IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF IOWA, Defendant.	Civil No. 4:22-cv-00398-RGE-SBJ MONITOR'S THIRD REPORT

Plaintiff, United States of America, and Defendant, the State of Iowa, jointly file the Court-appointed Monitor's Third Report as Attachment A to this filing.

Respectfully submitted this 4th day of October, 2024,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 4th day of October, 2024, the foregoing document, filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing.

/s/Rachel Scherle
RACHEL SCHERLE
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UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF IOWA

Independent Monitor's Report

Dates of Onsite: May 13-14, 2024 & August 7-8, 2024
Date of Draft Report: August 30, 2024
Date of Final Report: October 4, 2024

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

Provider visits were conducted over two-day periods in May 2024 and August 2024. Twelve individuals were chosen over the two onsite community visits. The home/center visits included discussions with the individual and staff and review of documents provided prior and during the visits. A score of "1" reflects the indicator was present, ".5" indicates partial presence, and "0" reflects its absence. When the indicator is based on individuals, the number of individuals showing presence of the indicator/total numbers of individuals will be listed. When an indicator consists of multiple measurables for individuals, those measurables also known as components will also be provided. Individual scores marked as a "1" reflect all components being present for that person.

Section H.iv 8b (Comprehensive ISP) received a more detailed close-up to offer more information to drive improvements in the needed areas.

Paragraphs not reflected in this report were determined to no longer be applicable due to GRC closure. Paragraphs noted to be in Substantial Compliance may move to less oversight with continued performance on the next 6-month status update. Paragraphs marked as "Less Oversight" have retained substantial compliance for two consecutive 6-month status reviews.

Summary

Overall, Providers appeared much more knowledgeable of the individuals than what was noted with previous reviews. The individuals appeared to be happy and content with their surroundings. .Identified supports and equipment was present in the individuals' homes and adaptive equipment and assistive technology were most often available, clean, and in good repair.

Most individuals were participating in community integration activities on a frequent basis. Many had had begun to visit the provider's day program to see if they would like to attend. All were going out regularly to the lake, museum, zoo, park, ice cream, and getting to know other individuals supported by the agency. Staff during the August review reported that individuals attended the agency sponsored prom and had a good time meeting others and dancing to the music. A few individuals participated in music lessons. At one home, two residents are very interactive with their neighbors and were invited to and attended a July Fourth celebration.

Case Managers were noted to complete visits at the cadence required. Positive environmental factors reflected that case management, was effective in many ways, and that the post-move monitoring, and CIM process had been strengthened. For example, environmental modifications related to sensory impairments had been made as needed and recommended. Issues remained, however, regarding the lack of a clear documentation system by case management that was precise in its ability to track an issue from beginning to end. Additionally, despite changes in status, case managers did not consistently convene the IDT to

discuss and develop a mitigation plan. Lack of revisions of GRC-based plans along revisions to plans without assessment were at times observed. While appointments appeared to be mostly scheduled, there were situations in which appointments, especially dental, were delayed up to 18 months. Areas in which delays were noted may benefit from an assessment regarding how to increase community capacity.

As stated previously, for most individuals, the provider was following the support plans from GRC and had not yet updated them to reflect current environment and/or status. Many reported they had not yet needed additional support from community specialists/support but could access it through MFP if needed. When they have needed some support, providers reported they had been able to contact the needed professionals from WRC. An issue noted during both reviews were the changing of supports without clear assessment to support such modification. This has been observed mostly with mealtime modifications such as diet texture. Changes in supports, especially those that may result in an increased risk, should be assessed by the appropriate professionals before alterations are made as changes often do not result in overt issues immediately.

Post-Move Monitoring (PMM) had occurred as required for all individuals reviewed. Generally, Post-Move Monitoring reports for individuals reviewed reflected "Interview" and some observation as the primary form of evidence reviewed during the PMM visits. For numerous supports, observation of the individuals with their existing supports or of added supports along with interview and review of documentation should be utilized to verify adequacy of implementation. Any supports not fully in place or pending should be identified for follow-up action. This was not consistently done; therefore, monitoring of transitions was not consistently revised and did not measure the timely and successful implementation of supports and services that were recommended for each individual's transition and in turn, did not guide the monitoring to identify potential events that could be disruptive to a successful transition or prompt the social worker and case managers to develop corrective measures.

The State has actively collaborated with the Independent Monitor to enhance their systems and improve care. The Systemic Threshold process was enhanced by building in a review by the Outreach Team which now has the final ability to determine if a threshold requires intervention and the type of intervention. as well as the limited death review where work has been done to improve the level of comprehensiveness. Other collaborations included the training of case management staff and the State's G/J tube training. Additionally, in June of 2024, the Department implemented a quality assurance process audit assessing a sample of monitoring visits to ensure the reliability of the process.

Individual #59 from the review group was taken to the Emergency Room on 8/7/24 (the day of the Monitoring Team's scheduled visit) and admitted. Therefore, the Monitoring Team was unable to conduct a full review and assessment of this transition. An area of focus was the CM follow-up therefore these will be scored.

The Monitoring Team was notified that Individual #59 passed away while in the hospital with a diagnosis of Aspiration Pneumonia, Sepsis, Respiratory Failure, Multi-Organ Failure and Septic Shock. He had a history identified in the ISP of slow transit constipation. His risk indicators included no BM in 2-3 days, nausea, vomiting, distention, pain, etc. His PNMP lacked any

information of his constipation. Training was noted for the PNMP, but none was focused on constipation and no follow or review of any health plans addressing constipation outside of drinking 3500 cc fluid daily and to track each bowel movement. Strategies contained within the GRC risk plan for constipation such as no BM in 2-3 days were not included in the Community Provider's risk plan. Though stated in the risk plan to track intake and output, there was no evidence of this provided to the Monitor as of 8/28/24, though data was still incoming. The Department will conduct a limited quality assurance death review to determine whether processes can be improved to achieve better outcomes. The Monitor will review and work with the State to ensure that any improvements, if needed, are identified and addressed.

Summary of Compliance		
Paragraphs	**Status**	
191	Substantial Compliance	
201	Substantial Compliance	
202	Not Applicable for this Review	
206	Substantial Compliance	
208	Partial Compliance	
209	Partial Compliance	
210	Partial Compliance	
211	Partial Compliance	
226	Partial Compliance	
229	Partial Compliance	
230	Partial Compliance	
233	Less Oversight	

Non-Active Paragraphs

Section A: Research (41-47)

Section B: Integrated Interdisciplinary Care and Services (48-57)

Section C: Clinical Care (58-67)

Section C.i – Supervision and Management of Clinical Services (68-72)

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Section C.iii Residents at Risk of Harm (77-81)

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Section C.vi: Medications (92-102)

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Section H.iv Community Integration Management (202-207)

Section I: State Staff (212-215)

Section J: Organizational Accountability (216-225, 227-228)

Section K: Effective Quality Management (231, 232, 234, 235)

Section H. Individual Support Planning, Discharge Planning, and Transition from Resource Center (177-178)

Section H.ii: In-reach and Community Engagement (189-192)

Summary: Specific to the Monitor's case management concerns, GRC and the state Medicaid team coordinated a training for case managers led by the Consent Decree Monitor's team. The State has also developed the Learning Management System (LMS) which focused on continued training for providers and case managers. case management training Further, as relayed by the Director at the August status conference, the current MCO contract amendments effective July 1, 2024, require certification of case managers which includes completion of competency-based training for individuals with IDD.

#	Indicator	Overall Score
1	a. Individuals receive information regarding community living options at least every six months. b. had opportunities to visit community-based residential and vocational settings and meet with other individuals with IDD receiving services in integrated settings at least quarterly. (par. 189)	N/A
2	In collaboration with the MCOs and community providers, the State shall develop and provide competency-based training and information for Glenwood and MCO staff about the provisions of this Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and effective community options counseling. These trainings will be provided to applicable disciplines during initial orientation and annually thereafter.(par.191)	SC
3	All staff responsible for directing, managing, or coordinating discharge planning and other informational activities regarding community options have sufficient knowledge about community services and supports to propose appropriate options about how an individual's needs could be met in a more integrated setting. (par. 190)	N/A
4	All residents shall be provided opportunities for engaging in community activities to the fullest extent feasible, consistent with their identified needs and preferences. (par 192)	Not Active

Comments:

2. Specific to the Monitor's case management concerns, GRC and the state Medicaid team coordinated a training for case managers led by the Consent Decree Monitor's team. The training was announced on 5/31/24 and held on 6/14/24. The two- and one-half-hour training focused on post-transition monitoring of former GRC residents. It provided education on the role of the Community Integration Manager, the GRC Social Workers, and the case management and transition specialists. The training focused on improved delivery of case management services, including providing specific questions for following up on individuals, specific documentation guidance for identifying concerns or gaps in support, and steps for following up on concerns and gaps. The training provided education on what to do when an individual's status changes. It discussed the thresholds included in GRC's Post-Move-Monitoring data gathering process, how to identify those thresholds, and what the next steps are once thresholds are identified. Approximately 82 case managers, transition specialists, and Medicaid and GRC leadership attended the training.

The State has also developed the Learning Management System (LMS) which focused on continued training for providers and case managers. case management training Further, as relayed by the Director at the August status conference, the current MCO contract amendments effective July 1, 2024, require certification of case managers which includes completion of competency-based training for individuals with IDD. Planned certification of case managers incorporated in the MCO contracts. LMS includes modules very specific to the IDD population including the following:

- Creating a good routine and making changes to routines.

- Dressing (and how to help with dressing individuals with IDD)
- Showering (3 related modules)
- Skin care (3 related modules)
- Oral care (3 related modules)
- Medication (3 related modules)
- Sleep and IDD (2 related modules)
- Mental illness support for people with IDD
- Anxiety and IDD (2 related modules)
- Trauma informed care.
- Building self-esteem and emotional resilience
- Reducing social isolation.
- Responding to aggression in people with IDD.
- Promoting social skills.
- Managing behaviors and non-verbal communication.
- Responding to challenging behaviors

Section H.iv: Community Integration Management (201-211)		
Summary: A Community Integration Manager (CIM) position was created as required under H.iv.201 of the Settlement Agreement. The Community Integration Manager has been a strong asset to support GRC with transitions and facility closure through identification of needed actions to address shortcomings of the discharge and transition planning process as well as the identification of systemic community barriers.		
#	Indicator	Overall Score
1	The Community Integration Manager provides oversight of transition activities. (par. 201)	SC
2	The Community Integration Manager is engaged in addressing barriers to placement, if applicable. (par. 202)	N/A
3	If an IDT recommended maintaining a placement at GRC or placement in a congregate setting with five or more individuals, the barriers to placement in a more integrated setting, and the steps the team will take to address the barriers were documented. (par. 203,204)	Not Active
4	If Woodward was the chosen provider, the individual was offered a meaningful choice of providers consistent with their identified needs and preferences. (par, 205)	Not Active
5	The State maintains public reports that identify monthly data regarding: a. status of GRC's community integration efforts b. number of residents in each stage of transition planning c. number of transitions d. types of placements e. number of individuals recommended to remain at GRC. (par. 206)	Not Active
6	Information about barriers to discharge from involved providers, IDT members, and individuals' ISPs is collected from GRC and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services. (par. 207)	Not Active
7	The State shall develop and implement quality assurance processes to ensure that ISPs, discharge plans, and transition plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being advanced. Whenever problems are identified, the State shall develop and implement plans to remedy the problems.(par. 208)	PC
8	A GRC staff member shall conduct monitoring visits within each of four (4) intervals (approximately seven, 30, 60, and 90 days) following an individual's transition. Documentation of the monitoring visit will be made using a standard checklist that encompasses all areas of the transition plan and addresses whether all supports and services are in place according to the timeframes in Paragraph 200. This review shall include ensuring that the new provider has a current person-centered individual support plan in place, consistent with the requirements in Paragraph 183 (par. 209) (sum of a-h)	PC 30% 3/10 individuals 69% 48/70 components
	a. GRC staff conducted monitoring visits seven, 30-, 60- and 90-days following transition. (par. 209)	100% 11/11

		Individuals
	b. The new provider has a person-centered individual support plan in place, consistent with the requirements in Paragraph 183. (par. 209). *Refer to Section H.iv.8b Detail immediately after this section for a more detailed breakdown.*	27% 3/11 Individuals
	c. Individuals who had transitioned to the community had a current ISP in place. (par. 209)	100% 11/11 Individuals
	d. All ancillary support plans are in place (par 209)	85% 8.5/10 Individuals
	e. Identified supports were in the home (par 209)	95% 9.5/10 Individuals
	f. Staff conducting post transition monitoring received adequate training and have been assessed for reliability of the process. (par. 209)	50% .5/1
	g. Environmental modifications related to sensory impairment (e.g., bed shaker or strobe alarm for fire alert) have been made as needed and/or recommended. (par 209)	100% 6/6 Individuals
	h. Adaptive equipment and assistive technology were available, clean, in good repair (including having charged batteries), and available to the person at all appropriate times and during community activities. (par 209)	95% 9.5/10 Individuals
9	The individual has received ongoing community case management services at the frequency required based on the individual's needs and preferences. (par. 210) (sum of a-f)	PC 0% 0/11 Individuals 44% 27/61 components
	a. The case manager observes the individual, assesses status along with environment and ensures implementation of the ISP. (par. 210)	15% 1.5/10 Individuals
	b. The case manager documented any issues/concerns noted from monitoring visits, convened the IDT to address noted issues/concerns, and documented resolution. (par. 210)	39% 3.5/9 Individuals
	c. The case manager followed any identified issues to resolution. (par. 210)	0% 0/9

		Individuals
	d. All needed appointments are scheduled in a timely manner. If not, there is evidence that the issue was reported and the CM documented the issue, convened the individual's service planning team to address it, and documented its resolution (par 210)	55% 6/11 Individuals
	e. Case Manager met with the individual face to face at least every 30 days; at least one such visit every 2 months at the individual's home (par. 210)	95% 10.5/11 Individuals
	f. PMM visits reflect review of all supports (ancillary, clothing, adaptive, environmental, training) (par 210-211)	50% 5.5/11 Individuals
10	Staff demonstrated competency in person-specific training needed to support the individual (e.g., sign language, behavior management, dining support, etc.) (par. 210) (sum of a-f)	85% 54.5/64
	a. Staff demonstrated competency in use of equipment/devices(par. 210)	85% 8.5/10 Individuals
	b. Individual's services are delivered by staff that understand the person's needs, preferences, and desired outcomes related to his/her ISP(par. 210)	91% 10/11 Individuals
	c. Staff able to describe medical/behavioral/habilitation needs. (par. 210)	91% 10/11 Individuals
	d. Staff was aware of the individual's SAPs, Outcomes, etc. (par. 210)	100% 11/11 Individuals
	e. Staffing was adequate to facilitate the individual community life outcomes (par 210)	95% 10.5/11 Individuals
	f. Staff had been trained on the individual and their supports. (par 210)	45% 4.5/10 Individuals
11.	Home is free of hazards and clean (par 210)	100% 11/11 Individuals
12.	Medicator are secure and given as prescribed. (par 210)	85% 8.5/10 Individuals
13.	Individual has seasonally appropriate clothes (par 210)	100%

		11/11 Individuals
14.	Room and home is personalized with opportunities for privacy. (Par 210)	100% 11/11 Individuals
15	The State implemented a system to identify and monitor individuals in the Target Population who transition from Glenwood Resource Center (for at least 365 days following transition) to another placement. (par. 211)	PC
	a. This system includes documentation as part of the PMM process to ensure that all supports are in place (carry over from Indicator 9f above)	50% 5.5/11

Comments:

1. A Community Integration Manager (CIM) position was created as required under H.iv.201 of the Settlement Agreement. The Community Integration Manager has been a strong asset to support GRC with transitions and facility closure through identification of needed actions to address shortcomings of the discharge and transition planning process as well as the identification of systemic community barriers.

The Community Integration Manager (CIM) was responsible for ensuring all services and supports for former Glenwood Resource Center (GRC) residents who have transitioned to the community are in place and maintained. The Lead CIM was the liaison between the TCMs or Regional CIMs and MCOs, HHS staff, the Home and Community Based Quality Improvement Organization, providers, post-move monitors, the Woodward Resource Center of Excellence, and other stakeholders. The Lead CIM is also scheduled to meet with the Regional CIMs on a regular basis. Additionally, the CIM will identify opportunities for training for case managers and providers and facilitate those opportunities.

During the closure process, the CIM met with the transition facilitators and social workers to discuss barriers to and status of transitions. The CIM reviewed and approved each transition plan, however, it should be noted that plans were not clearly reviewed for quality vs reviewed for presence of components.

The CIM worked with the MCO and MFP case managers to identify what was needed for each individual transition. The CIM has worked with case management agencies in improving the quality and consistency of case management contact notes. However, the quality of notes reviewed by the Monitoring Team for the August review for individuals visited varied greatly and few included substantive commentary, identified concerns, or included development of needed follow-up actions.

The CIM reported that Iowa HHS hired 4 regional Community Integration Managers to support transition oversight and integration efforts. The CIM was in process of providing training to the new CIMs with a goal for all to be fully operational in their roles by the end of August 2024. The State has requested collaboration with the Independent Monitor regarding how to continue to improve their PMM process and requested examples of where PMM fell short followed by examples on how to improve the quality.
Oversight will be transferred to external case management at 365 days, unless circumstances warrant continued state-led post-move monitoring is necessary to ensure the safety of the transitioned individual.

7. See K.2 for specifics regarding the QA system that was focused on individuals post transition. The quality management process and procedures were much improved and offered an improved level of knowledge regarding data specific to thresholds, but was lacking as it related to data reporting being based on a frequency (count) basis, which makes it challenging to assess whether changes in the data require action or if they are simply a result of fluctuations in census (the number of people being tracked).

8. Due to issues with CM follow-up and quality of documentation, paragraph 210 will remain in partial compliance. Primary concerns centered around the lack of follow up and clear documentation linking actions to mitigation. Examples are noted below.

a. Post-Move Monitoring (PMM) had occurred as required for all individuals reviewed. This included the 7, 30, 60, 90 visits.

b. Providers did not have a person-centered individual support plan in place, consistent with the requirements in Paragraph 183. While monitoring addressed the presence and currentness of the ISP, the quality was not a part of that review. Please see the detail slide for the noted issues.

c. Individuals who had transitioned to the community had a current ISP in place.

d. For most individuals, the provider was following the behavioral support plan from GRC. Many reported they had not yet needed additional support from community behavior specialists, but could access it through MFP if needed. When they have needed some support, providers reported they had been able to contact the contracted BCBA from WRC. The GRC plan for Physical and Nutritional Management (PNMP) for all individuals had mostly been carried over.

- For Individual #20, the provider had adapted this plan to make it more functional and user friendly.
- Individual #39's dining plan and PNMP were present. The PNMP indicated that if he ate less than 25% of his meal to offer nutritional supplement and that if he did not drink the supplement, to notify the nurse to provide enteral nutrition. When the Monitoring Team asked provider staff how the 25% was determined, they reported that it was by how much was gone from his plate. When further questioned if 25% was calculated in terms of protein intake versus other nutrients, staff could not articulate.
- Individual #39 had a recommendation in his transition plan for an epi-pen in case of reaction to allergy injection. This was not carried forward to post-move support and the provider did not have a specific plan in place other than a medication order. When asked about a protocol for his epi-pen, staff reported that they had the epi-pens, but now that his allergy injections had been discontinued, they would need to get the order for the epi-pen discontinued as well. A Dietary Assessment & Order (DAO) and associated dining card had been developed and implemented in January 2024. A nursing care plan was developed after his transition. The PNMP was carried over from GRC.
- Individual #80's behavioral support plan was not provided to the Monitoring Team for review. The transition plan indicated that the provider would use her support plan from GRC for the first 30 days until they were able to develop their own behavior support plan. A specific post-move support was not developed regarding development of a behavior support plan. PMM reports indicated that Individual #80 had not had any behavioral concerns since transition. There was no psychiatric symptom tracking to provide the psychiatrist with data related to her prescribed antipsychotic medication Chlorpromazine,

antidepressant medication Mirtazapine, or Buspirone for anxiety. The provider was continuing to follow Individual #80's PNMP from GRC.

- Individual #90's behavioral support plan from GRC was still in place. The transition plan post-move support indicated that the provider would support her behavioral needs as it relates to her generalized anxiety disorder, autism spectrum disorder, and insomnia disorder. PMM reports indicated that Individual #90 experienced minimal behavioral concerns since transition other than loud vocalizations when agitated. Staff indicated they offer her preferred items or her Chewelry and she quickly calms. There was no psychiatric symptom tracking to provide the psychiatrist with data related to her prescribed medication Carbamazepine or her antidepressant medication Mirtazapine. The provider was continuing to follow Individual #90's PNMP from GRC.
- Individual #1's behavior support plan, developed with input from the host provider, was present and in place at the time of the visit. No other support plans were required.

e. Identified supports/equipment, such as lifts, grab bars, monitors, bed alarms, gait belts, specialized beds, wheelchairs, etc. were noted as present and being utilized. Staff were observed using a lift to transfer one individual to and from his recliner and appeared confident with the support intervention.

- Individual #20 was using a front-wheeled tray top walker. She was observed walking throughout her home and when she came upon a flooring threshold, she had to lift the walker to continue her mobility. The home hallway was narrow and turned for her to access her bedroom. She again had to lift and reposition the walker to ambulate to her bedroom. Staff reported that she used the walker when on community outings and shopping and one time she had difficulty and knocked over an endcap display in a store. The Monitoring Team asked if she had been assessed by or linked to an occupational therapist since transition to evaluate her mobility and walker. Staff said she had not.
- Adaptive equipment for Individual #39 identified in his transition plan included a Stryker bed with padded side rials, Aquatec VIP shower chair with hip belt and footrests, divided plate, coated teaspoon, cup with straw (he also received nutrition and medications via his G-tube), and eyeglasses. During the Monitoring Team's visit, it was noted that the padded side rails on his bed allowed for a sizeable gap between the padding and mattress which posed a safety risk given that it was reported he could reposition himself in bed. Although the Monitoring Team did not observe Individual #39 at his day habilitation site (the visit was after day program hours), it was reported that he had a similar bed at that location, which should also be given prompt attention to ensure safety with bed rails and padding. Additionally, the transition plan noted that head of bed elevation was to be 10 degrees when in a lying position, but the PNMP indicated an elevation of 20 degrees when in a lying position. A mechanical lift was present in his bedroom and his shower chair was kept in the bathroom and taken to his bedroom for transport to the bathroom for personal care and showering. He received a new wheelchair with air compression seat cushion and lateral supports, headrest, shoulder/chest straps, and recline on 3/1/24 following a recommendation from the OT for better support for his back.
- Adaptive equipment for Individual #80 was present, in working order, and available. The equipment included a Rifton Activity Chair and wheelchair, white handle small spoon, divided plate, Dycem mat, Stryker bed elevated to 30 degrees, and a shower/commode chair.

- Adaptive equipment for Individual #90 was present, in working order, and available. The equipment included a Stryker bed, shower/commode chair, deep divided plate, Dycem mat, 4" white handle spoon, a gait belt, and wheelchair with footrests for community mobility.
- Staff reported that Individual #49 transitioned with a Nova Chat device, but was not using it as much as she had begun to use words more frequently to communicate with staff. The Monitoring Team asked if she had been assessed by a speech language specialist since transition and staff replied she had not.
- Individual #39's adaptive equipment was present, clean, and in good repair. However, as noted in Indicator 8 above, safety concerns were noted with regard to bed rails. He did not use assistive technology devices.
- Individual #1 did not require adaptive equipment or assistive technology.

f. Staff conducting post transition monitoring received adequate training, and a PMM quality process had been implemented that ensured a 10% sample of visits/documentation were monitored. In addition, the Independent Monitor has provided two trainings over the past year in addition to the state sponsored/directed training. Although the checklist was completed, the ability to identify and integrate new supports as well as changes in status appeared to be lacking as issues were at times noted, but were not addressed. See below under i.

g. Environmental modifications, such as Head of Bed (HOB) gauges, door chimes, and bed alarms were noted to be in place for all individuals who required such environmental supports. Some examples included:

- For Individual #39, a gauge was required and noted on the headboard of Individual #39's bed to indicate the degrees of elevation. No other environmental modifications were required other than an open floor plan to accommodate his wheelchair, lift, and shower chair.
- For Individual #80, no environmental modifications were specifically required for Individual #80.
- For Individual #90, no environmental modifications were specifically required for Individual #90.
- For Individual #1, no environmental modifications were specifically required, other than awareness of the environment for items that could be used for harm and supporting him to find a neutral environment if he showed signs of anxiety.

h. All adaptive equipment and assistive technology appeared to be overall in good repair and clean. The exception being Individual #39's bedrails.

h. For most individuals reviewed staffing during daytime shifts was adequate to facilitate appointments and community integration activities.

- For the duplex where Individual #68 and Individual #16 lived on one side and Individual #50 and Individual #42 lived on the other, staffing on each side was one staff during day shifts and one sleep staff overnight. Staff reported that a floater or supervisory staff could be brought in when needed.
- Staffing in Individual #49's home was based on all three individuals being in the home, requiring two staff be present, so it fluctuated depending on census and activities. There was one overnight sleep staff.

- Staffing in Individual #20's home was two staff per shift covering four individuals living in the home and one overnight awake staff.
- For Individual #33's home, there was one staff for the three individuals on day shifts and one overnight awake staff. The Monitoring Team questioned the staff working at the time of the visit as to what she would do in the event of a behavioral emergency if in the home by herself with the three individuals or on a community outing. She reported she would call the office for assistance and did not have a clear plan in place to act immediately. This process and ratio may be a barrier to safety during an emergency. This was shared during the onsite visit.
- Staffing in Individual #39's home was 1:3 when in the community, 1:4 at the home during awake hours, and 1:8 awake coverage overnight. Nursing was 24-hour on-call. Provider staff reported that they have flexibility with staffing coverage and staff are cross trained between the two houses and day habilitation program. Staff were unable to fully articulate how Individual #39 or others would be supported in more individualized community activities given the staffing ratio of 1:4.
- Staffing coverage in Individual #80's home was two staff on the morning and evening shift and one awake staff overnight. If needed, staff contact a nurse, and the provider has an internal positive support team that can be requested as needed to develop individualized supports and plans.
- Staffing coverage in Individual #90's home was two staff on the morning and evening shift and one awake staff overnight. If needed, staff contact a nurse, and the provider has an internal positive support team that can be requested as needed to develop individualized supports and plans.
- Staffing coverage in Individual #1's home was the host throughout the week (asleep overnight as he also lived in the home) and a subcontractor on weekends and when needed.
- Minimal staff coverage in the event of an emergency should be an area of potential focus for the State and the PMM process to ensure that a clear process is in place for the safe removal of physically complex or behaviorally complex individuals in the event of an emergency (e.g., weather, fire). Homes may benefit from a developed action process that outlines the evacuation process.

9. Overall, Case Management was not provided at the level needed by the individuals. Zero of eleven individuals received case management with all the needed components that make up successful management of services. There were areas that demonstrated stronger case management such as integration noted within the community and the personalization of the home, but areas lacking were more focused on the tracking of services and the needed follow up by the case manager, therefore this overall paragraph was determined to be partially present.

a. As reflected in the Monitoring Team's previous visit reports, case management notes did not reflect that case managers were reviewing data and documentation to assess ISP implementation, stability of the transition, and implementation of all supports and services. Case management notes reflected broadly stated observations or included pasted emails or summaries of correspondence with GRC and other provider representatives. There was also a lack of documentation as it related to medical or behavioral events, such as emesis, skin breakdown, aggression, etc. and if any follow-up occurred. Lack of documentation poses unneeded barriers to the provider's assessment.

- Case management services to monitor services, progress, and general well-being was a critical component of the transition process that continued to need attention. The CIM reported she had been meeting with MFP and MCO representatives to address this concern and to provide direction as to adequate documentation by case managers of service delivery and implementation.
- Specific to the Monitor's case management concerns, GRC and the state Medicaid team coordinated a training for case managers led by the Consent Decree Monitor's team. The training was announced on 5/31/24 and held on 6/14/24. The two- and one-half-hour training focused on post-transition monitoring of former GRC residents. It provided education on the role of the Community Integration Manager, the GRC Social Workers, and the case management and transition specialists. The training focused on improved delivery of case management services, including providing specific questions for following up on individuals, specific documentation guidance for identifying concerns or gaps in support, and steps for following up on concerns and gaps. The training provided education on what to do when an individual's status changes. It discussed the thresholds included in GRC's Post-Move-Monitoring data gathering process, how to identify those thresholds, and what the next steps are once thresholds are identified. Approximately 82 case managers, transition specialists, and Medicaid and GRC leadership attended the training.
- MFP case management notes provided to the Monitoring Team for the August visits reflected a more standardized note format and included a summary of the case management contact. However, the notes did not always provide substantive commentary of the required elements of this indicator, specifically with assessment of the environment, ISP implementation, and implementation of services and supports. Additionally, MCO case notes provided to the Monitoring Team included a narrative summary with each contact. This was an improvement on previous reviews, but remains a work in progress. Additional collaboration was planned in an effort to continue the growth of the required documentation.
- Individual #59 from the review group was taken to the Emergency Room on 8/7/24 (the day of the Monitoring Team's scheduled visit) and admitted. Therefore, the Monitoring Team was unable to conduct a review and assessment of his transition. The Monitoring Team was notified that Individual #59 passed away while in the hospital with a diagnosis of Aspiration Pneumonia, Sepsis, Respiratory Failure, Multi-Organ Failure and Septic Shock. He had a history identified in the ISP of slow transit constipation. His risk indicators included No BM in 2-3 days, nausea, vomiting, distention, pain, etc. His PNMP lacked any information of his constipation. Training was noted for the PNMP, but none was focused on constipation and no follow or review of any health plans addressing constipation outside of drinking 3500 cc fluid daily and to track each bowel movement. Strategies contained within the GRC risk plan for constipation such as no BM in 2-3 days were not included in the Community Provider's risk plan. Though stated in the risk plan to track intake and output, there was no evidence of this provided to the Monitor as of 8/28/24, though data was still incoming.

b. Case management documentation reflected numerous emails and communication to various team members throughout a given month related to identified concerns or issues, but IDT meetings were not consistently convened to discuss the identified issues or needed programmatic changes. Some of these meetings were virtual. Issues noted included:

- Only one month of MFP case management notes relative to individual #16 since his transition from GRC on 3/18/24 were provided to the Monitoring Team. The case manager documented a face-to-face home visit on 3/21/24 but the note did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments.
- MFP case management notes related to Individual #42 since his transition from GRC on 12/5/23 were provided to the Monitoring Team. Individual #42 experienced two episodes of aspiration within two days between 2/7/24 and 2/8/24, was taken to the Emergency Room, admitted and intubated. He was noted to have an esophageal stricture and underwent a procedure for esophageal stretching. He remained in the hospital until 2/23/24 when he was discharged home with antibiotics to treat hospital-acquired C-Diff. The MFP case notes reflected a team meeting on 2/22/24 to discuss the hospitalization and discharge plans. Case management notes related to monthly meetings were more substantive and listed appointments scheduled and follow-up appointments needed. However, aside from the monthly meeting minutes, the case management notes did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments.
- MFP case management notes related to Individual #50 since his transition from GRC on 12/5/23 were provided to the Monitoring Team. The case manager note from 12/8/23 was virtual due to COVID and documented that staff reported Individual #50 was having issues sleeping at night and refusing to sleep in his bed, preferring to stay up in the recliner. The provider requested assistance with the GRC behaviorist for problem-solving. Case management notes related to monthly meetings were more substantive and listed appointments scheduled and follow-up appointments needed. However, aside from the monthly meeting minutes, the case management notes did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments.
- Only one month of MFP case management notes for Individual #68 who transitioned from GRC on 3/18/24. The case manager documented a face-to-face home visit on 3/21/24 but the note did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments.
- Individual #B49 transitioned from GRC on 11/14/23. MFP case management notes reviewed were not substantive and did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments.
- Individual #33 transitioned from GRC on 10/20/23. MFP case management notes contained substantive commentary of his services and supports, medical appointments and recommended follow-up. However, notes did not indicate that the case manager had verified that supports were in place through a review of documentation, medication administration records, behavioral data, etc.
- Individual #20 transitioned from GRC on 11/1/23. MFP case management notes reviewed by the Monitoring following her transition, reflected numerous communications between the provider and the case manager requesting paperwork

not received, need for case manager to send mail to Individual #20 so she could obtain a photo ID in order to schedule medical appointments, and reimbursement for rent. For the months of November 2023 through March 2024, notes were mostly pasted email correspondence between the case manager, provider, and others and did not indicate that the case manager had verified that supports were in place, a review of documentation, review of medications, or status on scheduling of required appointments during face-to-face meetings.

- For Individual #80, no MFP case management notes were provided to the Monitoring Team. MFP case management notes for the months of February 2024 and March 2024 did not indicate the case manager had convened the team to discuss missing medications in February 2024. No documentation was available for review to indicate that the MFP or MCO case managers convened the team to discuss Individual #80's recent fracture and surgery. The most recent documentation from case managers provided was from May 2024.
- Since Individual #90's transition, there have been no significant issues for which the case manager would need to convene the team.
- Since Individual #1's transition to the host provider, there had been no significant issues for which the team would need to convene.
- Individual #59 from the review group was taken to the Emergency Room on 8/7/24 (the day of the Monitoring Team's scheduled visit) and admitted. Therefore, the Monitoring Team was unable to conduct a review and assessment of his transition. The Monitoring Team was notified that Individual #59 passed away while in the hospital with a diagnosis of Aspiration Pneumonia, Sepsis, Respiratory Failure, Multi-Organ Failure and Septic Shock. He had a history identified in the ISP of slow transit constipation. His risk indicators included No BM in 2-3 days, nausea, vomiting, distention, pain, etc. His PNMP lacked any information of his constipation. Training was noted for the PNMP, but none was focused on constipation and no follow or review of any health plans addressing constipation outside of drinking 3500 cc fluid daily and to track each bowel movement. Strategies contained within the GRC risk plan for constipation such as no BM in 2-3 days were not included in the Community Provider's risk plan. Though stated in the risk plan to track intake and output, there was no evidence of this provided to the Monitor as of 8/28/24, though data was still incoming

c. As noted above, case management notes for all individuals were not substantive in commentary and not focused on having the case manager review documentation and data. Therefore, identification of emerging issues was an area of concern.

- For Individual #80, no MFP case management notes were provided to the Monitoring Team. MFP case management notes for the months of February 2024 and March 2024 did not indicate the case manager had convened the team to discuss missing medications in February.
- Since Individual #90's transition, there have been no significant issues for which the case manager would need to convene the team.
- Since Individual #1's transition to the host provider, there have been no significant issues for which the team would need to convene.
- See above for Individual #59

d. During interviews, staff reported, and documentation reflected, that appointments were scheduled and attended as needed. The GRC transition process had ensured that individuals had an initial consultation appointment with their community PCP prior to transition to establish care. Other specialty consultations, such as psychiatry, neurology, cardiology, etc. had been obtained, but sometimes there were slight delays. It was reported during the Monitoring Team's visit that dental appointments could take up to 18 months to obtain, especially if an individual required sedation. Delay with obtaining dental exams was a systemic finding for several of the individuals and should receive the needed attention in the form of a clear plan to address the issue. Other professionals were only slightly delayed.

- Individual #20 had a dental appointment on 5/1/24 (she transitioned in November 2023).
- Individual #42 was on a waiting list of 18 months for a dental appointment.
- Individual #50 was waiting for a dental appointment.
- Individual #49 transitioned in November 2023 and had not received a dental exam, but the team had asked if the PCP could perform an oral exam as she is edentulous. On 2/9/24, at an appointment with her PCP, it was determined that he would perform oral exams for her moving forward.

Other appointments that were delayed or pending included:

- For Individual #49, the provider reported it took longer than anticipated to obtain a psychiatric appointment, which was scheduled for August 2024 (Individual #49 transitioned in November 2023). There were no noted adverse effects form the delay.
- Individual #50 was waiting on a neurology appointment.
- Individual #16 and Individual #68 both transitioned in March 2024 and the provider was still in process of getting appointments scheduled as recommended as of August 2024.
- Individual #20 had an appointment initially scheduled with her PCP, but it could not occur as she needed a State photo ID, so the appointment was rescheduled for December 2023. A neurology appointment was pending as well as a mammogram screening.
- Individual #39 had been seen by his community PCP and optometrist. He was scheduled to be seen by Advanced ENT on 3/19/24 for allergy shots, but the appointment did not occur and was rescheduled to 3/25/24. PMM of 6/27/24 indicated that the provider was notified via mail that Advanced ENT was closing. The provider obtained Individual #39's medical records and scheduled a follow-up consultation with his PCP who did not recommend that Individual #39 continue receiving the weekly allergy shots; the weekly injections were discontinued on 6/4/24.
- Individual #39 was to have an EGD procedure on 12/13/23, but according to PMM on 11/30/23, the PCP ordered the procedure to be canceled as he was doing well with his interal feedings and had not experienced any major vomiting. PMM documented a small emesis on 12/29/23 and a medium emesis on 3/27/24. Individual #39 was seen at the hospital in November 2023 where it was noted he had two loose teeth in the bottom front of his mouth, but were not considered a problem. The 1/30/24 PMM noted that he had some loose and rotting teeth that made his breath smell bad, especially in the morning. Although he was not recommended to return to the dental clinic until November 2024, he had

a dental appointment on 6/5/24 where all of his teeth (12) were removed. The 6/27/24 PMM indicated that Individual #39 would be seen at Family Dental due to the clinic no longer accepting Medicaid. Individual #39 was seen at Boys Town on 2/7/24 for new ear molds for chronic mastoiditis. According to 3/1/24 PMM, the provider reported that the right ear mold did not fit snug (they had two left ear molds due to loss of a right one) and that they were also using splash guard ear covers during showering to prevent water from getting in his ears. At this appointment, he received new standard ear plugs, but not specially molded for his ears as he had previously used. PMM report of 3/28/24 indicated that he had done well with the ear plugs, but would reach and rub his ears. The PMM reported on 6/27/24 that staff were no longer using the splash guards during showering, but were tilting his wheelchair to prevent water from entering his ears.

- Individual #39's weight was 97 pounds, and his height was 57 inches as of 10/16/23 prior to transition from GRC. The transition plan indicated that since May 2023 his weight fluctuated between 95 and 100 pounds. As of 8/6/24, his weight was 87.6 pounds. Since transition, he was receiving one can of Jevity 1.5 when he consumed less than 25% of a meal. He had been receiving Jevity regularly with every meal as well as one can prior to bedtime to provide additional calories and protein. Carnation shake was also being added to milk or a protein shake/Ensure was being offered with meals. A dietitian evaluation of 5/28/24 lowered his idea weight to 85 pounds with a daily caloric intake of 1412 calories and PRN Jevity and Jevity at bedtime. The Monitoring Team requested the dietitian evaluation and other documentation reflective of involvement of WRC or the Strike Team related to his ongoing weight loss. The PMM note of 3/1/24 indicated that the dietitian evaluated him in January 2024 and recommended a caloric intake of 1681 calories a day. The Dietitian evaluation was completed on 5/15/24, but as stated previously, did not contain specifics regarding 25% threshold and the impact type of food may have on overall nutrition. Nursing notes from the Strike Team reflected more conversation of the event than analysis of the potential cause and the development of a care plan to mitigate. Individual #39 received an ultrasound on 5/1/24 following elevated liver enzymes. Findings from the ultrasound indicated hepatic cysts with the largest being 5.2cm. Individual #39 received a gastroenterology consult on 8/16/24 which indicated simple hepatic cysts with no acute concerning findings and repeated liver enzymes were within normal limits.
- Individual #80's required appointments had been scheduled and initial consultations had been completed. However, dental was outstanding as the provider was trying to locate a new dental provider due to the old clinic refusing to accept Medicaid. The provider had inquired with the clinic if Individual #80 could privately pay as she had funds available to do so, but it was refused. The CIM asked the MCO case manager to assist.
- Individual #90's required appointments had been scheduled and initial consultations had been completed. However, dental was outstanding as the provider was trying to locate a provider due to UNMC refusing to accept Medicaid. The CIM asked the MCO case manager to help. Individual #90 was also due for a DexaScan screening.
- Individual #1 reported that he had been to see his PCP and his psychiatrist. He stated that he had an appointment coming up in October for his eyeglasses and an appointment for labs soon. His last dental appointment was in February, and another needed to be scheduled.

e. Documentation reflected that case managers for 10 of 11 individuals were making required monthly in-person visits. Case managers interviewed were knowledgeable of the individuals and could articulate status of medical appointments, progress they have seen since transition, and identified areas for possible goals to be implemented. Some examples included:

- Individual #39 was residing in an ICF/DD home and therefore was receiving only MCO case management services. The case manager was present during the Monitoring Team's visit and reported that she typically visited every four to five months and was required to provide face-to-face contact every six months and reported regular contact with the provider's program director of at least once a month.
- Individual #80's MCO case manager was present during the Monitoring Team's visit and reported that he visited at least monthly. No case notes were provided to reflect case management services were provided at the frequency required by the MCO. Notes provided by the MFP case manager for the months of February 2024 through May 2024 indicated regular face-to-face monthly contact.
- Individual #90's MCO case manager was present during the Monitoring Team's visit and reported that he had only just started in the position and planned to conduct visits at least monthly. No case notes were provided to reflect case management services were provided at the frequency required by the MCO. Notes provided by the MFP case manager for the months of February 2024 through May 2024 indicated regular face-to-face monthly contact.
- Individual #1's MCO case manager was present during the Monitoring Team's visit and reported that she has visited with him at least monthly. A new case manager who would become his primary case manager was also present. The MFP case manager participated via telephone call. MFP notes reflected at least monthly face-to-face visits with Individual #1.

f. Generally, Post-Move Monitoring reports for individuals reviewed reflected "Interview" as the primary form used to verify supports rather than the use of observation and documentation to verify the support. .reviewed during the PMM visits. For numerous supports, observation along with interview and review of documentation should be utilized to verify adequacy of implementation. Any supports not fully in place or pending should be identified for follow-up action. Therefore, monitoring of transitions did not measure the timely and successful implementation of supports and services that were recommended for each individual's transition and in turn, did not guide the monitoring to identify potential events that could be disruptive to a successful transition or prompt the social worker and case managers to develop corrective measures.

Examples from the August 2024 Monitoring Team visit where Post-Move Monitoring (PMM) was lacking sufficient detail and action included:

- PMM reports were provided relative to Individual #39's 11/1/23 transition to the provider. However, he initially transitioned to another provider on 3/15/23. The Monitoring team requested all PMM reports , but the PMM reports relative to that failed transition were not provided, Therefore, the Monitoring Team could not fully determine the extent of oversight and identification of emerging concerns/issues and any corrective actions taken to address his safety and the failing placement. Since his transition to the new provider on 11/1/23, pre-move visits were documented on 9/25/23 and 10/10/23 and post-move monitoring (PMM) activities occurred at required intervals of 30 days beginning 11/30/23 through 6/27/23 at the 240-day point after transition. There was no documentation of a 7-day PMM visit. PMM Support

#21 was added on 6/27/24 which indicated Individual #39 "was seen on 6/19/24 where it was determined that he would benefit from Botox injections due to salivation and range of motion (initial injections to begin 7/9/24). There were no PMM findings relative to this newly added support. The PMM reports identified a weight lost trend but did not carry any of the concerns forward as an area of concern for follow-up action. The PMM did not identify lack of dental services as an area of concern for follow-up action.

- PMM reports were provided relative to Individual #80's 2/7/24 transition to the provider. Since her transition, a pre-move visit was conducted on 2/5/24, a 7-day visit was conducted on 2/16/24, and post-move monitoring activities occurred at required intervals of 30 days beginning on 3/8/24 with the most recent being 7/3/24 at the 150-day point after transition. The PMM reports did not identify lack of dental services or actions to address.
- PMM reports were provided relative to Individual #90's 2/7/24 transition. Since her transition, a pre-move visit was conducted on 2/5/24, a 7-day visit was conducted on 2/16/24, and post-move monitoring activities occurred at required intervals of 30 days beginning on 3/8/24 with the most recent being 7/3/24 at the 150-day point after transition. The PMM reports did not identify lack of dental services or actions to address.
- PMM reports were provided relative to Individual #1's 9/26/23 transition to the host home. PMM reports began with the 90-day visit on 12/11/23; previous documentation of PMM was not included. There were no unmet supports identified for follow-up action.
- Individual #59 from the review group was taken to the Emergency Room on 8/7/24 (the day of the Monitoring Team's scheduled visit) and admitted. Therefore, the Monitoring Team was unable to conduct a full review and assessment of his transition. Being unable to see him impacts the ability to determine if supports are appropriate and effective. The Monitoring Team was notified that Individual #59 passed away while in the hospital with a diagnosis of Aspiration Pneumonia, Sepsis, Respiratory Failure, Multi-Organ Failure and Septic Shock.

10. Staff demonstrated competency in person specific training needed to support the individual.

a. Overall, for most individuals visited, staff reported they had been trained in the individual's adaptive equipment. Training records for individuals were provided to the Monitoring Team and included instruction given on maintenance and cleaning of equipment.

- Staff were observed using a lift to transfer Individual #16 to and from his recliner and appeared confident with the support intervention.
- Staff articulated use of Individual #39's equipment, but were not observed using any of the equipment aside from his wheelchair.
- Staff articulated use of Individual #80's equipment, but were not observed using any of the equipment aside from her wheelchair.
- Staff articulated use of Individual #90's mealtime equipment, but were not observed while using.
- Individual #1 did not require adaptive equipment or assistive technology.

b. Staff working at the time of the visit to all 11 individuals were mostly able to describe preferences, personal care supports, basic health care risks, and behavior supports. Some examples included:

- Staff interviewed during the Monitoring Team's visit with Individual #39 were able to describe his preferences, personal care supports, basic health care risks, and physical management supports, as well as use of adaptive equipment. However, there was no evidence of training on individual specific supports (e.g., signs of reaction to allergy injections and use of epi-pen) and no documentation to reflect how staff were trained to competency on Individual #39's PNMP and diet (e.g., how to determine 25% of meal intake and when to provide Jevity supplement). Therefore, demonstration of competency could not be fully evaluated.
- Staff interviewed during the Monitoring Team's visit with Individual #80 were able to describe her preferences, personal care supports, basic health care risks, behavioral supports, and physical management supports, as well as use of adaptive equipment. Staff described her experiences with community integration activities and what she has enjoyed and not liked.
- Staff interviewed during the Monitoring Team's visit with Individual #90 were able to describe her preferences, personal care supports, basic health care risks, behavioral supports, and physical management supports, as well as use of adaptive equipment. Staff described her experiences with community integration activities and what she has enjoyed and not liked. When the Monitoring Team asked staff to describe Individual #90's seizure protocol and use of Nayzilam 5mg spray, they did not seem confident in their response. The order was for one spray in a nostril for a seizure lasting longer than three minutes and may repeat in 10 minutes in opposite nostril if seizure activity had not resolved. Staff reported no observed seizures since her transition. Additionally, for individuals who have emergency seizure medication, such as Nayzilam, there should be a corresponding written protocol approved by the treating physician and the medication should accompany the individual on community outings. Staff reported that they had not thought about taking the medication with them when away from home.
- The host home provider interviewed during the visit with Individual #1 was able to articulate his person-specific support needs, preference and interests, and behavioral supports. He had worked with Individual #1 at GRC and was very familiar with his history and support needs. Individual #1 also talked with the Monitoring Team about how if he was feeling anxious, he can go to his room and listen to music or talk with the host.

c. Staff working at the homes at the time of the Monitoring Team's visit were interviewed and mostly could articulate the individuals' medical, behavioral, and habilitation needs. This support differs from competency and demonstration of competency.

- Individual #39 did not have identified behavioral needs. Staff reported that he communicated by grunting and with facial expressions when he was frustrated and would spit out his food. There was no emergence of behavioral support needs since transition. When asked about a protocol for his epi-pen, staff reported that they had the epi-pens, but now that his allergy injections had been discontinued, they would need to get the order for the epi-pen discontinued as well.

- Staff reported that Individual #90 would sometimes exhibit loud vocalizations when agitated, but when they offered her preferred items or her Chewelry, she would quickly calm. Staff were not able to fully describe Individual #90's seizure protocol and use of Nayzilam 5mg spray.
- The host reported that he was familiar with Individual #1 from GRC and that he was involved in development of the behavior support plan. He stated that the main issues Individual #1 faced were aggression (verbal and physical), and running away. Individual #1 stated "disruptive behavior."

d. Staff interviewed could articulate the individuals' goals and preferred activities. Some examples included:

- Individual #39's staff reported his objectives to be putting on his shirt each morning, but that it was really him making a choice of what to wear and staff providing range of motion when putting on the shirt, participating in a group activity every day for 15 minutes which consisted of being the day room area with housemates or at day habilitation, and allowing staff to brush his teeth (which staff reported would be changing to swabbing since his teeth were extracted).
- Individual #80's staff reported her goals to be housekeeping by wiping her spot at the table, taking her dishes to the sink, pushing button on the dishwasher, and generally any household task, and community outings and activities for integration.
- Individual #90's staff reported her goals to be community integration and walking for five minutes.
- Individual #1 stated (with prompting support) that he was learning his address and learning to do his laundry. The host supported him in describing his goals and reported that he was making progress and would be ready to expand his goals for the upcoming year.

e. For most individuals reviewed staffing during daytime shifts was adequate to facilitate appointments and community integration activities.

- For the duplex where Individual #68 and Individual #16 lived on one side and Individual #50 and Individual #42 lived on the other, staffing on each side was one staff during day shifts and one sleep staff overnight. Staff reported that a floater or supervisory staff could be brought in when needed.
- Staffing in Individual #49's home was based on all three individuals being in the home, requiring two staff be present, so it fluctuated depending on census and access.
- Staffing in Individual #20's home was two staff per shift covering four individuals living in the home and one overnight awake staff.
- For Individual #33's home, there was one staff for the three individuals on day shifts and one overnight awake staff. The Monitoring Team questioned the staff working at the time of the visit as to what she would do in the event of a behavioral emergency if in the home by herself with the three individuals or on a community outing. She reported she would call the office for assistance and did not have a clear plan in place to act immediately. This process and ratio may be a barrier to safety during an emergency. This was shared during the onsite visit.
- Staffing in Individual #39's home was 1:3 when in the community, 1:4 at the home during awake hours, and 1:8 awake coverage overnight. Nursing was 24-hour on-call. Provider staff reported that they have flexibility with staffing coverage

and staff are cross trained between the two houses and day habilitation program. Staff were unable to fully articulate how Individual #39 or others would be supported in more individualized community activities given the staffing ratio of 1:4.

- Staffing coverage in Individual #80's home was two staff on the morning and evening shift and one awake staff overnight. If needed, staff contact a nurse, and the provider has an internal positive support team that can be requested as needed to develop individualized supports and plans.
- Staffing coverage in Individual #90's home was two staff on the morning and evening shift and one awake staff overnight. If needed, staff contact a nurse, and the provider has an internal positive support team that can be requested as needed to develop individualized supports and plans.
- Staffing coverage in Individual #1's home was the host throughout the week (asleep overnight as he also lived in the home) and a subcontractor on weekends and when needed.
- Minimal staff coverage in the event of an emergency should be an area of potential focus for the State and the PMM process to ensure that a clear process is in place for the safe removal of physically complex or behaviorally complex individuals in the event of an emergency (e.g., weather, fire). Homes may benefit from a developed action process that outlines the evacuation process.

f. From the August 2024 visits, staff interviewed in each home visited verbalized they had been trained in individual supports as part of the transition process. However, the Monitoring Team could not verify if staff had been trained to competency on the individual's history, challenges, and support needs. Training materials were not provided to the Monitoring Team for review for Individual #80 and Individual #90.

- For Individual #1, training records provided to the Monitoring Team reflected staff who had been trained in CPR, MANDT, and medication administration and treatments. No training records on individual specific supports were provided (e.g., behavior supports, psychiatric supports).

- For Individual #39, a document titled "new admission paperwork; look through paperwork and get familiar with new individual" with staff signatures dated 10/25/23 was provided to the Monitoring Team. The training document also noted: "Biggest concern is him eating and drinking. We need to get weight back on him." The attached documents for staff to review included the GRC Individual Support Plan, PNMP, and medical orders. No training records on individual specific supports were provided (e.g., signs of reaction to allergy injections and use of epi-pen). There was no documentation to reflect how staff were trained to competency on Individual #39's PNMP and diet (e.g., how to determine 25% of meal intake and when to provide Jevity supplement).

From the May 2024 visits, training materials and tests for all individuals were provided to the Monitoring Team for review. Testing formats were not designed to fully assess staff competency because staff were not required to describe how strategies and interventions were applied to real-life situations and events. The tests were not comprehensive, that is, they did not include many

important aspects of the individual's history, challenges, and support needs. Training did not include methodologies, such as role-playing or scenario-based training, which were interactive and required learners to think about different potential responses and solutions, problem-solve, and practice for real-life situations they might face.

To help address a potential systemic issue regarding lack of knowledge as it related to enteral nutrition, the State contracted with Clarkson College to provide GJ and J tube training consisting of on-line coursework and in-person hands on training. As of 6/7/24, all of the GRC and WRC nurses had received both on-line and in-person training. A group of those nurses also received "train the trainer" training for the hands-on training. Clarkson College was now providing on-line training to providers through its website. The State sent a notice to providers who had former GRC residents with GJ and J tubes notifying them of the on-line training. GRC will also be setting up hands-on training to follow-up the on-line training. GRC limited the notice to providers with former GRC residents to allow it to focus and deliver the training to that group specifically. It will broaden that notification in a future notice to all providers

11. All homes were free of hazards and clean. Some examples are noted below:

- Individual #39 was residing in an 8-bed ICF/DD home. The home was located adjacent to another 8-bed home with buildings behind that housed administrative offices, conference rooms, and a day habilitation program. The home was clean and free of hazards.
- Individual #80 was residing in a newly constructed 4-bedroom home. She was living with three other ladies that she previously lived with at GRC. She had her own bedroom that was decorated with brightly colored artwork of dogs. The home was free of hazards, clean, and well decorated.
- Individual #90 was residing in a newly constructed 4-bedroom home. She was living with three other ladies that she previously lived with at GRC. She had her own bedroom that was decorated in pink with nice artwork. The home was free of hazards, clean, and well decorated.
- Individual #1 was residing in a home with one other individual with a host staff who also had additional staff support on weekends. The home was clean and well maintained.

12. The majority of medications were secure and given as prescribed, The Medication Administration Record (MAR) was reviewed and matched to medications. For all but three individuals, there were no discrepancies or errors noted.

- Individual #68 refused all morning medications on 5/9/24. This was a history with him and the agency was aware. However, a protocol had not been developed to guide staff for when to attempt to administer medications after a refusal, when to contact the nurse and management, how to document the refusal, and what to do with the refused medications.
- For the August review, Individual #39's medication administration records (MAR) for the past two months were reviewed and matched to medication orders. As noted in Indicators 13 and 14 below, the epi-pen order would need to be discontinued as his allergy injections had been discontinued. The PCP ordered Glycopyrrolate on 12/29/23 to address excessive drooling but there was no clear tracking of its effectiveness. No medication errors were noted.

- Individual #90's medication administration records (MAR) were reviewed and compared to orders and medications. Medications were securely stored in the kitchen in a vertical file cabinet with locked drawers. The label on the medication Nayzilam spray 5mg indicated discard after 5/9/24. Staff were unaware. Staff were advised to contact the PCP or neurologist without delay for a new order and to discard the expired spray. Additionally, the current MAR indicated a late administration of Mirtazapine 15mg on 8/6/24. Staff reported it was a late entry and not a missed dose.

13. Each individual had their own bedroom and adequate furnishings and ample storage for clothing and personal items. Individuals had clothing that was appropriate for seasons and weather. Some examples included:

- Individual #39 had adequate and seasonally appropriate clothing.
- Individual #80 had adequate and seasonally appropriate clothing. Staff reported that she enjoyed having her hair styled and nails polished.
- Individual #90 had adequate and seasonally appropriate clothing. Staff reported that she needed pajamas, and the MFP case manager was informed.
- Individual #1 had adequate and seasonally appropriate clothing. He had recently been shopping and purchased new T-shirts.

14. All individuals were offered opportunities for privacy. For all but one individual, the bedrooms were personalized and reflected the individual and their preferences.

- Individual #42's bedroom was stark and lacked personalization and décor. Staff reported that after he returned from the hospital, he was quarantined due to acquiring C-Diff and he experienced some behavioral issues and removed things from his walls. Staff reported they were planning to support him in shopping and choosing what he would like for decorations. Additionally, he needed a new dresser. Two drawers and the bottom support frame were broken.
- During the visit to Individual #33's home, staff reported that because he had difficulty sleeping and watched television all night, she had been taking the remote control to his TV away to try and get him to relax and sleep. The Monitoring Team raised concern that such an intervention was a restriction on taking his personal property and should stop until the team discussed it and, if this were to continue, it would require a plan and Human Rights Committee approval.
- While on the small side, Individual #39's bedroom was personalized (his hat collection was on the wall), and his furniture was in good repair.
- Individual #80's bedroom was personalized and decorated with brightly colored artwork of dogs.
- Individual #90's bedroom was personalized and decorated in pink which was a favorite color.
- Individual #1's bedroom was personalized and decorated with sports items. He said he liked his room and was proud of how it was decorated.

15. The State implemented a SharePoint site to track incidents that meet the 20 identified Community Thresholds for former GRC residents within the 365-day period post transition. An incident must be entered into the SharePoint site as a Post-Move Monitoring Incident Report. Once a threshold is met, a record is created in the Community Threshold Log. Documentation related to any incident within the scope of Community Thresholds is documented in the SharePoint site and the Individuals IPR. Appropriate follow-up is

completed and tracked on the site. Lacking was clear monthly review of individual and systemic thresholds with a designed agenda and an overall summary of what was addressed outside of the spreadsheet that focus on specific events not systemic discussions. For example, it stated that "on 8/6/24 data was reviewed by the group, and it was determined that Performance Improvement Plans (PIP) were to be addressed with 4 providers. Shawnna Eganhouse, CIM, will work with the identified providers on a Performance Improvement Plan (PIP)." This summary did not reflect why the PIPs were being developed.

See H.iv.9f for information regarding the Post Move Monitoring Process and its ability to identify and address issues. While overall, the majority of supports were present and available, the PMM process lacked in its ability to clearly demonstrate that the system was consistently effective in the identification and mitigation of issues noted during the 365-day timeframe.

Section H.iv.8.b Detail (par 209)		
Summary: This section reflects a deeper dive into Paragraph 209, Indicator 8b and the components of that indicator/score. Individuals had a current community plan that included at least two goals that had been developed to promote community participation and some independence skill training. However, few of the individuals had functional training formalized as in action steps/implementation strategies to support individuals and their goals. Goals overall were focused on acclimation to the environment as well as engagement within the environment and getting to know the community, but few focused on skill building Most individuals were participating in community integration activities on a frequent basis. Generally, for individuals visited, a daily schedule had not been developed. Lack of a daily schedule or calendar results in difficulty determining if outings, events, etc. occurred as intended.		
#	Indicator	Overall Score
8b	The new provider has a person-centered individual support plan in place, consistent with the requirements in Paragraph 183. (roll up of i.-viii)	PC 27% 3/11 individuals 73% 64.5/88 components
	i. The ISP defined individualized personal goals (such as community living, activities, employment, education, recreation, healthcare, and relationships). (209)	27% 3/11 Individuals
	ii. Individuals have ISPs that are current (par 209)	100% 11/11 Individuals
	iii. Personal goals are measurable. (par. 209)	82% 9/11 Individuals
	iv. The ISP identified the individual's strengths, needs and preferences (par. 209)	100% 11/11 Individuals
	v. ISP action plans indicated how they would support the individual's overall enhanced independence. (par. 209)	18% 2/11

		Individuals
	vi. Evidence of community integration (par. 209)	95% 10.5/11 Individuals
	vii. ISP is developed by a staff that is knowledgeable of the individual. (par. 209)	91% 10/11 Individuals
	viii. Individual has a daily schedule with evidence that it is followed(par. 209)	73% 8/11 Individuals

Comments

8b. i.-v. Individuals had a current community plan that included at least two broadly stated goals that had been developed to promote community participation and some independence skill training. However, few of the individuals had functional training formalized as in action steps/implementation strategies to support individuals and their goals (Individual #39 and Individual #1 had more formalized goals and action steps).

Goals overall were focused on acclimation to the environment as well as engagement within the environment and getting to know the community, but few focused on skill building. Additionally, individuals' plans did not clear strategies or intervention regarding for which progress with regard to their overall well-being, receipt of healthcare consultations, and status of their healthcare risks could be assessed. Additionally, documentation in case management notes or PMM reports did not reflect that teams had met to assess individuals' progress toward goal achievement or discussed additional goals for implementation based on what the individual has expressed he/she would like to do or what staff had observed might be beneficial for the individual.

- Individual #16's goals were to participate in community activities of his choice at least twice weekly and to communicate his wants and needs by indicating a preference between two options. Both goals had associated action plans, but the actions were limited with regard to frequency of implementation.
- Individual #42's goals were to become familiar with his new environment through activities in his home and the community and to assist in preparing meals at least once a day. Both goals had associated action plans, but the actions were limited with regard to frequency of implementation.
- Individual #50's goal was to become familiar with his new environment through activities in his home and the community which had two corresponding action plans to follow a daily schedule within his home and to become familiar with his new community. Neither action plan reflected specificity nor expectation for frequency of implementation that would support his overall goal.
- Individual #68's goals were to sleep in his own bed at least 25% of the time and to participate in community activities at least twice a week. Individual was reported to have a difficult time sleeping and preferred to sleep in his chair because he stated he sees ghosts in his bed, but the associated action plans for his goal to sleep in his own bed did not

address his expressed fears. The associated action plans for his community participation goal were limited with regard to frequency of implementation.

- Individual #49's goals were to develop a routine for being involved in her home and community, to learn skills to complete chores to take care of her home, to learn about and be active in her community, to be involved in preparation of her meals, and to increase her communication skills through socialization. The associated action plans were individualized and broadly stated, but provided no strategies for staff to support her in accomplishing the expected activity.
- Individual #33 did not have an individual support plan developed by the provider. The provider reported that the MFP plan was what was utilized for implementation and, from the MFP plan, Individual #33 had one goal: "to live his life to the fullest by engaging in preferred activities in his home and community." There were no specific action plans to guide implementation.
- Individual #20's goal was to become acclimated to her new home and routine through maintaining relationships with friends/family and picking a community outing once weekly. There were no specific action plans to guide implementation.
- Individual #39's plan of care was developed and implemented 11/1/23 and revised 12/4/23. The following objectives were part of his plan of care:
    - Individual #39 will put on his shirt each morning 50% of trials per month for six consecutive months with five verbal prompts and hand over hand assistance.
    - Individual #39 will participate in a group activity every day for 15 minutes with five verbal prompts from staff for 40% of trials for three consecutive months.
    - Individual #39 will allow staff to brush his teeth after each meal 95% of trials for six consecutive months with three verbal prompts. Since he was now edentulous, staff reported that the toothbrushing goal would be changed to swabbing.
- Individual #80's community ISP was not provided. A quarterly progress report for the period covering February 2024-April 2024 was provided that summarized her current medications, community activities, appointments, goals review, safety drills, and summary of incidents. The report indicated that Individual #80 met her objective for improving community integration 100% of the time by participating in at least one community outing per week. For her housekeeping goal, she met the objective 90% of the time for the quarter. The following incidents were documented:
    - 2/13/24: While assisting Individual #80 with a shower, staff asked to assist her in washing her face. She scratched herself in response. Staff assisted with cleaning up the scratch.
    - 2/18/24: Staff notified Team Leader that they could not find two of Individual #80's 8am medications (multivitamin and Sodium Chloride). Team Leader said they were there the previous day. The next day, the medications still had not been found. Team Leader called the PCP's office, and the nurse said not to worry, and they would order her replacement medications. The nurse also added that missing these two doses would not affect Individual #80.
    - 2/20/24 and 2/21/24: Individual #80's two missing medications still had not come through the pharmacy.

- Individual #90's community ISP was not provided. A quarterly progress report for the period covering February 2024-April 2024 was provided that summarized her current medications, community activities, appointments, goals review, safety drills, and summary of incidents. The report indicated that Individual #90 met her objective for improving community integration 100% of the time by participating in at least one community outing per week. For her objective to walk for at least 5 minutes with staff assistance, she met the objective 89% of the time for the quarter.
- Individual #1's plan was developed 10/23/23 and implemented 11/1/23. The goals in his plan were: to be safe in his home and community by learning and reciting his phone number and address at least weekly and to keep his clothes clean by completing his laundry at least once a week. The plan provided an overview of his support needs and strengths. The MCO case manager stated that his annual meeting would be coming up soon and they would begin talking with Individual #1 about what goals he would want to work on the upcoming year. Daily event logs were provided for review that reflected implementation of services and supports, appointments, and community activities.

vi. Most individuals were participating in community integration activities on a frequent basis. Many had had begun to visit the provider's day program to see if they would like to attend. All were going out regularly to the lake, museum, zoo, park, ice cream, and getting to know other individuals supported by the agency. Staff reported all four individuals had been to the agency sponsored prom and had a good time meeting others and dancing to the music.

- Individual #50 met his sister (also visited this week by the Monitoring Team) at prom and they held hands for most of the night. It was reported that although both lived at GRC, they did not have much contact with each other. The Monitoring Team hopes the provider will nurture this relationship so they can spend more time together if they want. Individual #50 had been on visits with her sisters and had spent Christmas with them. The family was not as involved with her brother, Individual #50, at this time.
- Staff reported that Individual #39 occasionally would go on van rides, but could not articulate anything specific that he had participated in for community integration or that he has enjoyed. There was little evidence of daily or weekly community outings.
- Staff reported that Individual #80 and her housemates had been to the zoo, Gretna Wildlife Safari Park, shopping at Bath & Body Works, At Home, to the lake, and out for ice cream. Generally, she participated in a community outing at least weekly. Staff reported that the neighbors were very sweet and friendly and had dogs that Individual #80 liked to pet. She enjoyed sitting outside on the patio and really enjoyed spending time in her room.
- Staff reported that Individual #90 and her housemates had been to the zoo, Gretna Wildlife Safari Park, shopping at Bath & Body Works, At Home, to the lake, and out for ice cream. Generally, she participated in a community outing at least weekly. Individual #90 enjoyed walking around her neighborhood and the park.
- Individual #1 participated in community integration activities almost every night. He also had been on vacation to Wisconsin and stated that he wanted to go to the State Fair.

vii. Staff interviewed in each home reported they had been trained in individual supports.

- Staff interviewed during the Monitoring Team's visit with Individual #39 were able to articulate his physical management supports and use of adaptive equipment.
- Staff interviewed during the Monitoring Team's visit with Individual #80 were able to articulate her mealtime and dietary supports, behavioral supports, physical management supports, and use of adaptive equipment. Staff described the parameters related to blood pressure and heart rate and what to do if readings are outside the paraments for medication administration.
- For Individual #1, training records provided to the Monitoring Team reflected staff who had been trained in CPR, MANDT, and medication administration and treatments. No training records on individual specific supports were provided (e.g., behavior supports, psychiatric supports).
- The host home provider interviewed during the visit with Individual #1 was able to articulate his person-specific support needs, preference and interests, and behavioral supports. Individual #1 also talked with the Monitoring Team about how if he was feeling anxious, he can go to his room and listen to music or talk with the host. The host prompted Individual #1 to talk with the Monitoring Team about what his goals were. Individual #1 said he was learning to do his laundry. The MCO case manager asked him to say his address and Individual #1 did with a reassuring question to the host if he said it correctly. He also stated that he carries his ID with him every day. Individual #1 also said that he goes to the basement when he hears the tornado siren, and he goes outside to the pole when he hears the fire alarm.
- For Individual #39, a document titled "new admission paperwork; look through paperwork and get familiar with new individual" with staff signatures dated 10/25/23 was provided to the Monitoring Team. The training document also noted: "Biggest concern is him eating and drinking. We need to get weight back on him." The attached documents for staff to review included the GRC Individual Support Plan, PNMP, and medical orders. No training records on individual specific supports were provided (e.g., signs of reaction to allergy injections and use of epi-pen). There was no documentation to reflect how staff were trained to competency on Individual #39's PNMP and diet (e.g., how to determine 25% of meal intake and when to provide Jevity supplement).

  From the May 2024 visits, training materials and tests for all individuals were provided to the Monitoring Team for review. Testing formats were not designed to fully assess staff competency because staff were not required to describe how strategies and interventions were applied to real-life situations and events. The tests were not comprehensive, that is, they did not include many important aspects of the individual's history, challenges, and support needs. Training did not include methodologies, such as role-playing or scenario-based training, which were interactive and required learners to think about different potential responses and solutions, problem-solve, and practice for real-life situations they might face.

viii. Generally, for individuals visited, a daily schedule had not been developed. A daily or weekly schedule would support staff to carry out their duties with regard to positioning, dining, medications, involving individuals in routine household activities, skill training, and appointments. Schedules would also support staff and individuals in planning community-based activities. Individuals and staff benefit from an expectation for routine and structure.

- For Individual #16, Individual #68, Individual #50, Individual #49, Individual #42, Individual #33, and Individual #20, staff reported that other than a general schedule for personal care and dining, individuals were offered choices of

activities and event calendars had been developed to support planning of activities. When in the home, individuals could choose to watch television, help with chores, spend time in their rooms, etc.

- No daily schedule was provided in the documents requested for Individual #39. Therefore, it could not be determined if the individual's daily routine was being adhered to with regard to implementation of supports and services.
- No daily schedule was provided in the documents requested for Individual #80. Therefore, it could not be determined if the individual's daily routine was being adhered to with regard to implementation of supports and services.
- No daily schedule was provided in the documents requested for Individual #90. Therefore, it could not be determined if the individual's daily routine was being adhered to with regard to implementation of supports and services.
- Individual #1's daily schedule was provided. The schedule reflected routine daily events as well as community integration activities. His support plan was developed 10/23/23 and implemented 11/1/23. The goals in his plan were to be safe in his home and community by learning and reciting his phone number and address at least weekly and to keep his clothes clean by completing his laundry at least once a week. The plan provided an overview of his support needs and strengths. The MCO case manager stated that his annual meeting would be coming up soon and they would begin talking with Individual #1 about what goals he would want to work on the upcoming year.

Section J: Organizational Accountability (216-228)

Summary: GRC is no longer in operation, but HHS support staff remains in place to monitor implementation of the statewide action plan, and the paragraphs contained within the Consent Decree. As part of the HHS website, there is access to multiple Consent Decree pages that explain the case and the process for GRC to close. GRC and now State policies continue to be updated and reviewed

#	Indicator	Overall Score
1	The State shall conduct the oversight necessary to ensure compliance with each provision of this Agreement and with HHS and GRC policies. The State, through HHS Central Office, shall supervise and monitor GRC services, supports, and residents; ensure full and accurate reporting of, and response to, relevant trends and concerns; and ensure the identification and resolution of necessary corrective actions. (par. 217)	SC
2	The State shall engage with Stakeholders to ID concerns, goals, and recommendations regarding the CD. (par. 218)	Not Active
3	HHS Central Office conducts regular in person visit at GRC. (par. 219)	Not Active
4	The State developed and trained staff in methods to report complaints with one method being anonymous. (par. 220)	Not Active
5	State shall implement timely and effective investigations into reported concern. (par 221)	Not Active
6	The State shall provide reporting GRC staff with a substantive response concerning the outcome of the investigation. (par. 222)	Not Active
7	GRC and HHS Central Office develop and implement effective mechanisms for identifying, tracking, and addressing trends regarding resident care and health outcomes. (par. 223)	Not Active
8	The State shall establish reliable measures to evaluate GRC's organizational accountability for resident well-being, and shall ensure regular reporting, analysis and, when necessary, corrective actions by GRC and HHS Central Office. (par. 217, 225)	Not Active
9	The State shall establish a Resident Council to enable GRC residents to make recommendations and provide information to the GRC Superintendent (par. 225)	Not Active
10	State shall establish a reliable method of public reporting that includes QM reporting (Section K) (par. 226)	PC
11	HHS Central Office shall review and approve all policies, and amendments to them. (par 226)	LO

Comments:

1. GRC is no longer in operation, but HHS support staff remains in place to monitor implementation of the statewide action plan, and the paragraphs contained within the Consent Decree. The Consent Decree is supported by Kelly Garcia-Director of Iowa Health and Human Services and Cory Turner-Division Administrator of Iowa Human Services. Additionally, the development of regional community integration managers and the outreach team were designed to ensure consistency and safety of those living in the community.

Cory Turner was currently serving as the Director for all State-Operated Facilities and reported directly to the HHS Director. Per his position description, he was directly responsible for the oversight of the six HHS 24/7 facilities. His role was to ensure the superintendent in charge of GRC developed and implemented strategic and effective operational plans. He along with other state leadership were routinely on site and involved as evidence of presence in meetings via signature sheet.

10. As part of the HHS website, there is access to multiple Consent Decree pages that explain the case and the process for GRC to close. GRC and State policies continue to be updated and reviewed. Missing was data related to the community. The State has requested meetings to discuss how this next stage of public reporting will look, therefore this paragraph will be explored further during the next review.

Section K: Effective Quality Management (229-235)		
Summary: The quality management process and procedures were much improved and offered an improved level of knowledge regarding data specific to thresholds, but fell slightly short as it related to data reporting being based on a frequency (count) basis, which makes it challenging to assess whether changes in the data require action or if they are simply a result of fluctuations in census (the number of people being tracked). Reporting data as a count may not provide sufficient context for meaningful analysis		
#	Indicator	Overall Score
1	GRC's quality management system shall include processes to ensure that the provision of clinical care and services at GRC are consistent with current, generally accepted professional standards and implemented in an appropriate manner. The State shall ensure data related to the provision of clinical care and services is shared with GRC's Quality Management program and that the data is valid, dependable, analyzed, and utilized for GRC's quality improvement, pursuant to the processes set forth in Section IV.K. (par. 66)	Not Active
2	Quality Management process and procedures are consistent with current, generally accepted professional standards of care. These processes timely and effectively detect problems and ensure appropriate corrective steps are implemented. (par. 229)	PC
3	GRC's quality management program shall effectively collect and evaluate valid and reliable data, including data pertaining to the domains and topics listed below, sufficient to implement an effective continuous quality improvement cycle. GRC's quality management program shall use this data in a continuous quality improvement cycle to develop sufficient reliable measures relating to the following domains, with corresponding goals and timelines for expected positive outcomes, and triggers for negative outcomes. A Quality Management program shall collect, report on, and analyze valid and reliable data regarding GRC sufficient to identify overall trends in the following domains: i. Safety and freedom from harm ii. Physical health and well-being iii. Beh health and well-being iv. Engagement and skill acquisition v. Choice/self-determination vi. Risk management. vii. Staff capacity viii. Compliance with policies and procedures ix. Referrals/transitions to other providers (par,230)	PC
4	The IDT utilizes the data provided through the QM process to drive the decision-making process. (par. 232)	Not Active
5	HHS reviews the routine QM reporting (par. 233)	LO
6	HHS Central Office shall routinely monitor the quality and effectiveness of GRC's Quality Management program and take action to improve the Quality Management program when necessary. The State shall effectively identify the need for and shall direct and monitor the implementation and effectiveness of needed corrective actions and performance improvement initiatives at GRC.	Not Active

	(par. 234,235)	
7	Ensuring accurate, effective, and timely documentation, reporting, investigation, analyses, and appropriate remedial action regarding potential and actual medication variances. i. Potential and actual medication variances shall be reviewed by the Medication Variance Committee. The Committee shall include at least one staff member from the GRC Quality Management Department, and all Committee members shall have received training in Quality Management. ii. The Committee shall address potential and actual medication variances using a continuous quality improvement model. (par. 102c i,ii)	Not Active
8	GRC's quality management system shall include processes to ensure that the use of restrictive procedures at GRC is consistent with current, generally accepted professional standards and implemented in an appropriate manner. The State shall ensure that the Psychology Department shares restrictive intervention data with GRC's Quality Management program, and that the data is valid, analyzed, and utilized for GRC's quality improvement, pursuant to the processes set forth in Section IV.K. (par. 126)	Not Active
9	GRC's quality management system shall include processes to ensure that the habilitation, training, education, and skill acquisition programs provided to GRC residents are consistent with current, generally accepted professional standards and implemented in an appropriate manner. The State shall ensure that data related to such programs is shared with GRC's Quality Management program and that the data is valid, analyzed, and utilized for GRC's quality improvement, pursuant to the processes set forth in Section IV.K. (par. 162)	Not Active
10	The State shall develop and implement quality assurance processes to ensure that ISPs, discharge plans, and transition plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being advanced. Whenever problems are identified, the State shall develop and implement plans to remedy the problems. (par. 208)	Not Active

Comments:
2-3-5. The quality management process and procedures were much improved and offered an improved level of knowledge regarding data specific to thresholds, but fell slightly short as it related to data reporting being based on a frequency (count) basis, which makes it challenging to assess whether changes in the data require action or if they are simply a result of fluctuations in census (the number of people being tracked). Reporting data as a count may not provide sufficient context for meaningful analysis. Examples of potentially skewed data may be the number of thresholds met by a provider vs number of thresholds met per member/ per provider.

The State implemented a SharePoint site to track incidents that meet the identified Community Thresholds for former GRC residents within the 365-day period post transition. An incident must be entered into the SharePoint site as a Post-Move Monitoring Incident Report. Once a threshold is met, a record is created in the Community Threshold Log. Documentation related to any incident within the scope of Community Thresholds is documented in the SharePoint site and the Individuals IPR. Appropriate follow-up is completed and tracked on the site.

Additionally, the dashboard can be manipulated to view incidents and thresholds by individual, provider, social worker, outstanding and completed corrective actions, and incident threshold categories. Currently, the policy required a monthly review of aggregate data to be completed by the HHS Central Office Management Analyst 3, the HHS Central Office Executive Officer 3, GRC

Superintendent, HHS Community Integration Manager and the Division Director, State-Operated Specialty Care Division (Iowa HHS Central Office) to identify trends in the data and determine any needed actions. Individual data is to be reviewed for individual incidents, and for trends. The State is then to respond on a case-by-case basis to any individual trends to determine whether training, corrective action, or other actions are necessary. The State has done a nice job ensuring that issues are responded by their Outreach Team. In addition, the State reviews trends within individual provider data on a monthly basis to identify individual provider trends and address those issues through potential development of a performance improvement plan.

While stated in policy, lacking was documentation of a clear monthly review/agenda of individual and systemic thresholds and an overall summary of what was addressed. For example, it stated that "on 8/6/24 data was reviewed by the group, and it was determined that Performance Improvement Plans (PIP) were to be addressed with 4 providers. Shawnna Eganhouse, CIM, will work with the identified providers on a Performance Improvement Plan (PIP)." This summary did not reflect why the PIPs were being developed.

It was recommended that the quality management processes and data reporting practices be revised to facilitate better analysis and decision-making by implementing a methodology for normalizing the data, reporting it as a rate rather than a count. Normalization allows for meaningful comparisons over time and across different contexts, potentially improving the accuracy of data analysis.

Other suggestions shared with the State included 1) providing greater detail regarding the reason for the outreach visit and 2) adding credentials to those members of the Outreach Team who visit the individual in the community. By offering increased detail, one will be able to determine the reason and therefore potentially the root cause of the visit. You will also be able to pull data regarding the utilization of certain professionals on the Outreach Team and be able to better plan for staffing along with cadence and types of intervention.

Following the Monitor's review of two limited death reviews, the State adopted additional recommendations from the Monitor on improving its limited quality assurance death review process and documentation. Issues noted included the use of open-ended statements and not offering the needed closure to events. Improvements included creating more defined timelines, adding the possibility of ancillary members to the Review Committee if needed based on the type of event, and ensuring training on documentation. With respect to the Committee Meeting Report document, the State incorporated the Monitor's recommendations that included:

- Providing more guidance on the documents to be reviewed by the Committee.
- Providing timeline and scope guidance for describing the circumstances surrounding death.
- Including a directive to specifically consider chronic health conditions and whether those conditions were appropriately managed.
- Including specific areas of inquiry for identifying, exploring, and summarizing the issues.
- Clarification that the Committee should be examining and making recommendations related to both clinical and administrative systemic improvements.
- Specific examples of potential corrective actions.