance with this provision. See earlier reports for more detail.
7	Psych screening for all; psych evals for persons with possible MI DX		GRC remains in compliance with this provision. See earlier reports for more detail.
8	Pharmacological & psychological (meds and BSPs) coordinated		GRC remains in compliance with this provision. See earlier reports for more detail.
8a	W/med use, ISP must specify alternative TX to encourage med red		GRC remains in compliance with this provision. See earlier reports for more detail.
8b	Medication risk vs medication benefit analysis by entire IDT		GRC remains in compliance with this provision. See earlier reports for more detail.
8c	PsychMed TX plan incl: DX; symptoms to monitor; est time for results		GRC remains in compliance with this provision. See earlier reports for more detail.
9	Psych rev occurs at least quarterly and contain minimum elements		GRC remains in compliance with this provision. See earlier reports for more detail.
10	SRC monthly rev of persons on intra-class polypharm or 3+ psy med		GRC remains in compliance with this provision. See earlier reports for more detail.
11	System to monitor, ID, report & respond to med side effects. Qrtly rev		GRC remains in compliance with this provision. See earlier reports for more detail.
12	Informed consent for restrictive interventions, incl psych med use		GRC remains in compliance with this provision. See earlier reports for more detail.

VII. PSYCHOLOGY

1	Psychology Director responsible for psych services	The facility has a qualified director of psychology who has provided good leadership with respect to establishing and maintaining quality psychological care.	Compliance
2	Psychology peer review system	The peer review process for BSPs continues to function well.	Compliance
3a	Data protocols will incl info on target/replacement behs-when, where, freq, etc.	A data collection protocol is in place that appears to meet the provision.	Compliance

3b	Monthly rev of data/progress by clinician - modify when no progress	Behavior data is reviewed and progress is characterized monthly. Behavior data review occurs in a variety of contexts (e.g., MIRs, psychiatric consults, BMC Data Reviews). However, MIR minutes continue to yield examples of failure to look at longer-term trends (i.e., referencing only the previous month's data in characterizing progress), missing the big picture and thus misinterpreting the data. Similarly, there is insufficient documentation of psychology and the IDT responding to significant events (e.g., dangerous behavior, injury). For example, in approximately 25% of the instances we reviewed during our tour, IDT meeting notes failed to state whether the individual's behavior plan was reviewed. A system for monitoring responsiveness to these events has been established. However, the system has not been in place long enough to evaluate its effectiveness.	Non-compliance
3c	Protocols for assessing/rectifying data integrity issues	The protocol includes a method for assessing the reliability of data collection.	Compliance
4a	Psychological assmt protocols in place with minimum elements	The facility has standard psychological assessment protocols that address the required areas.	Compliance
4b	other psychological needs that may require intervention, including but not limited to, physical or severe emotional abuse or Post Traumatic Stress Disorder.	Repeat screening for victimization, along with risk for future victimization, began in March 2008.	Compliance
5	Assmts based on current, accurate & complete clinical & beh data	The current process appears adequate to meet the provision.	Compliance
6	Complete psych assessment w/i 30 days of admission and annually thereafter	All new admissions in the last six months had psychological evaluations on time. The facility has contracted to catch up on overdue updated evaluations.	Compliance
7	Psych svcs w/i 30days of being ID'd as needing svcs per above	Additional therapists are providing substantially increased level of psychotherapy services, both individual and group; this is an impressive addition in a critical area.	Compliance
8	BSP w/i 30days of assessment & containing minimum components	All required components of the behavior plans are present (maintenance and generalization are addressed in the Functional Assessment report). Program integrity checks document implementation of the BSP.	Compliance
9	BSPs must be able to be understood & implemented by RTWs	BSP reviews now include consideration of the readability of the BSP.	Compliance
10	CBT on individualized BSP for staff implementing programs	The system for CBT on BSPs is well-established and serves as a model for CBT in other areas of the facility.	Compliance
11	BSPs revised when needed	Further emphasis on ensuring timely revisions in response to behavioral crises or lack of progress is needed. The quality improvement process noted should help establish and maintain improvement in timely documented responsiveness.	Non-compliance
12	Ratios of psychologists (1:30) & pscyh assts (1 asst: 1 psychologist)	All positions are filled and the requisite ratio is met.	Compliance

VIII. MEDICAL			
1	Medical Director responsible for medical services	Prior to our May 2008 review, GRC appointed one of its primary care physicians as the Interim Medical Director. When we visited GRC, the facility had secured a Medical Director who had just completed her orientation to the facility. A daily (Monday through Fridays) interdisciplinary meeting had been implemented and minutes of these meetings are being consistently recorded. This process was exceptional in the reporting of client information, teaching the members of the interdisciplinary team and addressing needed follow-up for issues that warranted resolution. The implementation of the daily interdisciplinary meetings was a significant step forward in the integration and communication of the disciplines at GRC. The Interim Medical Director and Medical Director did very well in facilitating the meetings we attended. The Neurologist, who was on leave at the time of the review, was on conference call during each meeting and provided feedback regarding individual cases. Recommendation: 1) continue current practice of daily Medical Rounds Meetings; and 2) develop and implement monitoring tools in alignment with the Medical Department's newly developed policies and procedures to ensure adequate oversight of the physicians' practices.	Compliance
2	Medical peer review system	See V.I.	Non-compliance
3	QA syst incl: clin indicators, trend analysis; corr actions & monitoring	At the time of our May 2008 tour, the facility had just implemented a committee to review all cases of pneumonia. In addition, the Medical Department was in the process of working with Quality Assurance regarding clinical indicators. However, much of this is in the beginning stages and trend analyses regarding outcomes for the Medical Department have not yet been implemented.	Non-compliance
4	Med error tracking system	GRC is in the process of establishing a medication variance system to address systematic issues regarding medication variances. GRC has also developed a new Medication Variance Report form that will replace the Incident Report form. In addition, omissions on the Medex are now included in the medication variance reports.	Compliance
5	Policies/procedures to ensure med svcs provided consistent with SOC	The Interim Medical Director had developed a number of policies and procedures regarding Medical Staff Bylaws; Medical Department Administration; General Medical; Preventative Health Care; Dental Services; Neurology; Psychiatry; Pharmacy; Code Blue/Medical Emergency; End Of Life; Death/Morbidity/Mortality; and Peer Review. Our review revealed that overall, there has been improvement in the frequency and quality of the physicians' documentation. There has been an increase in physician documentation regarding updates in status while an individual was hospitalized. Although there has been improvement in this area, there continues to be a number of physicians' notes that describe the treatments implemented but lack an adequate assessment of the individual.	Non-compliance

		During our May tour, we noted the following deficiencies with physicians' notes: lack assessment of status regarding individual's transfer to and upon return from a hospital stay; lacked of assessment surrounding an individual's transfer to a mental health facility; lack of assessment following an individual's being kicked in the eye; and the lack of an adequate assessment of an individual found unresponsive. Recommendation: 1) continue development and implementation of policies and procedures to ensure that the medical care at GRC is consistent with current, generally accepted standards of practice; and 2) initiate regular monitoring of compliance with the Medical Department's policy and procedures.	

IX. NEUROLOGY			
1	Each admit w/sz disorder evaluated by neurologist w/i 30 days		GRC remains in compliance with this provision. See earlier reports for more detail.
2	Standard seizure management plans in place		GRC remains in compliance with this provision. See earlier reports for more detail.
3	Persons w/sz disorder examined by NeuroMD not less than annually		GRC remains in compliance with this provision. See earlier reports for more detail.
4	Neurological interventions must be in line with current PSOC		GRC remains in compliance with this provision. See earlier reports for more detail.
5	A/C meds monitored for side effects		GRC remains in compliance with this provision. See earlier reports for more detail.
6	Minimize older meds or document clinical justification for continued use		GRC remains in compliance with this provision. See earlier reports for more detail.
7	Persons on A/C meds & seizure-free for 2yrs evaluated for med reduction		GRC remains in compliance with this provision. See earlier reports for more detail.
8	Neurology & psychiatry coordinate med use when used for dual purposes		GRC remains in compliance with this provision. See earlier reports for more detail.

X. NURSING			
1	Update Nursing assessment quarterly	GRC is reviewing the structure of the Nursing Department including its table of organization and nursing job descriptions. The current Nurse Administrator was retiring soon and a nurse from QM and Education was to be taking over that position. In addition, the department has developed a Plan of Correction regarding protocols for assessments and the monitoring and analyses of nursing data. However, it was concerning that often the answer to our questions regarding the development and implementation of nursing systems was that the State's Nursing Consultant was addressing most of these areas. The Nursing Department has continued to update their assessments on a quarterly basis. However, they need to focus on the quality of these assessments to ensure that the nursing staff provide a clinical analysis of the past quarter and not merely repeat data . In addition, Nursing needs to update its policy on minimum staff to ensure that, during lunch breaks, the facility has not fallen below their minimum staff requirements.	Non-compliance
2	Nursing diagnoses and care plans updated no less than quarterly	The current Nurse Administrator indicated that this process was to be initiated within the month when the State's Nursing Consultant was due back to the facility.	Non-compliance
3	Establish nursing protocols for assessment & reporting of medical conditions	From our review of ten individuals who warranted transfers to community hospitals due to acute changes in status, nursing documentation remains below generally accepted professional standards. Below are some examples we found of the problematic issues: KS - PRN of Maalox noted that it will be given, but no note indicating that it was given or individual's response; time actually transferred to hospital not documented; no nursing assessment upon return to the facility; note indicating return from hospital was written nearly four hours after his return. FT - note 5/10/08 indicated thick yellow nasal drainage and nurse waiting until oncoming nurse can assess individual nearly 2 hours later; no description from nursing regarding mouth sores; a number of nursing assessments only note "PNM Event" or "Condition Change" without providing a description of the event or condition change; no status assessed by nursing prior to transfer to hospital; notes indicated that he was found on the ground, but no nursing note found addressing this. TU - no reason documented for admission to infirmary on 5/11/08; no mental status assessments documented for an individual who received the wrong diabetic medications; no assessment documented upon return from the infirmary. TS - no indication that the physician was called when individual was experiencing dramatic change in behaviors; vital signs for 3:30 pm, 4:30 pm and 5:30 pm not documented until 8:30 pm; Psychologist/Behavior Analyst documented four days later on 11/12/07 that the psychiatrist was notified of change of status; no assessment of status upon transfer to Mental Health facility; the notes indicated that a chemical restraint was given prior to transfer, but no documentation found.	Non-compliance

		UT - no indication that the physician was called when individual was experiencing dramatic change in behaviors; vital signs for 3:30 pm, 4:30 pm and 5:30 pm not documented until 8:30 pm; Psychologist/Behavior Analyst documented four days latter on 11/12/07 that the psychiatrist was notified of change of status; no assessment of status upon transfer to Mental Health facility; the notes indicated that a chemical restraint was given prior to transfer, but no documentation found. UC - no mental status assessment or neuro check documented after individual was kicked in the eye with steel-toed shoes; no nursing assessment prior to transfer to hospital; nursing documentation upon return to facility done 6 hours after returning to GRC; note 2/18/08 indicated "pain pill" given, but documentation of prn not according to nursing standards of practice which would include the name of the medication, the route, assessment of pain, and time actually given with follow-up documentation indicating response to medication. MS - no assessment when she reported not feeling well 5/7/08; allergy injection not documented according to nursing standards of practice on 5/7/08; no documentation that Tylenol was actually given on 5/8/08 by the nurse; no assessment or transfer note addressing transfer to Mental Health facility on 5/10/08. UB - nursing note regarding second seizure documented three hours later; vital signs for 4:00 pm and 8:00 pm not documented until 9:37 pm. In addition, we found a number of inappropriate abbreviations in the nurses' notes and a number of notes that were actually late entries but not documented as such. As noted in some of the examples above, there were significant time delays in the documentation of acute events. Also, it was difficult to determine from the documentation when the individual was in the facility or in the community hospital. The Nurse Administrator indicated that 85 nursing protocols have been currently updated. The department is currently reviewing a standardized Assessment/Reassessment form for implementation. See recommendations from my last report.	
4	Est clinical indicators w/plans of care, incl integrated team dialogue of the same	GRC has developed and implemented a monitoring tool for ISP/MIR Nursing Quality Assurance regarding nursings' performance in integrating information during the MIRs. No formal analysis has been conducted regarding trends or problematic issues from these data thus far.	Non-compliance
5	System to monitor/doc progress & modify nsg care plans when needed	During our May 2008 tour, a draft of a monitoring tool was provided regarding Healthcare Reviews. The current Nurse Administrator indicated that she reviewed the medical records of individuals who had experienced acute issues, but did not formally document these reviews. There was no set date provided or indicated on the Plan of Correction as to when the monitoring tool for Healthcare Reviews will be implemented. In addition, the current Nurse Administrator indicated that inappropriate interventions were removed from the nursing care plans after our last review. However, she reported that no new appropriate or proactive interventions were added to the plans thus far.	Non-compliance

6	Procedures for med admin, incl training, supervision, med error tracking	GRC has developed a draft of the medication administration policy. However, it had not been finalized at the time of our May 2008 tour. The facility has implemented an observation and tracking schedule for medication administration. However, there was no analysis being conducted on the medication administration data as of yet. The data that we reviewed from the Medication Observation audits indicates 100% compliance with appropriate practices. However, the findings from the Department of Health and Human Services Centers For Medicare & Medicaid Services review in January 2008 indicated that individuals were not consistently provided the opportunity to participate in the administration of their medication. Regarding Code Blue Drills, the facility has changed its policy to include nursing and physicians participation in the Code Blue Drills. Technical Assistance/Recommendation: The documentation from the Code Blue Drills indicated that physicians are not consistently participating in the drills. Although GRC is running more Code Blue drills than previously, there appears to be no set schedule. In addition, documentation that corrective actions were actually completed/implemented for problematic issues was inconsistent on the Code Blue drill forms. Also, there are a significant number of staff members who are not current in the First Aid/CPR certification. We recommend that GRC address these issues. We commend GRC for implementing a Code Blue/Emergency Response Committee protocol that designates the Administrator of Nursing as the chairperson.	Non-compliance

XI. PHYSICAL & NUTRITIONAL MANAGEMENT

A. COMMON ELEMENTS

Team consisting of RN; PT; OT; RD; SLP; and MD (when needed)	GRC has developed a single Physical Nutritional Management (PNM) team which consists of the required disciplines as outlined in this agreement. Jill Cuff, OT has been appointed the lead for the PNM team. However, a number of the prior systems implemented had to be disassembled, reassembled and aligned with the team's restructuring. The facility had put together a basic framework for a PNM Manual. However, since the system was not totally outlined and structured at the time of my review, additional work will be needed on the manual as the system is further developed and implemented. Although problematic issues existed with the PNM system in place at the time of our review, the team was aware of these issues and was able to clearly articulate their plans for corrective actions. This is a significant change from our last review. There is a significant number of high risk individuals in this facility, and all of the clinicians on the core team basically have other duties aside from their work with the individuals at risk. Recommendation: In order to provide adequate services to this population, the facility needs to evaluate making PNM a formal department, staffed with the appropriate number of clinical professionals and clerical assistance.	Compliance

1	Identify persons with PNM issues and causes for PNM issues	GRC has established a PNM risk, Aspiration Risk and Upper Airway Obstruction Risk Protocol and has reassessed individuals' risk levels. The facility has changed the risks levels from 1-4 to High (including Critical), Moderate, At Risk and No Risk. At the time of our review, there were 70 individuals who were designated High Risk. A critical care list designation was determined for the individuals at GRC from an established criteria in February 2008. We found appropriate documentation indicating individuals' risk levels on the Meal Plans reviewed.	Compliance
2	Implement/maintain mealtime and positioning plans for those identified	Our clinical case review of three High Risk Critical individuals (ET, LL, EN) found that there were some systems for PNM nursing assessments that had been put in place regarding triggers. However, from our review and discussions with the teams, we found that a number of triggers (coughing episodes) that were identified by staff during the clinical reviews had not been documented on the Daily Activity Records (DARs) for each of the three individuals reviewed. Consequently, the PNM nurse and core team were not activated to conduct assessments when individuals had subtle triggers. It appeared that RTWs were making interpretations regarding the cause for the triggers which are noteworthy but cannot substitute for clinical judgements, for instance, speculating that the individual had a cold or nasal drainage that caused the coughing or the coughing was not related to aspiration.	Non-compliance
		Further, from our review of three High Risk Critical individuals who had been in the hospital for respiratory issues /pneumonias during the past year (ET 12/15/07, 12/26/07, 1/10/08, 1/23/08; LL 12/10/07, 1/4/08, 4/4/08; EN 3/17/08, 4/10/08) we found a lack of documented triggers on the DARs during these same time periods. In fact, we found a lack of individual triggers noted on the DARs. In addition, there was inconsistent documentation regarding bowel management, weights and intake information on the DARs. In some cases, there was no documentation of who was reviewing the information on the DARs. Probably contributing to this problem is that monitoring and supervision of the completion of the DARs in not being consistently implemented. Without reliable data documented consistently on the DARs, significant symptoms are going unnoticed and unassessed. Consistent documentation of triggers is the keystone to an effective and proactive PNM program. The current lack of consistent documentation regarding triggers on the DARs continues to place individuals at risk for harm. In addition, although the triggers that were documented within the past few months had usually been followed up in a timely manner by the PNM nurse, a number of these nursing assessments did not provide a clear basis for the conclusion that no changes to the current PNM plan were warranted. It was difficult, if not impossible, to determine if the PNM core team actually reviewed the individuals' overall PNM plan and their status to determine if modification to the PNM plan was needed. It appeared that the PNM team is waiting for their weekly review to address issues. However, waiting a week for a clinical review of a critical high risk individual is not acceptable and there needs to be an immediate response from the PNM core team.	Non-compliance

		From our review of the Justification Support Plans for positions that included mealtimes, bedtimes, personal care times, and all other activates for individuals identified at risk, we found that the information was specific as to why certain positions or degrees of elevation were prescribed using clinical objective measures (o2 saturations, lungs sounds, vitals) that now constitute baseline data. However, we found no formal connection between the clinical justifications determined by the PNM team and how the IDTs use or review this information when assessing the adequacy or need for PNM modifications. Also, neither the Justification Support Plan or the PNMP was included in the electronic Medical Record. This is a significant clinical barrier to being able to review triggers, DAR data, and PNM interventions in a timely manner. In addition, nursing has not implemented proactively monitoring and documenting lungs sounds for high risk individuals. We recommend that GRC: 1) ensure accurate reporting and documentation of triggers and other pertinent information on the DARs from house staff; 2) identify individual triggers to monitor and track for individuals at risk; 3) ensure that the staff are reviewing the DARs; 4) ensure timely review by the PNM core team for individuals who experienced a trigger; 5) develop and implement a formalized system regarding the IDTs' use and review of the data from the justification support plans; 6) have nursing implement proactive interventions for the most high risk individuals, such as monitoring lung sounds prior and after meals and bedtime; and 7) significantly increase the IT support regarding clinical data collection tracking, competency-based training tracking, and entering the Justification Support Plans and PNMPs into the Electronic Medical Records.	
3	Ensure staff implement plans, incl positioning before, during & after meals	From our observations of five high risk individuals in Building 128 (RT, KD, ED, XP, MT), we found that the house staff did not implement the meal plans as written for four of the individuals. We also noted individuals who were clearly coughing during the meals without responsive action being taken. Triggers that we observed during one meal were documented, suggesting that triggers are often not documented in the DARs and, consequently, do not get addressed. In addition, we found a number of beds that were not at the incline as prescribed in the PNM plans. It was very apparent that a number of staff had little to no understanding regarding the life-threatening risk of aspiration. Also, there was clearly a lack of staff involvement regarding the rationale for the specific PNM plans, as noted by concerns voiced by staff that, after years of working with an individual who had been eating regular food, they saw changes in diets, such as pureed food, as unnecessary or as a punishment. In addition, staff voiced issues such as a lack of computer access and workload issues as barriers to documenting triggers.	Non-compliance

		Unfortunately, the compliance data indicated that PNM plans are being implemented 100% of the time. However, from one meal observation, it is obvious that the compliance data is not reliable. The lack of implementation of the PNMPs is a major issue that if not adequately addressed and corrected, will collapse the PNM system. Also, regarding individuals who are admitted to the community hospitals, there has been no system developed and implemented addressing the need for a member of the PNM team to assess the adequacy of the current PNMP while the individual is hospitalized. We recommend that GRC: 1) address the barriers regarding reporting of triggers and implementation of PNM plans; 2) develop and implement a system to ensure accurate compliance data; and 3) develop and implement a system for evaluation of the current PNMP by a member of the PNM team for individuals who are hospitalized.	
4	Implement positioning plans for non-ambulatory persons w/PNM issues	See above.	Non-compliance
5	CBT for staff implementing plans, both general and individual-specific	The facility has provided CBT for its clinical staff from consultants. However, there has been no resolution regarding CBT for direct support staff, especially for staff that float to other buildings at mealtimes. During our last review, we discussed at length potential problems associated with using float staff who have not been competency-based trained on the individuals' PNMP but who assist high risk individuals with meals. This practice still continues. We recommend that GRC: 1) 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; 2) provide IT staff to assist with automating a tracking system for staff and CBT.	Non-compliance
6	Monitoring of program implementation to ensure appropriateness	The facility's compliance monitoring that is conducted by the house supervisors to ensure compliance with the implementation of the PNMPs is, unfortunately, not reliable. This is a severe deficit to the current PNM system in that it does not identify problematic areas for timely corrective actions. Consequently, the core PNM team is left in a position of reacting to an individual's acute change in condition by focusing its efforts on modifying the PNMP when often the real issue was that the plan was not correctly implemented. This issue needs to be addressed at the house supervisor level.	Non-compliance
7	System to monitor individual progress and modify interventions as needed	As noted previously, the use of the DARs in not consistent, thus evaluating progress or lack of progress based on the DAR data would be erroneous. Due to the issues cited above, the current system at GRC does not adequately capture individuals' clinical progress and thus, the system continues to be reactive. Focusing on getting reliable DAR data and compliance data needs to be a priority. House staffs' lack of understanding of dysphagia is troubling, since the entire implementation of an effective PNM program depends on the residential staff. These issues need aggressive attention before looking at simplifying the PNM system for implementation in the community. We recommend that GRC: 1) ensure reliability of DAR data and compliance data; 2) aggressively address barriers to house staff compliance.	Non-compliance

8	Eval medical necessity for g-tubes; return to oral feeding when appropriate	GRC stopped the practice of non-licensed personnel performing therapeutic feedings and is in the process of developing a policy and procedure for guiding decisions regarding therapeutic feedings versus pleasure feedings. GRC is also currently in the process of developing and implementing a policy and procedure addressing Medical Necessity of Enteral Tube use. We recommend that GRC: 1) develop and implement policies regarding therapeutic feedings; and 2) develop and implement policies regarding medical necessity of enteral tube use.	Non-compliance
B. PHYSICAL AND OCCUPATIONAL THERAPY			
1	Screening/comprehensive assessments will incl minimum elements	PT continues to maintain compliance with requirements of this agreement.	Compliance
2	Plans w/indiv interventions/outcomes/adapt equip & plan to minimize regression		Compliance
3	CBT for staff implementing plans, both general and individual-specific		Compliance
4	QA system to monitor individual status; equip avail/cond & TX efficacy		Compliance
XII. COMMUNICATION			
1	SLP competent in augment/alter comm; assmts; prog dev/impl/monitoring & CBT	Speech/Language/Pathology staff includes individuals with training and experience in augmentative and alternative communication. However, that competence is not reflected in the development of communication programs or coordination with other disciplines. The facility-wide implementation of the communication matrix has been a positive step. However, it is essential for teams to recognize that a matrix does not represent a communication plan. While it documents what behaviors individuals use to communicate, it does not guide staff in how to support individuals in developing more effective and more generally understood communication behaviors.	Non-compliance
2	System to ID persons needing augment/alternative communication devices	It is clear that not all individuals who would benefit from the use of alternative communication systems are being identified. The communication screening process is not adequately identifying individuals with a need for communication training and those individuals are not being aggressively sought out and provided with appropriate services. Further, there are examples in the individuals' charts of clear indications of a need for communication training where none is being provided.	Non-compliance

3	Implement functional/adaptable comm plans for persons above; rev annually	Communication training continues to be a serious deficit at the facility. The absence of effective communication training is undermining efforts to offer individuals choices and to honor their preferences. Further, a lack of effective communication training undermines efforts to address challenging behaviors that serve a communicative function. Among the concerns noted in this report, the failure of the facility to respond to concerns about communication training is central and critical. The facility is virtually at the beginning of the process with respect to instituting a system for creating, implementing, and monitoring communication training programs. Accomplishing this will require strong and effective leadership to arrive at a process for interdisciplinary collaboration in communication training that works, that makes best use of resources, and that doesn't undermine other areas of effort. If this problem is to be solved, it will require administrative commitment and guidance and it will not get better until that commitment and guidance are realized.	Non-compliance

XIII. HABILITATION			
1	Ann assmts/qrtly rev of indiv strengths/pref/skills/needs/barriers to comm liv	Assessment in these areas has been improved and appears to be generally adequate. Additional vocational opportunities have been made available.	Compliance
2a-e	Develop training/education/skill acquisition progs from above & incl min elements	Integration of habilitation programs is improved but not well established throughout the facility.	Non-compliance
2f	Programs have explicit data reqs, incl what data, freq, who collects & who reviews	The required components are included in the Individual Habilitation Plans	Compliance
3	CBT for staff implementing plans, both general and individual-specific	The implementation of the ISP system shows good promise for helping to address the concerns regarding staff training on skill acquisition programs. However, further effort still needs to be made. We encourage GRC to gain experience with the system and extend it to the remaining houses.	Non-compliance
4	Monthly rev by IDT member on progress/status/prog efficacy, revising as needed	GRC continues to struggle with the issue of judgments concerning individuals' progress. There is a need to provide staff with clear guidance regarding principles and practices regarding judgment of progress. It may help to put in place a process of regularly monitoring team decisions about programs and providing a peer review of the appropriateness of those decisions based on the data.	Non-compliance
5	Ensure Habilitation QA process in place	The peer review for ISPs appears to be an adequate quality assurance process that will over time allow the facility to meet this requirement	Compliance

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.	GRC 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, GRC has: 1) worked with families to attend a provider fair in the community; 2) continued to work on committees whose efforts help to build community capacity, such as county committees in Rolling Prairie and Mills counties, and the state's Money Follows the Person Grant committee and sub-committees; 3) continued to expand the work of the Mental Health Services Committee to ensure that individuals who require such services are provided them; and 4) worked with Mosaic, a community provider, to implement a grant designed to develop additional community resources for children and adolescents (i.e., the Host Family model). Another important component of what GRC continues to do is to work with the State on diverting people from admission to GRC. 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 as well as respite services to individuals residing in the community. When individuals are admitted to GRC, it appears that discharge planning continues to begin immediately. GRC 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 GRC 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 GRC 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. For example, OE was admitted in July 2007, and through continuing work with a provider who was identified at the time of his admission, he was successfully transitioned back home with in-home supports in February 2008.	Compliance (for GRC). Not fully compliant for State.

		However, the efforts of GRC 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 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 they should.	
1a	IDT annually identify/rev barriers to placement & strategies to overcome	Since the last review, it appears that GRC teams have improved considerably the way in which they identify barriers and the strategies to overcome them. In addition to identifying the barriers that the team perceives may be preventing an individual from transitioning to the community, teams also are listing the community supports that need to be in place to address the barriers. The plans that were reviewed listed specific supports with regard to, for example, staffing ratios, training or expertise that community provider staff would need to have, accessibility issues, access to other community supports (such as therapies), etc. Finally, the teams had identified an action plan to overcome each barrier. Again, these were specific, and included the implementation of supports and services at GRC as well as steps to identify appropriate community supports. GRC social workers also have become responsible for the development of the discharge plan for each individual on their caseloads. Since the last review, a revised format for the discharge plan has been developed and implemented. It is a well-organized format that provides key information about the individual's placement history; placement efforts over the last year, including outcomes of these efforts; and a plan for future discharge planning. The plan for future discharge planning includes what needs to be done, how it will be accomplished, and time frames for completion of activities. In conjunction with the barrier/strategy sections, the discharge plans reviewed were individualized and provided concrete steps to move the individuals toward discharge.	Compliance

		GRC continues to work with individuals and guardians who are reluctant to move or to have their family members move to the community. Some of the strategies that GRC has employed include working with providers to develop and share a AMy Life@ book that includes stories about individuals who are successfully living in the community as well as information about the provider agencies, inviting guardians to provider fairs, including articles in newsletters about people who have successfully transitioned to the community and showcasing specific community providers, attending family group meetings, sending letters to families providing information about HCBS Waiver services, surveying families about their current thoughts about transitions to the community, inviting providers to campus to meet with individuals to discuss services and supports available in the community, and maintaining binders in each of the homes on campus that include information about community providers.	Compliance
1b	ISP to specify protections, services/supports required for most integrated setting	It appears that GRC 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. GRC 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. GRC is encouraged to continue this valuable process.	Compliance
1c	Trans plans will ID SRC/DHS actions, pers resp, compl date & solicit county CM role	It appears that GRC staff are developing detailed transition plans and documenting that they are implemented. These plans consistently include individualized essential and non-essential supports that need to be in place at the new setting. However some, but not all of the plans, include specific action steps that need to occur prior to the individual's transitions to community settings to ensure their safety and the success of the moves. Some examples include activities designed to ensure that GRC staff have opportunities to share their knowledge and experience about the individuals who are transitioning with the new provider staff who will begin supporting them, visits by the individuals to their proposed new homes and day programs, formal training to be provided to community provider staff by GRC staff, and observations that community providers are expected to complete at GRC. GRC is encouraged to ensure that such activities are viewed by the teams as essential to the transition process, they be detailed in the Essential Supports@ or Activities of Transitioning@ section of the plans.	Compliance

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. For example, Social Workers at GRC have taken over responsibility for the drafting of discharge plans. Training was provided to them prior to their assuming this role. Likewise, Social Workers have received more specific training on the development of barriers and strategies to address them. At each monthly Social Work department meeting, a segment of the meeting is devoted to training. The documentation shows that a wide variety of topics are covered during this portion of the meeting. Peer review is also conducted of discharge and transition plans at these meetings. This also appears to be a training opportunity for all involved. GRC staff members also have begun to attend training on the "Big Picture". This training is designed to assist teams in identifying what is really important in a person's life, and developing plans to assist individuals to meet their goals and attain their preferred lifestyle.	Compliance
3	Rev assessments, trans plan & proposed supp with individ/guardian PRIOR to move	It appears that teams are continuing to meet to update assessments, transition plans, and proposed supports within 30 days prior to the individuals' move to the community.	Compliance
4	Current comprehensive assmt of needs and supports within 30 days of move	It appears that teams are continuing to meet to update assessments within 30 days prior to the individuals' move to the community.	Compliance
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 appear to be taken to correct issues identified. In some cases, additional time has been requested to extend the final discharge date from GRC to allow for additional actions to be taken. The Social Work Director and Community Living Specialist also regularly review transition plans and the related documentation to determine if the appropriate steps have been taken and documented. They review all transition plans and related entries in the Event Log. When issues are identified, a written report is provided to the Social Worker involved. The report lists any follow-up action that must be taken. In addition to specific actions that individual Social Workers are required to take to correct identified issues, information gained from this process is used to identify additional training areas for all Social Workers. GRC is encouraged to continue this beneficial quality improvement process.	Compliance
6	QA sys ensuring trans plans current w/ PSOP, & correct problems when identified	As noted above, 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.	Compliance

7	Data mgmt system to analyze barriers w/ annual report to MH, MR, DD, and BIC	GRC, in conjunction with WRC, has continued to refine the system used to aggregate and analyze information about barriers to movement to community settings. GRC has automated this system, and Social Workers were supposed to be trained in July 2008 on how to enter barriers into the new computerized system. 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 were plans to share the information with the Olmstead Commission in July 2008. Resource Center staff have asked the State what type of information would be helpful to them and were 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. 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.	Compliance (for GRC). Not fully compliant for State. Compliance
B. FOR SERVING PERSONS HAVING MOVED FROM SRC TO MORE INTEGRATED SETTINGS APPROPRIATE TO THEIR NEEDS			
1	Monitor placements w/i 60 days of move/post-move assmt to ensure plans in place	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.	Compliance. See WRC Report regarding the state's QA 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.

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		Compliance
2	Establish/maintain unified record, incl 15 audits/mo with corrective action PRN		Compliance