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.

SETTLEMENT AGREEMENT and CONSENT DECREE
TO RESOLVE THE DEPARTMENT OF JUSTICE'S INVESTIGATION OF
GLENWOOD RESOURCE CENTER CONDITIONS

I. Introduction

1. In 2019, the United States initiated an investigation pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, and Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq*. (ADA). The investigation focused on:

    a. Whether the State of Iowa ("State") engages in a pattern or practice of violating the federal rights of residents of Glenwood Resource Center ("Glenwood" or GRC), who have intellectual or developmental disabilities (IDD). The investigation looked at whether the State places residents at serious risk of harm by subjecting them to: (1) harmful and uncontrolled human subject experiments; (2) inadequate medical and nursing care, physical and nutritional management, and behavioral health care; (3) needless and harmful restraint practices; or (4) incidents causing needless physical injury;

    b. Whether the State violates the rights of residents of Glenwood and Woodward Resource Center ("Woodward" or WRC) (collectively, "the Resource Centers") to receive services in the most integrated setting appropriate under the ADA.

2. On December 22, 2020, the United States issued a CRIPA Notice to the State, concluding that there is reasonable cause to believe that the State violates the Fourteenth Amendment of the U.S. Constitution by subjecting Glenwood's residents to unreasonable harm and risk of harm because it exposes them to: uncontrolled and unsupervised experimentation; inadequate physical and behavioral healthcare; and inadequate protections from harm, including deficient safety and oversight mechanisms. The United States concluded that these violations form a pattern or practice of resistance to the full enjoyment of rights protected by the Fourteenth Amendment.

3. On December 8, 2021, the United States issued a second Notice to the State, concluding that that there is reasonable cause to believe the State violates Title II of the ADA by failing to provide services to qualified people with IDD in the most integrated setting appropriate to their needs. This conclusion applies to individuals residing in the State Resource Centers and those at serious risk of institutionalization. The investigation found that the State plans, administers, and funds its public healthcare service system in a manner that unnecessarily segregates people with IDD in Resource Centers, and almost certainly many other institutions, rather than providing these services where people live, in their community.

4. The State has decided to close Glenwood in approximately two years. The State and the United States (collectively, "the Parties") are committed to remedying the conditions at Glenwood identified in the December 22, 2020 Notice while Glenwood remains open, and the conditions identified in the December 8, 2021, Notice. The purpose of this Agreement is to ensure that the State meets the Fourteenth Amendment rights of individuals residing at Glenwood to adequate care and safety, and the rights of all individuals in Target Population under Title II of the Americans with Disabilities Act.

5. In order to resolve the issues pending between the Parties without the expense, risks, delays, and uncertainties of litigation, the Parties agree to the terms of this Agreement as stated below. This Agreement resolves the United States' investigation of the conditions at Glenwood. This Agreement is also the first part of a phased effort to resolve both investigations. The Parties agree to negotiate in good faith regarding additions to this Agreement to address the December 8, 2021, Notice as well. The parties acknowledge that circumstances may change given the length of the Agreement. Both parties agree to reasonably, and in good faith, negotiate amendments to this decree upon request.

6. This Agreement is enforceable only by the Parties and the Court. No person or entity is intended to be a third-party beneficiary of the provisions of this Agreement for purposes of any civil, criminal, or administrative action. Accordingly, no person or entity may assert any claim or right as a beneficiary or protected person under this Agreement.

II. Target Population

7. The Target Population of this Agreement shall include people with IDD who:

    a. Live at Glenwood; or

    b. Lived at Glenwood during the course of this Agreement, or within 365 days prior to the Effective Date of this Agreement.

III. Definitions

8. An **Administrator on Duty** means a designated member of GRC Leadership with on-call availability and decision-making responsibility at a particular time.

9. An **Authorized Representative** means a person who is authorized by law to act on behalf of an individual.

10. A **Behavior Support Plan (BSP)** is a comprehensive, individualized plan, developed consistent with current, generally accepted professional standards. A BSP contains intervention strategies designed to modify the environment to minimize antecedents of problematic behaviors and maximize antecedents of positive behaviors, teach or increase adaptive skills, and reduce or prevent the occurrence of target behaviors. It does so through interventions that build on the individual's strengths and preferences and that exclude aversive or punishment contingencies. The BSP is based on an accurate, comprehensive assessment of target behaviors, including an assessment of the antecedents and consequences of those behaviors, that integrates assessment information from psychiatric, medical, and other disciplines. The BSP is a component of the Individual Support Plan (ISP) and includes:

    a. The objective delineation of target behaviors, including baseline levels of behavior;

b. Training for the individual to acquire or increase replacement behaviors that are selected on the basis of the assessment in Paragraph 105, and specific implementation procedures for how staff will provide such training; and

c. Target behavior reduction strategies, based on the assessment in Paragraph 105, and specific implementation procedures for such strategies.

11. A **Behavioral Health Professional** has a minimum of a Master's degree, and a certification or license, in psychology, behavioral analysis, or social work, and has experience working with adults with IDD who have significant challenging behaviors and the co-occurrence of mental health issues.

12. A **Case Manager** is an individual with experience in coordinating or providing community-based services and person-centered planning to members of the Target Population, as defined in Paragraph 7. Case Managers must be trained and knowledgeable about the resources, supports, services, and opportunities available in the state and be independent of Community-Based Service providers who may provide direct services to their assigned clients, and of the Resource Centers.

13. **Community-Based Services** are person-centered services delivered in an integrated and coordinated manner to members of the Target Population provided as necessary to support individuals to live in the community and avoid unnecessary institutionalization.

14. A **Community Provider** is an individual or entity who provides Community-Based Services, paid in whole or in part by the State, or through a managed care arrangement, to a member of the Target Population.

15. **Competency-Based Training** is the provision of knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through that person's demonstration of such knowledge or skills in a context similar to one in which such knowledge or skills would be required.

16. A **Developmental Disability** means a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. Developmental disability is diagnosed by a qualified professional. 42 U.S.C. § 15002.

17. **HHS** means the Iowa Health and Human Services department (HHS), and any past or future departments with the same functions, including the Department of Human Services, which merged into HHS effective August 30, 2022.

18. **HHS Central Office** means the Director of HHS and subsidiary Divisions including the Divisions of Disability and Behavioral Health; Medicaid; Strategic Operations; State-Operated Facilities; and any other past, current, or future Bureau, Division, or intra-departmental support within HHS that is responsible for overseeing GRC staff or operations or community-based services and integration for people with IDD.

19. A **Discharge Plan** is a person-centered plan that identifies supports and services enabling a person to move to the most integrated setting appropriate to the person's needs and that accounts for the person's preferences.

20. The **Effective Date** is the date on which the Court enters this Agreement as an order of the Court.

21. **GRC Leadership** are GRC staff who are responsible for supervising departments, including the Superintendent, department heads, and assistant superintendents.

22. The **Human Rights Committee** is a group that includes at least one Behavioral Health Professional, at least one Treatment Program Manager, at least one Residential Treatment Worker, at least two residents of GRC, at least one person not employed or compensated by the State who is the family member of a resident at GRC, at least one community member who has knowledge of community-based behavioral services and is not employed or compensated by the State, and at least one advocate or representative of the disability community or of individuals with disabilities who is not employed or compensated by the State. GRC staff may never be the majority of Human Rights Committee members. The Human Rights Committee reviews recommended programmatic restrictive interventions and environmental restrictions, approves or denies approval of those interventions, and monitors the implementation of those interventions; reviews grievances or allegations of rights violations; makes recommendations for program improvement; and maintains a record of the decisions of the Committee.

23. **IDD** for purposes of this Agreement means an intellectual disability, a developmental disability, or both.

24. An **Individual Support Plan** (ISP) is a document that sets out, in an integrated and coherent manner, all of the protections, supports, and services to be provided to the individual. An ISP is developed by the individual's Interdisciplinary Team through comprehensive assessments of the individual; reflects, to the fullest extent practicable, the individual's preferences, strengths, needs, informed choices, and desires; and includes methods to track and document progress toward identified goals and objectives.

25. An **Institutional Review Board** is an entity that ensures complete and adequate review of research activities, consistent with the requirements of 45 C.F.R. §§ 46.107 to 115. For purposes of this agreement, the Institutional Review Board includes at least one member external to the HHS.

26. An **Intellectual Disability** or **ID** means a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive

behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18 and is diagnosed by a qualified professional. An intellectual disability is a type of developmental disability.

27. An **Interdisciplinary Team** (IDT) is a collection of people with varied professional backgrounds (including people from all disciplines relevant to a particular individual's care needs, that individual, and people who support the individual and know his or her strengths, preferences, and needs) who develop and implement an integrated plan of care to meet the individual's need for services. It includes the individual, the Authorized Representative (if any), the assigned case manager, and people whom the individual has freely chosen or requested to participate (including but not limited to family members and close friends).

28. **Medicaid Managed Care Organization** (MCO) is a private entity that contracts with the State to provide core benefits and services to Iowa Medicaid MCO program enrollees in exchange for a monthly prepaid capitated amount.

29. **Money Follows the Person** (MFP) is Iowa's initiative to assist people in transitioning from institutions to community homes of their choice, funded through a federal Demonstration grant.

30. **Not Compliant** indicates that most or all of the components of a provision of this Agreement have not yet been met.

31. **Partially Compliant** means the State has made tangible progress in achieving substantial compliance with key components of a provision of this Agreement, but significant work remains.

32. **Person-centered Planning** is a process driven by the individual that identifies supports and services that are necessary to meet the individual's needs in the most integrated setting and accounts for the individual's preferences. The individual directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the individual; reflects the cultural and linguistic considerations of the individual; provides information in plain language and in a manner that is accessible to the individual; and includes strategies for resolving conflict or disagreement that arises in the planning process.

33. **Quality Management** is a formalized quality assurance and continuous quality improvement system that ensures that all activities and services for individuals in the Target Population are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, increased community integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and ensures that appropriate services are available and accessible. A quality management system includes the determination of policies and procedures regarding quality management, and the

creation and implementation of quality planning and assurance, and quality control and quality improvement activities.

34. **Research** is a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. This includes any activity that involves the introduction of an untested clinical intervention when any purpose of such introduction is to collect information about patient outcomes for the purpose of establishing evidence to determine how well the intervention achieves its intended result, even if there are additional purposes for such introduction.

35. **Restraints** include procedures within one of the following categories:

    a. A **Chemical Restraint** is any drug that: is administered to manage an individual's behavior in a way that reduces the safety risk to the resident or others; has the temporary effect of restricting the individual's freedom of movement; and is not a standard treatment for the individual's medical or psychiatric condition.

    b. A **Mechanical Restraint** is any device attached or adjacent to an individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. The term does not include mechanical supports used to achieve functional body position or proper balance.

    c. A **Medical Restraint** is a health-related protection that is prescribed by a physician and that is necessary for the conduct of a specific medical (including dental) procedure, or only is necessary for protection during the time that a medical or dental condition exists, to prevent a person from inhibiting or undoing medical or dental treatment.

    d. A **Physical Restraint** is any manual method that restricts freedom of movement or normal access to one's body, contingent on maladaptive behavior, including hand or arm holding to escort an individual over his or her resistance to being escorted. Physical restraint does not include brief, limited, and isolated use of: physical guidance and/or prompting techniques that are used to redirect an individual or assist, support, or protect the individual during a functional therapeutic or physical exercise activity; response blocking and brief redirection used to interrupt an individual's limbs or body without the use of force so that the occurrence of maladaptive behavior is prevented; holding, without the use of pressure or force, to calm or comfort, or hand holding to escort from one area to another; and response interruption used to interrupt an individual's behavior using approved techniques.

36. A **Restrictive Intervention** is an action by GRC to limit or restrict an individual's movement; access to other individuals, locations, preferred items, or activities; or privacy or autonomy.

37. **Seclusion** is isolating an individual from others to interrupt and intervene with a target behavior. It includes placing an individual in their own house or room for the purposes of behavior management or for the protection of the individual or others, and restricting the individual's ability to exit.

38. **Substantially Compliant** means the State has met or achieved all or nearly all the components of a particular provision of this Agreement.

39. A **Transition Plan** is the plan, developed when an appropriate discharge setting has been identified for an individual, that specifies the actions that need to be taken by the Resource Center, the receiving provider, the MCO, the Money Follows the Person Program, and any other involved entities, to accomplish the discharge and assure success in the new setting. It identifies all needed supports, protections, and services, who shall provide them, and when, to ensure successful transition to the new living environment, including what is most important to the individual as it relates to community placement.

40. **Well-being** means a person's general positive status in the areas of cognitive, behavioral, psychological, emotional, social, and physical health.

IV. Substantive Provisions

A. Research

41. No GRC resident shall be subjected to any Research unless:

    a. The resident has provided written Informed Consent for such Research. If the resident has a guardian, written Informed Consent must be obtained from the guardian, and the resident must assent to participate in the Research;

    b. The Research has been independently reviewed and is under active approval by an Institutional Review Board.

42. GRC, subject to confirmation by an Institutional Review Board, will ensure that any risks associated with Research are minimized and reasonable.

43. GRC, subject to confirmation by an Institutional Review Board, will ensure that residents subject to Research are monitored by an individual with experience in conducting research to ensure safety while the Research is ongoing, and that Research is terminated if it poses an undue risk to resident safety. All residents subject to Research will be free to cease participation in such Research at any time and for any reason without perceived or actual repercussion or other negative impact to the resident.

44. The State shall implement and enforce policies and procedures concerning Research that are consistent with the provisions of this Section and with current, generally accepted professional standards regarding the conduct of research.

45. All staff involved in conducting research shall demonstrate competence in the responsible conduct of research.

46. The State shall conduct effective oversight throughout the implementation of this Agreement to detect noncompliance with the requirements of Section IV.A.

47. For purposes of this Section, Informed Consent is consent that meets the requirements set forth in 45 C.F.R. §§ 46.116(a), (b), and (c).

B. Integrated Interdisciplinary Care and Services

48. Every GRC resident shall receive, consistent with current, generally accepted professional standards of care: person-centered planning, and individualized protections, services, supports, and treatments.

49. Every resident's protections, planning, services, supports, and treatments shall be documented in the ISP, which shall be updated annually, and when the resident's service needs and preferences change. Each resident shall have the opportunity to participate in service planning meetings about their services and will have the opportunity to provide input to each of their service plans and/or revision of that plan. If a resident has a guardian, these same participation and input opportunities will be offered to the guardian. GRC will include a reason for non-participation in the documentation.

50. The ISP shall include goals and objectives that align with and support the resident's wishes and preferences regarding developing skills, working, daily routines, and engagement with their community, including community-based living options.

51. Protections, planning, services, supports, and treatments shall be coordinated through the resident's IDT and a complete and coherent ISP.

52. Protections, planning, services, supports, and treatments shall be based on reliable comprehensive assessments, conducted routinely and in response to significant changes in the resident's life.

53. GRC shall provide protections, planning, services, supports, and treatments to residents only after the resident (to the greatest extent practicable) and the resident's guardian (if there is one) have provided informed consent confirmed in writing following disclosure and understanding of all benefits and risks and appropriate strategies, if any, to mitigate the risks.

54. GRC shall ensure effective transparency, communication and information-sharing between and among professional and direct care staff regarding residents' physical and behavioral health status, and residents' integrated programs and supports, on a routine and an as-needed basis in response to potential changes in status or condition.

55. GRC shall ensure effective transparency, communication, and information-sharing between and among a resident's IDT members, the resident, and the resident's family and guardian, regarding changes in treatment or status.

56. Unless otherwise expressly indicated, the responsible IDT member(s) for each program or support included in the ISP shall review and analyze the data and other information

necessary to assess the resident's physical and behavioral health status progress and the effectiveness of current interventions. This review and analysis shall occur at least monthly, and more often if the needs of the resident dictate. If expected progress has occurred, the IDT will identify strategies to build on such success. If there is a lack of expected progress, and/or a significant change in the resident's status has occurred, then the IDT shall meet to determine if the ISP should be modified, and shall modify the ISP as appropriate.

a. These reviews shall include reviewing data for any emerging risks. When emerging risks are identified, an At-Risk Plan shall be developed and implemented consistent with the provisions of Section IV.C.iii.

57. The State shall implement and use a procedure for resolution of disagreement between IDT members. This procedure shall include mechanisms to obtain external clinical consultations when appropriate.

a. All members of the IDT shall have the ability to initiate this resolution process regarding a resident served by the IDT.

b. No IDT member shall discourage use of this resolution process.

c. No IDT member shall be retaliated against for initiating or participating in this resolution process.

C. Clinical Care

58. GRC residents shall receive quality integrated preventative, chronic, and acute clinical care and services, including psychiatric, psychological, medical, nursing, pharmaceutical, pain management, seizure management, and habilitation therapy services, consistent with current, generally accepted professional standards of care.

59. Assessments shall be performed on a regular basis and in response to developments or changes in a resident's medical, behavioral, or functional status to ensure the timely detection of and response to residents' needs.

60. Diagnoses shall be clinically appropriate and consistent with the current Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

61. Treatments, supports, and interventions shall be timely and clinically appropriate based upon assessments and diagnoses. Clinicians shall conduct direct assessments consistent with current, generally accepted professional standards of care.

62. Clinical indicators of the effectiveness of treatments, supports, and interventions shall be determined in a clinically justified manner.

63. Clinical indicators of the effectiveness of treatments, supports, and interventions shall be effectively monitored.

64. Treatments, supports, and interventions shall be modified in response to the results of monitoring of clinical indicators.

65. GRC shall routinely collect, analyze, and act on valid and reliable data sufficient to ensure that the clinical care and services provided to GRC residents are consistent with current, generally accepted professional standards and implemented in an appropriate manner. Where such data show that clinical care and services, or their implementation, do not meet such standards, GRC clinical staff shall appropriately address the deficiency.

66. 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, analyzed, and utilized for GRC's quality improvement, pursuant to the processes set forth in Section IV.K.

67. Whenever problems are identified under the processes set forth in Paragraphs 65-66, GRC shall develop and implement plans to remediate the problems.

i. Supervision & Management of Clinical Services

68. The State shall ensure appropriate and competent supervision and management of clinical services by individuals with appropriate training and credentials.

69. GRC shall employ adequate numbers of clinical staff with appropriate training, credentials, competence, and expertise to provide the clinical services identified herein to a reasonable caseload of individuals with IDD consistent with generally accepted professional standards of care.

70. Clinical staff shall demonstrate maintenance of the requisite training, credentials, competence, and expertise throughout their period of employment.

71. The State shall regularly have board-certified clinicians, who do not have a professional or personal relationship with GRC clinicians or GRC Leadership, assess the adequacy of clinical services in the clinical areas for which they are board-certified, including, at a minimum, all medical staff. The assessment findings shall be written and shared with the clinician whose work was the subject of the review and the clinician's supervisor. Action steps to remediate identified issues shall be developed as necessary. Where action steps are not deemed necessary, the rationale shall be provided in writing. The findings, action steps, and rationale for not taking action steps shall be provided to and reviewed by the Superintendent and HHS Central Office as part of a comprehensive oversight process.

72. Clinical services shall engage in and be subject to Quality Management, to include appropriate peer review and appropriate mortality reviews.

    a. For every death of a Glenwood resident, an appropriate interdisciplinary mortality review will be conducted by a Mortality Review Committee, that includes Glenwood and HHS Central Office staff with appropriate expertise, knowledge,

and skills in conducting mortality reviews, and includes at least one member not otherwise employed or compensated by the HHS.

b. No primary care provider (PCP) shall be responsible for conducting a mortality review for an individual under that PCP's care during the relevant review period.

c. The Mortality Review Committee shall continuously collect and analyze mortality data, including data from external mortality reviews, to identify trends, patterns, and problems, and shall develop and implement quality improvement initiatives to remedy such trends, patterns, and problems to the fullest extent practicable.

d. The State shall ensure that:

i. Mortality Review Committee recommendations are documented and implemented, or a reasonable and supported explanation provided;

ii. Implementation of Mortality Review Committee recommendations is effective, or, if not effective, the implementation or recommendation, as warranted, is adjusted to advance the recommendation's intended outcome.

ii. Medical Services

73. The GRC Medical Director shall be a board-certified individual with successful experience in providing medical services to individuals with IDD and in supervising medical providers. The Medical Director shall have training or experience in quality management and research, or shall undergo such training within the first six months of employment.

74. Clinical staff shall timely and appropriately respond when residents experience changes in condition, including, when appropriate, prompt coordinated transfer to a higher level of care and coordinated return from a higher level of care.

75. GRC shall effectively use specialist consultations with staff, contract staff, or external consultants. This includes ensuring:

a. There is timely referral to appropriate and competent specialists;

b. The consultant is provided with information necessary to obtaining the consultant's informed assessment and recommendations about the resident;

c. Question(s) for the specialist are identified in advance of the consultation and communicated in writing;

d. GRC shall make reasonable efforts to ensure that appropriate responses to the questions are received following the consultation;

e. The consultation report is reviewed by the resident's PCP, as well as all other IDT members whose review would be appropriate under the circumstances and provided to the resident and/or the resident's guardian; and

f. The PCP, in consultation with appropriate IDT members, documents the basis for agreeing or disagreeing with the consultant's recommendations, the actions taken in response (including obtaining a second opinion), or the basis for taking no action.

76. GRC shall ensure timely and appropriate use and review of laboratory and diagnostic testing and testing results. This includes ensuring:

    a. Timely initiation of laboratory and diagnostic testing;

    b. Urgent notification of critical results;

    c. Review of all results by the resident's PCP, along with other IDT members as appropriate under the circumstances, and identification, development, and timely implementation of either a plan in response to abnormal results, or the basis for taking no action in response. The review, actions taken in response, or the basis for taking no action in response, shall be documented in the resident's medical file.

iii. Residents at Risk of Harm

77. The State shall implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable the State to adequately address harms and risks of harm to GRC residents.

78. After a resident is identified as at risk of harm, and in response to changes in an at-risk individual's condition as measured by established at-risk criteria, the resident will receive a timely interdisciplinary assessment of services and supports. This assessment process shall begin as soon as possible after a resident is identified as at risk of harm.

79. GRC shall identify risk-relevant thresholds and shall create appropriate facility protocols to respond to the risks. Those protocols and the interdisciplinary assessment of the individual will then be used by the interdisciplinary team to establish an appropriate individualized plan of care (At-Risk Plan). Both protocols and At-Risk Plans will include preventative interventions to minimize the condition of risk. After development of the thresholds and protocols, GRC shall create and implement At-Risk Plans of care in response to risks within 14 days of identification of the risk.

80. GRC shall develop effective methods of gathering and incorporating feedback from direct care and clinical care staff so that input is received and the interdisciplinary team remains able to timely respond. Direct care staff shall provide input, receive competency-based training, and shall monitor and report on the progress of, implementation of the At-Risk Plan.

81. GRC shall revise the At-Risk Plan, its implementation, or both, as warranted based on the at-risk resident's condition. The At-Risk Plan shall be reviewed and revised as warranted as part of the annual ISP process.

iv. Nursing Services

82. Nurses shall perform comprehensive nursing assessments routinely and as necessitated by a change in resident condition; identify health care problems; communicate with PCPs regarding health care problems and changes in health status; plan, implement, and evaluate the effectiveness of nursing care; and keep appropriate records of residents' health care status and plan of care, sufficient to readily identify changes in status and residents' response to treatment.

83. Nurses shall routinely assess residents for symptoms of pain, in response to changes in client condition when one would reasonably expect pain to result, and when other relevant staff communicate the suspicion of resident pain in the event the resident is not able to verbalize pain. The nurse shall attend to and treat the residents' pain in a timely manner, communicating with the PCP or on-call provider as needed.

84. Nurses shall, in coordination with other relevant staff, conduct a routine review of each resident's health care status and the effectiveness of related interventions, and more frequent reviews when a resident's health care status so requires, and take appropriate action in response to findings of the review and assessment.

85. Nurses shall, in coordination with other relevant staff, ensure residents are appropriately protected from infection. GRC shall establish and maintain an effective infection control committee, and ensure ongoing access to and consultation with experts in infection control and infectious diseases.

86. Nurses shall, in coordination with other relevant staff, ensure residents maintain maximum skin integrity.

87. Nurses shall, in coordination with other relevant staff, ensure residents receive their medications and treatments as prescribed.

v. Psychiatric Services

88. No GRC resident shall receive psychiatric medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board eligible or board-certified psychiatrist.

89. Psychiatric medications shall not be used in the absence of a behavioral treatment program, for the convenience of staff, or as a punishment, and shall be integrated with behavioral and other interventions through combined assessment and case formulation.

90. Before the non-emergency administration of psychotropic medication, and to the extent possible before the emergency administration of a chemical restraint, the psychiatrist and PCP, and others as appropriate, shall determine whether the risks of medication outweigh the benefits of medication and whether reasonable alternative treatment strategies are likely to be less effective or more dangerous than the medication.

91. For any resident receiving psychological and psychiatric services, the resident's IDT shall determine the least intrusive and most positive interventions to treat the resident's behavioral or psychiatric condition(s), and whether the resident will best be served primarily through behavior supports, individual or group counseling, education, adaptations to the environment, adjustments to the daily routine, pharmacology, or other interventions, in combination or alone. If the IDT concludes that the resident is best served through the use of psychiatric medication, the IDT must also specify non-pharmacological treatment, interventions, or supports in order to minimize the need for psychotropic medication as much as possible.

vi. Medication

92. GRC residents shall not be prescribed a medication unless there is an appropriate diagnosis justifying prescription of the medication.

93. Upon the prescription of a new medication:

    a. Potential interactions, side effects, allergies, adverse reactions will be reviewed by nursing staff or the medical provider.

    b. There shall be a documented review by a pharmacist (on the same business day, or by the next business day for new medications prescribed on the weekend), with recommendations when clinically indicated, of:

        i. Potential interactions with the resident's current medications;

        ii. Potential consequences given the resident's diagnoses and active medical problems;

        iii. Potential side effects;

        iv. Potential allergies;

        v. Current clinically relevant laboratory and other diagnostic testing results;

        vi. The need for additional laboratory and other diagnostic testing or other measures in connection with risks associated with use of the medication;

        vii. The potential to use alternative medications to minimize the occurrence and/or severity of side effects, or interactions with the resident's current medications or active medical problems, or the severity of such interactions with underlying conditions or active medical problems; and

    c. The need to consider dose adjustments if the prescribed dosage, or the cumulative dosage of the resident's entire medication regimen, is not consistent with State policy or generally accepted standards of care. The prescriber and the resident's PCP, as well as any other clinicians as appropriate, shall document review of the pharmacist's review; agreement or disagreement with the pharmacist's

recommendations, if any; the clinically justified basis for agreeing or disagreeing; and any changes in the prescription made in light of the pharmacist's review.

94. A pharmacist shall conduct Quarterly Drug Regimen reviews to identify abnormal or sub-therapeutic values and consider, note, and make recommendations to address, as appropriate, residents' laboratory results.

95. Prescribing practitioners, the pharmacist, and other physicians as appropriate shall collaborate in monitoring the use of medications to ensure clinical justifications and attention to associated risks. Prescribing practitioners shall document consideration of the pharmacist's recommendations and, for any recommendations not followed, shall document a clinical justification for why the recommendation is not being followed.

96. GRC shall implement a review system to monitor at least monthly the prescriptions of any first-generation antipsychotic medication, two or more psychiatric or neurological medications from the same general class (e.g., two antipsychotics) to the same resident, and the prescription of three or more psychiatric or neurological medications, regardless of class, to the same resident, to ensure that the use of such medications is clinically justified and that medications that are not clinically justified are eliminated. Monitoring shall be conducted by the Pharmacy and Therapeutics Committee, which shall include: the Medical Director; the Pharmacy Director; one PCP, if available, who is not the resident's treating physician; and other appropriate staff.

    a. Before a prescriber initiates treatment with a medication that would render a person subject to the monthly review described above (e.g., by prescribing a third psychiatric or neurological medication to a resident already prescribed two such medications), the person's IDT shall meet to consider the recommended medication and alternative nonpharmacological interventions, and shall document the rationale for the selected decision.

97. GRC residents receiving psychiatric or neurologic medications shall be monitored on at least a quarterly basis, and more frequently as clinically indicated, for medication side effects using validated rating instruments such as MOSES or DISCUS. The PCP and neurologist and/or psychiatrist as appropriate shall document review of the quarterly monitoring, including a plan to respond to abnormal findings or a clinically justified basis for not acting upon abnormal findings.

98. GRC shall regularly perform drug utilization evaluations in accordance with current, generally accepted professional standards of care.

99. GRC shall identify all medications prescribed for dual purposes, and for all medications so identified, ensure ongoing collaboration between relevant disciplines (e.g. psychiatry, neurology) regarding their continued use. Collaboration among necessary disciplines regarding use of the dual-use medication shall be coordinated by the resident's PCP. To the extent a resident's existing medication is subsequently determined to be for dual purposes,

even if it was not intended to be used for dual purposes when initially prescribed, this provision shall apply to its ongoing use.

100. Within three months of the Effective Date of this agreement, GRC shall conduct an external clinical review to verify the continuing propriety of the resident's prescriptions with respect to every resident who falls into the following categories, and shall then implement the recommendations arising from that review:

a. Residents who are prescribed Dilantin (phenytoin sodium), valproic acid, Thorazine (chlorpromazine), Loxatine (loxapine), fluephenazine, perphenazine, haloperidol, primidone, or phenobarbital;

b. Residents who are prescribed oral bisphosphonates (e.g., Fosamax) and:

i. Have esophageal motility disorders;

ii. Have GERD;

iii. Are at increased risk of aspiration; or

iv. Who are unable to stand or sit upright for at least 30 minutes after dose administration.

101. GRC shall ensure the timely identification, reporting, and completion of appropriate remedial action regarding all significant or unexpected adverse drug reactions.

102. GRC shall administer medications safely. This includes:

a. Ensuring the safe dispensation and administration of medications by appropriately trained and competent staff consistent with current generally accepted professional standards of care;

b. Ensuring the supervision and training necessary to minimize medication variances;

c. 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.

vii. Psychological Services

103. GRC shall review its psychological assessment protocols to ensure they are consistent with current, generally accepted professional standards of care, and revise them as warranted. The assessment protocols shall:

a. Include protocols for a functional behavioral assessment to identify target behaviors and the function of each target behavior;

b. Identify medical, psychiatric, environmental, diagnostic, or other reasons for target behaviors; and

c. Identify other psychological and mental health needs that may require intervention, including history of trauma.

104. In conducting the review of psychological assessment protocols set forth in Paragraph 103, GRC shall ensure that its suicide assessment protocol is consistent with current, generally accepted professional standards of care and shall revise it as needed. GRC shall ensure that staff members responsible for administering suicide assessments have training in assessing suicide risk for people with IDD and are demonstrably competent to assess such risk.

105. Within the later of 12 months from the Effective Date or one month from the resident's admission, and thereafter as often as needed, the State shall ensure that a GRC Behavioral Health Professional completes a psychological assessment of each GRC resident, which shall include a functional behavioral assessment for at least those residents with behavioral needs, pursuant to GRC's psychological assessment protocols set forth in Paragraph 103. Those residents needing psychological services other than BSPs shall receive such services in a documented manner enabling progress to be measured in a reliable manner to determine the effectiveness of treatment. Absent extraordinary circumstances (i.e. shortage of available providers for a service that is not typically needed by the Target Population), those residents shall begin receiving such services within four weeks of the psychological assessment. Documentation shall reflect efforts to initiate recommended services and that barriers to initiating services are addressed.

106. Psychological assessments shall be based on current, accurate, and complete clinical and behavioral data.

107. By one month from the date of the resident's assessment, GRC shall develop an individual BSP, consistent with the resident's ISP and with current, generally accepted professional standards and taking into account relevant factors such as history of trauma and other mental health needs, for each resident who is exhibiting behaviors that constitute a risk to the health or safety of the resident or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By 14 days from obtaining necessary approvals and consents, GRC shall implement the BSP.

108. Each resident with behavioral health needs as determined by the assessment process set forth in Paragraphs 103-106 shall be assigned a Behavioral Health Professional whose caseload and expertise are sufficient to meet the resident's behavioral health needs. Any resident with severe behavioral needs (including any resident who engages in intense or frequent self-injury, aggression, pica, or property destruction) shall be assigned a Behavioral Health Professional who is a Board Certified Behavioral Analyst.

109. Each Behavioral Health Professional shall be responsible for a caseload of residents with needs within the Behavioral Health Professional's scope of practice and experience. The size of each caseload and the level and type of Behavioral Health Professional expertise shall be commensurate with the severity of needs of residents on that caseload.

110. GRC shall retain a sufficient number of Behavioral Health Professionals who are Board Certified Behavioral Analysts to meet the behavioral health needs of GRC's residents. The State may utilize recruitment incentives, including on-the-job training to obtain BCBA certification, with appropriate supervision, consistent with generally accepted professional standards.

111. GRC shall provide residents requiring a BSP with individualized services and comprehensive programs developed by a Behavioral Health Professional that are trauma-informed; consider the mental health needs of the residents; promote the growth, development, and independence of all residents; minimize regression and loss of skills; and ensure reasonable safety, security, and freedom from undue use of restraint.

112. GRC shall employ a qualified Director of Psychology who is responsible for maintaining a consistent level of psychological care throughout the GRC. The Director of Psychology shall be a Board Certified Behavioral Analyst with a minimum of five years of experience working with adults with IDD with serious behavioral needs and co-occurring mental health diagnoses, and with demonstrated success managing staff in the provision of behavioral health services.

113. GRC shall conduct reliable reviews to assess the quality of behavioral assessments and BSPs of each Behavioral Health Professional at least semi-annually. The reviews shall be conducted by Behavioral Health Professionals who did not prepare the behavioral assessments and BSPs under review. Each resident's behavioral assessment and BSP shall be reviewed at least every two years, and each resident with severe behavioral needs (including any resident who engages in intense or frequent self-injury, aggression, pica, or property destruction) shall have their behavioral assessment and BSP reviewed through this process at least every six months. The findings of the peer-based reviews shall be utilized to improve behavioral assessments, BSPs, and behavioral programming.

114. GRC shall develop and implement standard procedures for collection of valid and reliable data, including methods to collect data regarding instances of behavior as it occurs and to monitor and review each resident's progress in meeting the goals of the resident's BSP, consistent with generally accepted standards of care. At least monthly, Behavioral Health Professionals shall review data collected pursuant to these procedures to assess progress,

and shall re-evaluate and promptly revise assessments and interventions if target behaviors do not improve or have substantially changed.

115. Documentation regarding the BSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the frequency and variability of behavioral incidents and the effectiveness of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.

116. BSPs at GRC shall be written so that they can be understood and implemented by direct care staff.

117. BSPs at GRC shall be implemented by all staff as written, and significant deviations from residents' BSPs shall be reported to the resident's Behavioral Health Professional and GRC administration, and appropriate action shall be taken.

118. All Behavioral Health Professionals and psychology assistants shall successfully complete annual competency-based training in providing trauma-informed behavioral services to individuals who have IDD and challenging behaviors.

119. All staff responsible for training and monitoring implementation of behavioral programming shall be demonstrably competent to implement behavioral programming and shall be monitored by Behavioral Health Professionals.

120. All direct contact staff and their supervisors shall successfully complete competency-based training on severe behavioral needs, the co-occurrence of mental health needs and IDD, and the principles of applied behavioral analysis at least annually. GRC direct contact staff and their supervisors shall successfully complete competency-based training on the overall purpose and objectives of the specific BSPs for which they are responsible and the implementation of those plans, annually and every time a new BSP is written, a BSP is changed, or the staff member becomes responsible for the support of a new individual.

121. GRC shall regularly monitor the implementation of BSPs, including assessing staff's knowledge through assessments and observations that determine the staff person's knowledge and skills about the BSP in a context similar to one in which such knowledge or skills would be required.

122. Behavioral Health Professionals shall assess the mental health needs of GRC residents pursuant to the protocols in Paragraphs 103-106 at least annually, but as often as needed. GRC shall ensure that needed counseling and other therapeutic interventions are available and provided to residents.

D. Restrictive Interventions

123. GRC shall provide residents with a safe and humane environment and ensure they are protected from harm, including the unnecessary use of restrictive interventions, consistent with current, generally accepted professional standards of care.

124. All residents' restrictive interventions and alternative positive interventions shall be discussed at the monthly integrated reviews, to ensure that a plan to implement the alternative interventions is being implemented, and to update or revise the plan to implement the alternative interventions as warranted.

125. GRC's Psychology Department shall routinely collect, analyze, and act on valid and reliable data sufficient to ensure that the use of restrictive procedures at GRC is consistent with current, generally accepted professional standards and implemented in an appropriate manner.

126. 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.

127. Whenever problems are identified under the processes set forth in Paragraphs 125-126, GRC shall develop and implement plans to remediate the problems.

i. Restraints

128. Within six months of the Effective Date, the State shall review GRC's restraint policies and practices and conform them to the requirements of this Section. The policies shall identify restraints that may be used and the criteria for their use, and shall categorize permitted restraints by level of restriction.

129. Restraints shall only be used:

a. when the resident poses an immediate and serious risk of harm to him- or herself or others and if the restraint is the least restrictive intervention necessary;

b. as a last resort and after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner;

c. in the least restrictive form and duration of restraint necessary and appropriate for the circumstances; and

d. in accordance with applicable written policies, procedures, and plans governing restraint use.

130. Restraints shall not be used for punishment, for convenience of staff, or in the absence of, or as an alternative to, treatment.

131. Under no circumstances shall prone restraints be used.

132. Restraints shall be terminated as soon as the resident is no longer a danger to him/herself or others.

133. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.

134. Within 30 minutes after a resident is placed in restraint, a physician, physician's assistant, nurse practitioner, or a Registered Nurse with training in application and assessment of restraint, shall conduct and document a face-to-face examination of the resident, including a check for restraint-related injury.

135. Staff who are competent to apply and assess the use of the restraint, as demonstrated by successful annual certification in the restraint's use, and who are not involved in administering the restraint, shall check the resident as soon as possible but, in the exceptional circumstances where restraints exceed 15 minutes, no later than 15 minutes from the start of the restraint, to review the application and consequence of restraint.

136. A registered nurse shall monitor and document vital signs and mental status of a resident in restraints at least every 30 minutes from the start of the restraint, and at the restraint's conclusion, except for medical restraint pursuant to a physician's order. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.

137. Every resident in physical or medical mechanical restraint shall receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan, consistent with generally accepted professional standards of care; and shall be under continuous one-to-one supervision.

138. Mechanical restraints shall not be used other than as prescribed for necessary medical care.

139. Every use of restraint shall be documented consistent with generally accepted professional standards of care.

140. After three instances of restraint of a resident in 30 days or an increasing trend in restraint data over the course of three months of a resident, the IDT shall examine and refine that resident's behavioral programming using data-based decision-making. In conducting this review, the IDT shall:

a. review the individual's adaptive skills and biological, medical, psychosocial factors;

b. review possibly contributing environmental conditions;

c. review or perform assessments of the behavior provoking restraints;

d. develop (if one does not exist) or revise (if necessary) and implement a BSP based on that individual's particular strengths, specifying the objectively defined behavior to be treated that leads to the use of the restraint; alternative functionally equivalent, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in a separate safety plan, the necessity for which shall be reassessed at least every 30 days;

e. ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and

f. as necessary, assess and revise the BSP.

141. Within three months of execution of the agreement, before working with residents, all GRC staff responsible for applying restraints shall have successfully completed competency-based training on applicable BSPs and safety plans; approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any resident in restraint.

142. GRC Behavioral Health Professionals shall be involved in the selection of any crisis management system used by GRC. All Behavioral Health Professionals at GRC shall have a high degree of expertise with the crisis management system. Training shall be conducted by certified trainers.

143. Within six months after the Effective Date, for each GRC resident restrained from January 1, 2020 until the Effective Date, the resident's IDT shall review the resident's BSP and ensure that it contains the objectively defined behavior to be treated that leads to use of the restraint and alternative, positive adaptive behaviors to be taught to the resident to replace the behavior that initiates the use of restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint.

ii. Seclusion

144. By six months from the Effective Date, GRC shall eliminate, to the extent practicable, the use of seclusion.

145. GRC shall ensure that to the extent seclusion is used, it is used only if the resident poses an immediate and serious risk of harm to him/herself or others; only as a last resort and after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; only for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and only in accordance with applicable written policies, procedures, and plans governing seclusion.

146. Seclusion shall not be implemented without a recommendation by the resident's assigned Behavioral Health Professional and inclusion in the resident's BSP, following a thorough assessment reliably identifying the causes and functions of, and precursors to, the behaviors leading to seclusion and a documented exhaustion of less restrictive interventions. Seclusion shall not be implemented for any resident without approval by the Human Rights Committee.

147. Seclusion shall not be implemented unless the resident has a BSP, developed by the resident's Behavioral Health Professional and implemented by the resident's IDT, identifying the specific criteria for use and discontinuation of seclusion. Such a plan shall set forth specific steps to be taken by the resident's IDT and Behavioral Health Professional to address the behaviors that led to the resident's seclusion and to minimize and ultimately eliminate its use. Use of seclusion, and the corresponding behavioral interventions, shall be subject to the processes described in Paragraph 140.

148. Seclusion shall not be implemented until the resident's IDT, GRC's Human Rights Committee, and guardian have approved the use of the seclusion following a thorough discussion of seclusion's likely consequences. Within seven days of the initiation of use of seclusion for a GRC resident, HHS Central Office shall review the use of seclusion and ensure that sufficient protections are in place. Seclusion shall not be approved in a resident's BSP for a period of more than 30 days at a time without reapproval by the resident's Behavioral Health Professional, the Director of Psychology, the resident's IDT, GRC's Human Rights Committee, the resident's guardian, and HHS Central Office.

149. No resident experiencing seclusion shall be denied access to typical items that a resident at GRC has access to, absent a well-defined treatment reason and approval from the resident's Behavioral Health Professional, guardian, and IDT; the Director of Psychology; and GRC's Human Rights Committee. If a resident is denied access to such items, GRC shall ensure that the resident's BSP provides a plan to return access and that such a plan is implemented.

iii. Other Restrictive Interventions

150. GRC shall ensure that other restrictive interventions, such as heightened levels of supervision, are used only as needed, in conjunction with positive behavioral interventions that address functionally equivalent replacement behaviors, and after a range of less restrictive measures have been exhausted. GRC shall ensure that any restrictive interventions are used only consistent with current, generally accepted professional standards of care.

151. In the event of an imminent safety risk, brief restrictive interventions may be used for up to 15 minutes, and may continue for up to 12 hours with the advance approval of the Administrator on Duty.

152. Unless there is an imminent safety risk, no restrictive intervention shall be implemented until:

a. The resident's IDT, GRC's Human Rights Committee, the Director of Psychology, and the resident's guardian have approved the use of the restrictive intervention following a thorough discussion of likely consequences; and

b. When the Director of Psychology is absent, an appropriate acting Director of Psychology may review and determine whether to approve on the Director's behalf. The Director of Psychology shall subsequently review and determine whether to approve within 5 business days of their return.

c. The resident has a BSP, developed by the resident's Behavioral Health Professional and implemented by the resident's IDT, identifying the specific criteria for use and discontinuation of the restrictive intervention. The BSP shall be developed from a thorough functional behavioral assessment that reliably identifies the causes and functions of, and precursors to, the behaviors leading to restrictive interventions and a documented exhaustion of less restriction alternatives. The BSP shall set forth specific steps to be taken by the resident's IDT and Behavioral Health Professional to address the behaviors that led to the resident's restrictive interventions and to minimize and ultimately eliminate the intervention's use. Use of restrictive interventions, and the BSP to address the behaviors leading to restrictive interventions, shall be subject to the processes described in Paragraph 140.

153. After three instances of a restrictive intervention of a resident in 30 days or an increasing trend in restrictive intervention data over the course of three months of a resident, the IDT shall examine and refine the resident's behavioral programming as set forth in Paragraph 140.

154. Restrictive interventions shall not be approved in a resident's BSP for a period of more than 90 days at a time without reapproval by the resident's Behavioral Health Professional, the Director of Psychology, the resident's IDT, GRC's Human Rights Committee, and the resident's guardian.

E. Engagement and Skill Acquisition Programs

155. GRC shall provide habilitation, vocational training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care.

156. GRC shall provide residents with adequate habilitation services, including individualized training, education, and vocational and skill acquisition programs developed and implemented by IDTs to promote the growth, development, integration, and independence of all residents, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.

157. Residents at GRC shall be provided meaningful and appropriate vocational, day, and skill-acquisition programming, including programming outside their homes, on a daily basis, unless the resident refuses to participate, has restrictions on such programming in his or her ISP or BSP, or it is contraindicated by community health restrictions. Residents shall

also be provided integrated community-based activities unless the resident refuses to participate or has restrictions on such programming in his or her ISP or BSP. If the resident has restrictions on such programming or community-based activities resulting from the resident's behavior, the resident's Behavioral Health Professional shall develop a plan to minimize the existence of those behavioral barriers and the resulting restrictions.

158. GRC shall conduct annual assessments, with quarterly reviews, of residents' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities. For residents with behavioral barriers to community integration, the resident's Behavioral Health Professional shall assist with developing a Community Integration Plan to minimize the existence of behavioral barriers.

159. GRC shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each resident's needs. Such programs shall:

a. Be current, individualized, and integrated with other supports and services;

b. Incorporate the person's preferences and strengths;

c. Specify individualized, observable and/or measurable goals/objectives, the strategies to be employed, and the necessary supports to attain identified outcomes, in sufficient detail to enable staff to appropriately implement the programs;

d. Include interventions, strategies and supports that: (1) effectively address the resident's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the resident's needs;

e. Include to the degree practicable training opportunities in community settings; and

f. Identify the data to be collected and/or documentation to be maintained, and the frequency of data collection, in order to permit the objective analysis of the resident's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.

160. The State shall ensure that all GRC direct care staff have successfully completed competency-based training on the implementation of the habilitation programs, including training, education, and skill acquisition programs, of the residents they work with, annually and every time a new habilitation program is implemented, a habilitation program is changed, or the staff member becomes responsible for the support of a new individual. This training shall include the purpose and objective of the particular habilitation program so that the staff implementing the program understand what the program is intended to achieve. Up to one-quarter of the staff assigned to work with a particular resident at any point in time may receive abbreviated training or information in lieu of competency-based training if

necessary to meet basic staffing requirements, as approved by the Superintendent, because they are pulled staff.

161. GRC shall routinely collect, analyze, and act on valid and reliable data sufficient 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.

162. 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.

163. Whenever problems are identified under the processes set forth in Paragraphs 161-162, GRC shall develop and implement plans to remediate the problems.

F. Recordkeeping

164. GRC shall maintain complete and accurate records.

165. GRC shall ensure pertinent information about assessment, treatment, and diagnosis, including information justifying decisions not to treat or diagnose, is accurately and timely documented within the resident's integrated electronic health record.

166. GRC shall maintain and produce records in a manner that clearly demonstrates:

a. The time and date when a particular record or entry was created or entered;

b. The identity and job title of the person creating or entering the record or entry;

c. The time and date to which the record or entry pertains;

d. Whether the record or entry was created or entered timely according to State policy; and

e. If a record or entry is subsequently changed:

i. The time and date the change is made;

ii. The identity and job title of the person making the change;

iii. The reason for the change;

iv. The nature of the change; and

v. A version of the record or entry as it existed before it was changed.

G. Incident Management

167. GRC shall implement and maintain policies, procedures and practices that include a commitment that GRC shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.

168. GRC shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:

a. Staff to immediately report serious incidents, including death, abuse, neglect, exploitation, and serious injury, as follows:

i. for deaths, abuse, neglect, and exploitation, report should be made to the Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Iowa law; and

ii. for serious injuries and other serious incidents, report should be made to the Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.

b. Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Center staff take immediate and appropriate action to protect the residents involved, including removing alleged perpetrators, if any, from direct contact with residents pending either the investigation's outcome, or where warranted based on a preliminary assessment as set out at Paragraphs 171-174.

c. Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.

d. Notification of all staff when commencing employment and at least yearly thereafter of their obligation to report abuse, neglect, or exploitation. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at Glenwood evidencing their recognition of their reporting obligations. Glenwood shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.

e. Mechanisms to educate and support residents and primary correspondents (i.e., a guardian or another person, identified by the IDT, who has significant and ongoing involvement with a resident who lacks the ability to provide legally adequate consent and who does not have a guardian) to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.

f. Posting in each living unit and day program site a brief and easily understood statement of residents' rights, including information about how to exercise such rights and how to report violations of such rights.

g. Mechanisms for residents, visitors, and other persons to report anonymously allegations of abuse, neglect, exploitation, other possible violations of residents' rights, or other unusual incidents.

h. Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.

i. Mechanisms to ensure that any staff person, resident, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including reprimands, discipline, harassment, threats or censure. A staff person who reports an incident but does not do so in an appropriate or timely manner may be subject to appropriate counseling or discipline.

j. Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.

169. The State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving residents. Such policies and procedures shall:

a. Provide for the conduct of all such investigations by qualified investigators who have training in working with people with IDD, and who are not within the direct line of supervision of the alleged perpetrator, with assistance, where appropriate, from an appropriate clinician who is not within the direct line of supervision of the alleged perpetrator.

b. Require the cooperation of Glenwood staff with outside entities that are conducting investigations of abuse, neglect, and exploitation within the bounds of their existing legal authority.

c. Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.

d. Provide for the safeguarding of evidence.

e. Require that an investigation of each serious incident commence within 24 hours or sooner, if necessary, of the incident being reported.

f. Require that an investigation of each serious incident be completed within 10 calendar days of the incident being reported unless, where extraordinary circumstances exist (i.e. critical evidence is temporarily unavailable due to reasons beyond the investigator's control), the Superintendent or Chief of the Department of Inspections & Appeals Bureau of Special Services and Adult Services, as applicable, grants a written extension. The need for an extension of time frame for investigation shall be reported to HHS Central Office. HHS Central Office shall track and trend the number of extensions requested and take appropriate remedial action.

g. Require that an investigation of each serious incident result in written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format:

i. each serious incident or allegation of wrongdoing;

ii. the name(s) of all witnesses;

iii. the name(s) of all alleged victims and perpetrators;

iv. the names of all persons interviewed during the investigation;

v. for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;

vi. all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;

vii. the investigator's findings; and

viii. the investigator's reasons for his/her conclusions.

h. Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.

i. Require that Glenwood shall also prepare a written report, subject to the provisions of subparagraph h, for each unusual incident that does not meet the criteria for serious incident.

j. Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, Glenwood shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.

k. Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.

170. For all sentinel events (unexpected events involving death or serious injury), Glenwood shall conduct an effective root cause analysis of the incident. Glenwood shall ensure the implementation of all recommendations identified by such an analysis or, in the alternative,

document a substantiated and compelling justification for not implementing a recommendation. Glenwood shall track the effectiveness of such recommendations and, if such recommendations do not have their anticipated or intended effect, shall make adjustments to such recommendations or their implementation.

171. Glenwood may conduct a preliminary assessment of an allegation of abuse, neglect, or exploitation, solely for purposes of determining staff assignments, where:

a. Within the previous six months, the resident has made four or more allegations of abuse, neglect, or exploitation, all of which were determined to be unfounded (i.e. lacking any evidence that the action alleged to be abuse, neglect, or exploitation occurred);

b. The allegation fits the characteristics of the resident's previous allegations that were determined to be unfounded, and was made within 30 days of such a previous allegation;

c. An initial assessment shows no evidence other than the resident's allegation that the alleged conduct occurred; and

d. The resident has a BSP or other support plan that includes:

i. Identification of what may be maintaining the behavior of making unfounded allegations,

ii. Methodology for accurately counting the frequency of unfounded allegations,

iii. Establishment of relevant individualized prevention protocols to reduce future likelihood of the behavior occurring (e.g., teaching of alternative behaviors, increasing the number and types of activities, providing access to preferred staff),

iv. Regular review of the effectiveness of the protocols,

v. Modifications to the protocols if determined to not be effective,

vi. Explicit language that allegations are not prohibited or restricted, and

vii. A requirement that the resident receive documented training in rights and responsibilities.

172. Where a preliminary assessment is permitted, Glenwood's Superintendent or designee must immediately remove the alleged perpetrator(s) from contact with residents:

a. until the full investigation is completed; or

b. until, after reviewing the preliminary assessment and any other relevant information, Central Office determines that the risk to residents from contact with the alleged perpetrator(s) on the Center's grounds has been sufficiently

minimized, at which time the Superintendent may allow the alleged perpetrator(s) to have continued on-campus client contact, but only with ongoing supervision (i.e. frequent, intermittent visual observation over the course of a person's shift) of the alleged perpetrator(s) by a supervisor.

173. Pending the full investigation's completion, the alleged perpetrator(s) shall not have off-grounds contact with residents.

174. The preliminary assessment shall:

a. Not conflict or interfere with the concurrent full investigation conducted by Glenwood or State investigators;

b. Focus exclusively on determining the appropriate action to take regarding the work duty assignment of the alleged perpetrator(s);

c. Where the preliminary assessment recommends allowing the alleged perpetrator to work in a resident contact position, provide the rationale for doing so; and

d. Require the prior review and approval of the Superintendent or the Administrator On Duty.

175. Glenwood shall track unusual incidents and investigation results and analyze trends. Trends shall be tracked and analyzed by the categories of the type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.

176. Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any resident, the State shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation, in order to determine whether there is an indication that the staff person or volunteer would pose a risk of harm to residents. Volunteers for whom an investigation has not been completed shall be directly supervised by a State staff person when the volunteer is working directly with residents.

H. Individual Support Planning, Discharge Planning, and Transition from Resource Center

177. To ensure that individuals are served in the most integrated setting appropriate to their needs, the State shall develop and implement individual support planning, discharge planning, and transition processes at Glenwood, consistent with the terms of this Agreement and person-centered principles, within six months of the Effective Date.

178. All residents shall participate in their individual support planning, discharge planning, and transition planning to the maximum extent practicable, unless the individual chooses not to participate. All residents shall be provided the necessary support (including, but not

limited to, communication supports) to ensure that they have a meaningful role in the process.

i. Individual Support and Discharge Planning

179. An individual support plan (ISP) and discharge plan shall be prepared consistent with the terms of this Agreement for all residents within 30 days of admission or readmission to Glenwood, and shall be updated at least annually thereafter and more frequently as appropriate.

180. Discharge planning shall begin upon admission and shall continue throughout an individual's stay at Glenwood. It shall be based on the presumption that, with sufficient supports and services, all residents (including residents with complex behavioral and/or medical needs) can live in an integrated setting.

181. Individual support and discharge planning shall assist all residents in achieving outcomes that promote their growth, well-being, and independence, based on their individual strengths, needs, goals, and preferences, in the most integrated settings in all domains of their lives (such as community living, activities, employment, education, recreation, healthcare, and relationships).

182. The ISP and discharge plan shall integrate information from the behavior support plan; crisis plan; physical and nutritional management plan; clinical, medical, and nursing plans; skill acquisition programs; and other evaluations and assessments.

183. Each resident's ISP shall:

a. Be prepared by the IDT as defined above;

b. Be consistent with current, generally accepted professional standards of care and person-centered planning principles;

c. Be based on reliable comprehensive assessments, conducted routinely and in response to significant changes in the individual's life as specified in appropriate GRC protocols;

d. Identify individualized protections, services, supports, and treatments;

e. Identify the individual's strengths, preferences, needs, and desired outcomes;

f. Specify individualized, observable and/or measurable goals/objectives that align with and support the individual's wishes and preferences regarding developing skills, working, daily routines, and engagement with their community (including exploring community-based living options) and specify the services and supports and strategies needed to achieve each goal and objective, build on the individual's strengths and preferences, and overcome identified barriers to living in the most integrated setting appropriate;

g. Identify the amount, duration, and scope of all necessary services and supports, the methods for implementation, time frames for completion, and the staff responsible.

184. The IDT shall prepare a discharge plan for each resident. Each resident's discharge plan shall:

a. Be derived from the ISP and developed in accordance with the requirements for individual support planning set forth in Paragraph 183;

b. Identify the barriers preventing the individual from transitioning to the most integrated setting appropriate and a plan for addressing those barriers. For individuals with a history of readmission or crises, the factors that led to readmission or crises shall be identified and addressed;

c. Describe at a general level how each of the services and supports the individual currently receives could be provided in the community;

d. Describe any other supports and services that would allow the individual to transition successfully to a home in the community and avoid unnecessary readmission to an institutionalized setting, regardless of whether those services and supports are currently available;

e. Document the information provided to the individual and, where applicable, the Authorized Representative, regarding community options, including the date and method of communication, in accordance with Section H.i-ii;

185. If the IDT determines that necessary supports and services are unavailable in the community, it shall document the services and supports it believes are necessary for the individual; the basis for those determinations; and the efforts made to identify those services and supports (and/or reasonable alternatives) in the community.

186. In developing discharge plans, staff who are part of the IDT shall provide to individuals and, where applicable, their Authorized Representatives, specific options for community placements, services, and supports identified through the steps described above, and the opportunity to discuss and meaningfully consider those options.

187. Staff who are part of the IDT shall coordinate with community providers that offer the placements, services, and supports identified in the discharge plan, and give individuals and, where applicable, their Authorized Representative, opportunities to speak with those providers, visit community placements (including, where feasible, overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, regardless of whether the resident or, where applicable, their Authorized Representative, has made a choice regarding options;

188. Notwithstanding the State's rights under 42 C.F.R. § 483.440(b)(4), in the event that a resident or, where applicable, Authorized Representative opposes the IDT's proposed

options for placement in a more integrated setting after being provided the information and opportunities described in Section H.i-ii, the IDT shall:

a. Identify, and make reasonable efforts to resolve, the concerns of individuals and/or their Authorized Representatives prior to making a determination with regard to community placement;

b. Develop and implement individualized strategies to address concerns and objections to community placement; and

c. Document the steps taken to resolve the concerns of individuals and/or their Authorized Representatives and provide information about community placement.

ii. In-reach and Community Engagement

189. Upon admission, the State shall provide all residents and where applicable their Authorized Representatives, regular individualized, reliable information regarding community options in a way that enables them to make an informed decision about community transition. This shall include: holding individualized discussions, at least every six months, about a range of community options and alternatives, presented in a way the person can understand; addressing concerns about community living; and providing information about the benefits of community living options. In addition, the State shall provide all residents, and where applicable their Authorized Representatives, frequent (at least quarterly) individualized opportunities to visit community-based residential and vocational settings and to meet with other individuals with IDD who are living, working, and receiving services in integrated settings, with those individuals' families, and with community providers.

190. All staff responsible for directing, managing, or coordinating discharge planning and other informational activities regarding community options (including the Qualified Intellectual Disability Professional (QIDP); the Community Integration Manager (CIM); and social work, case management, and Money Follows the Person (MFP) staff) shall 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; present individuals and, where applicable, their Authorized Representatives with specific options for community placements, services, and supports; and, together with providers, answer individuals' and Authorized Representatives' questions about community living.

191. 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.

192. All residents shall be provided opportunities for engaging in community activities to the fullest extent feasible, consistent with their identified needs and preferences.

iii. Transition Planning

193. All residents shall be offered a meaningful choice of community providers consistent with their identified needs and preferences. In looking for places for the individual to live, the IDT shall evaluate the type of setting most likely to ensure a successful transition (e.g. number of roommates; urban or rural; preferred geographic location; proximity to family), based on the individual's strengths, preferences, and needs.

194. IDTs shall assist the resident and, where applicable, their Authorized Representative in choosing a provider, after providing the opportunities described in Section H.i-ii, and ensure that providers are identified and engaged in preparing for the resident's transition.

195. Once a specific provider is selected by an individual, the State shall require (absent extraordinary circumstances) the provider to actively participate in the transition of the individual from Glenwood to the future setting. This shall include, as warranted by the individual's needs and preferences, repeated opportunities for the individual to visit the provider's home for meals, overnight stays, and other experiences enabling the individual to become familiar and comfortable with the home.

196. All residents who transition from Glenwood to a more integrated setting shall have the right to a return agreement, which will guarantee a right to return to either State Resource Center, as long as the request is made within six months after the date of transition.

    a. Upon receiving a request to return, the State shall ensure:

        i. The identification of barriers with regard to community placement;

        ii. Implementation of individualized strategies to resolve those barriers (including, as appropriate, strategies to support the community service provider's ability to care for and support the individual, and to thoroughly search for other community service options); and

        iii. Documentation of the steps taken to resolve the barriers with regard to community placement.

    b. If after two months from the receipt of a request to return, the individual or, where applicable, their Authorized Representative determines that the issues cannot be resolved, the individual will be permitted to return to either State Resource Center.

197. Once a resident has selected a provider, and the provider agrees to serve the individual, transition shall occur within a planned and appropriate time frame (no longer than six weeks, absent conditions beyond the State's control). If transition does not occur within the planned timeframe, the reasons it did not occur shall be documented and a new time frame for discharge will be developed by the IDT. Where transition does not occur within three months of selecting a provider, the IDT shall identify the barriers to discharge and notify the Superintendent and Community Integration Manager in accordance with Section H.iv below.

198. Each individual transitioning from Glenwood shall have a current transition plan, updated within 30 days prior to the individual's discharge.

199. Based on the resident's ISP and discharge plan, the IDT shall identify in the transition plan the individual's preferences and desired outcomes, and all needed supports, protections, and services (including amount, duration, and scope) to ensure successful transition to the new living environment. The transition plan shall identify:

a. Assistance to be provided by Glenwood to the receiving setting;

b. Coordination with and training of the receiving setting's staff; and

c. Who, by name, will take what specific actions, and when, to deliver all needed supports, protections, and services for the individual, or ensure that they are in place.

200. The State, in consultation with the IDT, shall determine the essential supports needed for successful and optimal transition.

a. The State shall ensure that essential supports are in place prior to the individual's discharge from Glenwood, including behavioral supports, a crisis plan, and provision for both physical and mental health care. This determination will be documented.

b. The absence of those services and supports identified as non-essential by the State, in consultation with the IDT, shall not be a barrier to transition. However, supports and services identified as non-essential shall be in place 60 days from the individual's discharge.

iv. Community Integration Management

201. The State will create a full time Community Integration Manager ("CIM") position. The CIM will be a Central Office staff member. The CIM will be responsible for oversight of transition activities, including ensuring effective communication and planning with residents at Glenwood, their Authorized Representatives, the IDT, and private providers about all aspects of an individual's transition and will address identified barriers to discharge. The CIM will have professional experience working in the field of IDD, and an understanding of best practices for providing community services to individuals with IDD. The CIM will also be responsible for identifying, evaluating, and addressing barriers to discharge. The CIM will provide oversight, guidance, and technical assistance to the IDTs by identifying strategies for addressing or overcoming barriers to discharge, ensuring that IDTs follow the processes described in this Agreement, and identifying and developing corrective actions, including the need for any additional training or involvement of supervisory staff. By the Effective Date, and until the position is filled, the State will designate a Central Office staff member with the appropriate experience to fulfill the CIM's duties. The CIM position will be filled within six months of the Effective Date.

202. The CIM shall be engaged in addressing barriers to discharge, including in all of the following circumstances:

a. The IDT is having difficulty identifying or locating a particular type of community placement, services and supports for an individual within 60 days of development of a discharge plan.

b. The IDT cannot agree on a discharge plan outcome within 30 days of the annual ISP meeting, or within 60 days after the admission to the Resource Center.

c. The individual or his or her Authorized Representative opposes discharge after all the requirements described in Section H.i-ii have been satisfied or refuses to participate in the discharge planning process.

d. The individual is not discharged within three months of selecting a provider.

e. The IDT recommends that an individual remain at Glenwood.

f. An individual is readmitted to Glenwood.

203. If an IDT recommends maintaining a placement at Glenwood or placing an individual in a congregate setting with five or more individuals, it shall document in the discharge plan the decision, the barriers to placement in a more integrated setting, and the steps the team will take to address the barriers. If the individual remains at Glenwood, an assessment by the IDT and the CIM will be performed at 6-month intervals from the decision for the individual to remain at the Glenwood, to ensure that the individual is in the most integrated setting appropriate to his or her needs.

204. No resident shall remain at Glenwood or be placed in another congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the CIM.

205. Paragraph 204 shall not prevent the State from transferring residents to Woodward Resource Center, provided that no resident shall be transferred unless they have been offered a meaningful choice of community providers consistent with their identified needs and preferences, and have made an informed choice to continue receiving services in a Resource Center. If, at any point over the course of this Agreement, more than 50 members of the Target Population (approximately one third of the Glenwood census as of the Effective Date) are residing at Woodward, the terms of this Agreement shall apply to both Resource Centers.

206. The State shall produce routine public reports or maintain current public data dashboards regarding the status of Glenwood's community integration efforts, including historical data reflecting by month: the proportion of residents in each stage of transition planning, the number of transitions accomplished, and the types of placements, and recommendations that individuals remain at Glenwood.

207. The State shall ensure that information about barriers to discharge from involved providers, IDT members, and individuals' ISPs is collected from Glenwood and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.

208. The State shall develop and implement quality assurance processes to ensure that ISPs, discharge plans, and transition plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being advanced. Whenever problems are identified, the State shall develop and implement plans to remedy the problems.

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

210. The State shall provide ongoing community case management to members of the Target Population who transition to the community.

    a. For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs and preferences. The individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence.

    b. At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager

shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.

211. The State shall develop and implement 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 in order to: ensure health and safety; ensure a current support plan is in place consistent with the requirements in Paragraph 183; ensure whether supports identified in the individual's transition plan and current support plan are in place and achieving outcomes that promote their social, professional, and educational growth and independence in the most integrated settings; identify any gaps in care; and address proactively any such gaps to reduce the risk of readmission, crises, or other negative outcomes. The monitoring system shall include both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data.

I. State Staff

212. Glenwood shall maintain appropriate and adequate staffing, including by ensuring:

a. Retention of sufficient residential treatment workers per resident to safely staff GRC at all times. When determining how many residential treatment workers are needed, GRC shall use a relief factor multiplier formula of 1.8 (meaning there will be 1.8 residential treatment workers filled and budgeted for every residential treatment worker needed on shift) or more if necessary to account for staff vacancies and leave;

b. Retention of an adequate number of supervisory staff, and GRC leadership to sufficiently and safely staff GRC at all times;

c. Retention of demonstrably competent, appropriately trained and credentialed, staff and facility leadership in sufficient numbers to ensure GRC residents' safety and well-being and to comply with the mandates of this agreement, GRC and HHS policies and procedures, and current generally accepted professional standards of care;

d. Staff responsibilities and workloads are appropriate.

213. Within six months of the Effective Date, Glenwood shall develop and implement a reliable performance evaluation process for all GRC staff, providing for, at a minimum, comprehensive evaluations of each GRC staff member conducted at least annually by someone competent to reliably assess that staff member's performance. The State and the United States may agree to exclude certain individual staff members, or certain categories of staff members, from this requirement. When the GRC staff member to be evaluated is responsible for the delivery or supervision of clinical services, the evaluation of the quality of the GRC staff member's clinical care must be conducted by, or be informed by input from, a licensed professional of the same specialty.

214. The State shall ensure that complaints about the conduct of Glenwood staff are investigated to ensure that the complaints genuinely relate to staff performance or quality of care, and that discipline and other adverse employment actions are taken on the basis of performance or quality of care only. No adverse employment actions shall be taken for improper purposes such as retaliation or intimidation.

215. The State shall ensure that HHS Central Office conducts a timely review of the hiring and firing and discipline of GRC Leadership, including review of the relevant documentation. No hiring, firing, or discipline of GRC Leadership shall occur without approval from HHS Central Office.

J. Organizational Accountability

216. The State shall define the role and responsibility of an administrative position in HHS Central Office with the full responsibility to oversee the operations at GRC and with the authority to take appropriate action to improve services and remediate problems. The position shall have full authority over all aspects of GRC, including policy development, program design, personnel actions, and quality management, and shall be supported by appropriate staff members with the competence and resources to conduct this oversight through routine, comprehensive, and reliable evaluations.

217. 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. The HHS Director shall receive reliable information, including through routine briefings, regarding these activities.

218. Early on and throughout the planning and implementation process, the State shall engage with stakeholders (including staff, parents, guardians, non-governmental entities with oversight responsibilities for GRC, and other stakeholders) to identify their goals, concerns, and recommendations regarding implementation of this Agreement. This shall include establishing mechanisms for regularly sharing with, and receiving information from, these stakeholders. The State shall conduct meetings at least semi-annually to discuss implementation, the public reporting referenced in Paragraph 226, and any actions to be taken in response.

219. HHS Central Office shall conduct regular in-person visits, engaging with persons served, guardians, and staff at various levels within the organization, with the goal of establishing multiple points of contact and sources of information.

220. The State shall develop, and train staff on, effective reporting policies and procedures that enable staff to report concerns, including at least one anonymous mechanism, without experiencing retaliation.

221. The State shall implement timely and effective investigations into reported concerns. The results of the investigations shall be provided to the Superintendent and HHS Central Office.

222. The State shall provide reporting GRC staff with a substantive response concerning the outcome of the investigation of the issues reported by the staff where legally permissible and not related to a confidential personnel action.

223. The State shall ensure that GRC and HHS Central Office develop and implement effective mechanisms for identifying, tracking, and addressing trends regarding resident care and health outcomes.

224. 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.

225. The State shall establish a Resident Council to enable GRC residents to make recommendations and provide information to the GRC Superintendent and the HHS Central Office administrator supervising the Superintendent regarding any topic the Council chooses to elevate. The State shall keep minutes of the Resident Council and provide those minutes to the Quality Council for the identification of necessary action steps.

226. Within one year of the Effective Date, the State shall establish reliable public reporting at least every six months, on the HHS website. The public reporting shall include the Quality Management reporting produced pursuant to Section IV.K below.

227. The State shall review GRC's policies to ensure they conform to the requirements of this Agreement and are implemented. The State shall update policies as needed.

228. HHS Central Office shall review and approve all policies, and amendments to them.

K. Effective Quality Management

229. The State shall implement reliable Quality Management processes and procedures consistent with current, generally accepted professional standards of care. Such processes shall timely and effectively detect problems with the provision of protections, services and supports; and ensure appropriate corrective steps are implemented.

230. The State shall maintain a Quality Management program that effectively collects and evaluates valid and reliable data, including data pertaining to the domains and topics identified in Paragraphs 211 and 231, sufficient to implement an effective continuous quality improvement cycle as set forth below. The Quality Management program shall use this data in a continuous quality improvement cycle to:

a. Develop sufficient reliable measures relating to the domains and topics identified in Paragraphs 211 and 231, with corresponding goals and timelines for expected positive outcomes, and triggers for negative outcomes;

b. Produce routine, valid and reliable reporting on the defined measures and related trends;

c. Identify significant trends, patterns, strengths, and problems at the individual and systemic levels;

d. Implement preventative, corrective, and improvement actions to address identified trends, patterns, strengths, and problems; and

e. Track the effectiveness of preventative, corrective, and improvement actions, and adjust such actions as needed if they do not result in expected prevention, correction, or improvement.

231. The Quality Management program shall collect, report on, and analyze valid and reliable data regarding GRC sufficient to identify overall trends in the following domains:

a. safety and freedom from harm (including neglect and abuse, exploitation, injuries, critical incidents, and deaths; timely reporting, investigation, and resolution of incidents);

b. physical health and well-being (including medication management; disease and wound management; admissions to emergency rooms or hospitals; incidence of physical health crises; occurrences of pneumonia; occurrences of pressure ulcers; accurate receipt of medication as prescribed; and access to and receipt of timely preventative, chronic, and acute healthcare and interventions – particularly interventions in response to changes in status);

c. behavioral health and well-being (including use of physical, mechanical, chemical, or medical restraints, use of restrictive interventions, incidents of behavioral health crises, and incidents of aggression);

d. engagement and skill acquisition;

e. choice and self-determination (including individual service plans developed through a person-centered planning process, inclusion of the resident in the planning process, individualized goals, self-direction of services, and meaningful and informed choices regarding community-based services and providers);

f. community inclusion (including community activities, integrated day and employment, educational opportunities, and relationships with non-paid individuals);

g. risk management (including risk thresholds and triggers);

h. staff capacity (including caseloads by discipline, training, staff turnover, and competency);

i. compliance with policies and procedures (including timely incident reporting and investigation, and timely provision of appropriate medical care);

j. referral to, admission and readmission to, diversion from, and length of stay in GRC; discharges and transitions from GRC and related planning; and barriers to serving individuals in more integrated settings.

232. The Quality Management program shall ensure that each IDT utilizes this continuous quality improvement information to track and trend the measures and triggers regarding resident outcomes, and to effectively identify, assess, and appropriately respond to positive and negative outcomes at the individual level.

233. HHS Central Office shall receive and review routine, valid and reliable Quality Management reporting regarding the domains described above, and related trends; notification of complaints regarding resident well-being and staff relations, and related trends; and other relevant reporting regarding GRC and the Target Population. This shall include a review of the information described in Paragraph 211.

234. 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.

235. 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.

V. Monitor

236. The Parties agree that a Monitor will be appointed to assess and report whether the provisions of the Agreement have been implemented and to provide technical assistance to help the State comply with its obligations under the Agreement. The Parties agree to file a joint motion asking the Court to appoint the Monitor. The Monitor may hire consultants and staff as necessary to assist in carrying out these duties. In addition, the Parties anticipate that responsibilities for monitoring may be divided among a number of experts. Funding for work by these personnel or entities will come out of the Monitor's budget. The Monitor shall select the experts, subject to the Parties' agreement. If the Parties cannot agree regarding the selection of an expert, the Monitor shall submit names to the Court for consideration and the Court shall determine whether to appoint an expert and, if so, select the expert.

237. The Monitor will be appointed for a period of three years from the Effective Date, subject to an evaluation by the Court to determine whether to renew the Monitor's appointment until the termination of this Agreement. In evaluating the Monitor, the Court will consider the Monitor's performance under this Agreement, including whether the Monitor is completing his or her work in a cost-effective manner and on budget, and is working effectively with the Parties to facilitate the State's efforts to comply with the Agreement's terms, including by providing technical assistance to the State. The Monitor may be removed for good cause by the Court at any time, on motion by any of the Parties which shall be granted for good cause shown, or the Court's own determination.

238. The Parties recognize the importance of ensuring that the fees and costs of monitoring the Agreement are reasonable. The Monitor will submit a proposed budget annually to the parties for comment, and to the Court for approval.

a. The Monitor shall submit monthly invoices to the State, and the State will pay the Monitor's invoices promptly. If the State disputes the invoice, the State may raise the concern by motion and the Court will rule on the appropriateness of the charge before payment is due.

b. The Court retains the authority to resolve any dispute that may arise regarding the reasonableness of fees and costs charged by the Monitor.

239. The Monitor shall only have the duties, responsibilities, and authority conferred by this Agreement. The Monitor shall be subject to the supervision and orders of the Court.

240. The Monitor shall conduct compliance reviews. The purpose of the compliance reviews is to determine compliance with the material requirements of this Agreement. Compliance reviews shall be conducted in a reliable manner based on accepted means and methods and shall set forth the basis for the Monitors' conclusions. The Monitor shall provide a verbal report of impressions following each on-site review and engage in collaborative problem-solving with the State.

241. Neither the State, the United States, nor any of their staff or agents shall have any supervisory authority over the Monitor's activities, reports, findings, or recommendations.

242. The Monitor may contract or consult with other persons or entities to assist in the evaluation of compliance. The Monitor shall pay for the services out of his or her budget. The Monitor is ultimately responsible for any compliance assessments made under this Agreement.

243. At the Monitor's discretion, the Monitoring Team (including the Monitor, subject matter experts, consultants, and staff) shall be permitted to engage in ex parte communications with the State and the United States regarding this Agreement. At the Monitor's discretion, the Monitoring Team may also have ex parte communications with the Court, only upon the Court's request or with the consent of the Parties. Members of the Monitoring Team shall not be required to disclose such communications, communications within the Monitoring Team, or draft or other internal work product, unless there is a substantial need as determined by the Court.

244. In the event the Monitor is no longer able to perform his or her functions or is removed, within 60 days thereof, the Parties shall together select and advise the Court of the selection of a replacement Monitor, acceptable to both. If the Parties are unable to agree on a Monitor, each Party shall submit the names of up to two candidates, along with the resumes and cost proposals, to the Court, and the Court will select and appoint from among the qualified candidates.

245. Should a Party to this Agreement determine that the Monitor has exceeded his or her authority or failed to satisfactorily perform the duties required by the Agreement, the Party

may petition the Court for such relief as the Court deems appropriate, including replacement of the Monitor, and/or any individual agents, employees, or independent contractors retained in this matter by the Monitor ("Monitoring Team Member"). In addition, the Court, on its own initiative and in its sole discretion, may replace the Monitor or any Monitoring Team Member for failure to adequately perform the duties required by this Agreement.

246. The Monitor and the United States (and its agents) shall have full access to persons, staff, facilities, buildings, programs, services, documents, data, records, materials, and things that are necessary to assess the State's progress and implementation efforts with this Agreement. However, the United States shall coordinate its access with the Monitor's as much as feasible to limit duplication of effort and burden on the State. Access shall include departmental or individual medical and other records. This access shall extend to individuals who move from Glenwood to any other setting, for one year from the date of the move, for the purpose of confirming that the transfer does not violate the federal rights of those former Glenwood residents and that they are receiving the necessary supports and services in that alternative setting. The State shall comply with reasonable requests by the Monitor or the United States (and its agents) to speak with State staff outside the presence of attorneys for the State and/or outside the presence of persons within the staff's supervisory chain. The United States and/or the Monitor shall provide reasonable notice of any visit or inspection or request for access. Reasonable notice shall include a list of persons or topics to be addressed. All requests for documents must be presented to counsel or the designated point of contact. All document requests shall allow a 30-day period for production. However, advance notice and a 30-day document production period shall not be required if the Monitor or the United States has a reasonable belief that a Glenwood resident faces a risk of immediate and serious harm. Access is not intended, and shall not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with information disclosed to the Monitor or the United States under this paragraph.

247. In completing his or her responsibilities, the Monitor may require written responses and data from the State concerning compliance.

A. Monitoring Plan and Tool

248. Within 90 days of the Monitor's selection the Monitor shall develop a draft monitoring plan and tool, to include outcome measures by which the Monitor will measure compliance. Compliance will be measured in part through a Quality Service Review (QSR) model.

a. The State and the United States shall both have 21 days to offer comments on the monitoring tool.

b. The Monitor shall consider all comments and issue a final Monitoring Plan and Monitoring Tool within 21 days of receiving the Parties' comments.

c. As necessary, the Parties and the Monitor may agree to amend and revise the Monitoring Plan and Monitoring Tool throughout the period of this Agreement.

B. Monitor Reports

249. Within 60 days of the Effective Date, the Monitor shall conduct a baseline review of Glenwood to become familiar with Glenwood and this Agreement.

250. Within 120 days of the Effective Date, the Monitor shall provide his or her preliminary observations and recommendations in a baseline Monitoring Report (which will follow the same draft and comment process as in Paragraph 251).

251. The Monitor shall both conduct a review and issue a Monitoring Report no later than six months after the baseline Monitoring Report, and every six months thereafter. A draft Report shall be provided to the State and the United States in draft form for comment at least 30 days prior to its issuance. Prior to issuing each Monitoring report, at a reasonable time designated by the Parties, the Monitor shall provide the Parties with verbal impressions based on each review, unless the Parties agree otherwise. The State and the United States shall provide comments, if any, to the Monitor within 15 days of receipt of the draft Report. The Monitor shall consider the responses of the State and the United States and make appropriate changes, if any, before issuing the final Report.

252. The Monitoring Reports shall describe the steps taken by the State to implement this Agreement and shall evaluate the extent to which the State has complied with each substantive provision of the Agreement. Each Monitoring Report:

a. Shall evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance and (3) Non-compliance. The Monitor shall review a sufficient number of pertinent documents and interview or observe a sufficient number of staff and residents to accurately assess current conditions. The Monitor may also communicate with Glenwood residents and former residents, family members, and relevant community members to assist the Monitor's assessment of current conditions;

b. Shall describe the steps taken by each member of the monitoring team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed or observed, and the factual basis for each of the Monitor's findings;

c. Shall contain the Monitor's independent verification of representations from the State regarding progress toward compliance, and examination of supporting documentation; and

d. May provide recommendations for each of the provisions in the Agreement outlining proposed actions for at least the next six months for the State to complete toward achieving compliance with the particular provision.

253. These Monitoring Reports shall be filed with the Court and shall be written with due regard for the privacy interests of Glenwood residents. The Monitoring Reports provide relevant evidence regarding compliance. Accordingly, information in the Monitoring

reports will be considered persuasive, but rebuttable, in any court proceeding regarding this Agreement. The State shall publish the Monitoring Reports on the HHS website.

254. Nothing in this Section prohibits the Monitor from issuing interim letters or reports to the United States, the State or the Court via the public record in this case, should he or she deem it necessary.

C. Monitor's Relationship with Others

255. In completing his or her responsibilities, the Monitor may testify in enforcement proceedings regarding any matter relating to the implementation, enforcement, or dissolution of the Agreement, including, but not limited to, the Monitor's observations, findings, and recommendations in this matter.

256. The Monitor, and any staff or consultants retained by the Monitor, shall not:

a. Be liable for any claim, lawsuit, or demand arising out of their activities under this Agreement (this paragraph does not apply to any proceeding for payment under contracts into which they have entered in connection with their work under the Agreement);

b. Be subject to formal discovery in any litigation involving the services or provisions reviewed in this Agreement, including deposition(s), request(s) for documents, and request(s) for admissions, interrogatories, or other disclosure;

c. Testify in any other litigation or proceeding with regard to any act or omission of the State or any of the State's agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement, nor serve as a non-testifying expert regarding any facts that he or she may have learned as a result of his or her performance under this Agreement.

257. The State and the United States shall not otherwise employ, retain, or be affiliated with the Monitor, or professionals retained by the Monitor while this Agreement is in effect, and for a period of at least one year from the date this Agreement terminates, unless the other Party gives its written consent to waive this prohibition.

258. If the Monitor resigns from his or her position as Monitor, the former Monitor may not enter any contract with the State or the United States on a matter encompassed by this Agreement without the written consent of the other Party while this Agreement remains in effect.

VI. Implementation

259. Within 30 days of the Effective Date, the State shall designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the Monitor.

260. The State shall create an annual Implementation Plan that describes the actions it will take to fulfill its obligations under this Agreement. Implementation of this Agreement shall be completed in phases as outlined in the Agreement and the Implementation Plan. Within 90 days of the Effective Date, the State shall provide the first Implementation Plan ("Implementation Plan #1") to the United States and the Monitor. The United States and the Monitor shall have an opportunity to review and comment on each annual Implementation Plan before it is finalized.

261. In its Implementation Plan, the State shall: (1) identify the issues to be addressed that year, and, for each issue: the planned actions; the persons or positions responsible; the resources needed; the target completion date; a completion status measure; and expected outcome; (2) a general forecast of issues to be addressed in successive years; and (3) beginning with Implementation Plan #2, an assessment of what worked and what should be adjusted in the previous plan's implementation. In Implementation Plan #1, the State shall address at least: clinical care; client rights and protections; and community integration. Over time, the Implementation Plans shall address the issue areas subject to the public reporting required in Paragraph 226, above.

262. The United States and the Monitor may provide comments regarding the Implementation Plan (and any further Implementation Plans) within 30 days of receipt. The State shall timely revise its Implementation Plans to address comments from the United States and the Monitor.

263. The Parties and the Monitor shall meet and consult at least monthly during the first year of this Agreement and at least quarterly thereafter.

264. Annually, the State, in conjunction with the United States and the Monitor, shall supplement the Implementation Plan to focus on and provide additional detail regarding implementation activities. The State shall address in its further Implementation Plans any areas of non-compliance or other recommendations identified by the Monitor in his or her reports.

265. The State shall make the Implementation Plan publicly available, including by posting the Plan, and its supplements, on the State's website.

VII. Enforcement

266. The State of Iowa is responsible for ensuring compliance with the provisions of this Agreement.

267. The United States District Court for the Southern District of Iowa will retain jurisdiction over this matter for the purposes of enforcing this Agreement as an order of the Court.

268. During the period that the Agreement is in force, the parties shall move for a status conference with the Court at least semi-annually to update the Court on the State's compliance with this Agreement. Either party may file these motions.

269. During the period that the Agreement is in force, if the United States determines that the State has not made material progress toward substantial compliance with an obligation under the Agreement, the United States may initiate enforcement proceedings against the State in Court for an alleged failure to fulfill its obligation under this Agreement.

270. Prior to taking judicial action to initiate enforcement proceedings, the United States shall give the State written notice of its intent to initiate such proceedings, and the parties will engage in good-faith discussions to resolve the dispute.

271. The State shall have 30 days from the date of such notice to cure the failure (or such additional time as is reasonable due to the nature of the issue and agreed upon by the parties) and provide the United States with sufficient proof of its cure. At the end of the 30-day period (or such additional time as is reasonable due to the nature of the issue and agreed upon by the United States), in the event that the United States determines that the failure has not been cured or that adequate remedial measures have not occurred, the United States may initiate contempt proceedings without further notice. The United States commits to work in good faith with the State to avoid enforcement actions. The State retains all available defenses against such actions, including moving to modify the terms of the consent decree.

272. In case of an emergency posing an immediate threat to the health or safety of any GRC resident or staff member, however, the United States may omit the notice and cure requirements herein and seek enforcement of the Agreement.

VIII. Termination

273. Except where otherwise agreed to under a specific provision of this Agreement, the State will have achieved:

a. Substantial compliance with all provisions in Section IV.A (Research) by the Effective Date;

b. Substantial compliance with all provisions in Sections IV.B (Integrated Interdisciplinary Care and Services) and IV.H (Individual Support Planning, Discharge Planning, and Transition Planning from the Resource Centers) of this Agreement within six months of the Effective Date;

c. Tangible progress in achieving substantial compliance with at least the following sections of this Agreement within one year of the Effective Date: IV.C (Clinical Care); IV.D (Restrictive Interventions); and IV.G (Incident Management);

d. Substantial compliance with all provisions of this Agreement within two years of the Effective Date, unless an earlier date is specified above.

274. This Agreement shall terminate in five years if the Parties agree that the State has attained substantial compliance with all provisions and maintained that compliance for a period of one year.

275. The State may seek termination of any substantive section (i.e. any capitalized section tabbed on the far left of the Agreement, such as "Clinical Care," "Restraints," "Recordkeeping," etc.) by filing with the Court a motion to terminate that section. The burden will be on the State to demonstrate that it has attained and maintained its substantial compliance as to that section for at least one year, or that circumstances have made compliance with that section irrelevant.

276. The burden will be on the State to demonstrate that it has maintained substantial compliance with each of the provisions of this Agreement. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, will not constitute failure by the State to maintain substantial compliance. At the same time, temporary compliance during a period of sustained non-compliance will not constitute substantial compliance.

277. The burden will be on the State to demonstrate it has achieved substantial compliance with a particular section of this Agreement.

278. Regardless of this Agreement's specific requirements, this Agreement will terminate, or substantive sections as described in Paragraph 275 may terminate, upon a showing by the State that it has come into durable compliance with the requirements of the Constitution that gave rise to this Agreement. In order to demonstrate durable compliance, the State must establish with the Court that it is operating in accordance with these requirements and has been doing so continuously for one year.

279. Should any provision of this Agreement be declared or determined by any court to be illegal, invalid, or unenforceable, the validity of the remaining parts, terms, or provisions will not be affected. The Parties shall not, individually or in combination with another, seek to have any court declare or determine that any provision of this Agreement is invalid.

280. The Parties agree to work collaboratively to achieve the purpose of this Agreement. In the event of any dispute over the language, requirements or construction of this Agreement, the Parties agree to meet and confer in an effort to achieve a mutually agreeable resolution.

281. This Agreement shall constitute the entire integrated agreement of the Parties.

282. Any modification of this Agreement shall be executed in writing by the Parties, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.

IX. General Provisions

283. Interpretation of this Agreement shall be governed by the following rule of construction: "including" means including without limitation, unless otherwise specified.

284. The State shall coordinate with or enter into Memoranda of Understanding or other contractual arrangements with all appropriate agencies and State vendors in order for the State to comply with provisions of this Agreement.

285. The United States and the State shall each bear the cost of their own fees and expenses incurred in connection with this case.

286. All services mentioned or described in this Agreement are subject to reasonableness standards and nothing herein shall be interpreted to mean that the provision of services is unlimited in amount, duration or scope.

287. The Agreement is binding on all successors, assignees, employees, agents, contractors, and all others working for or on behalf of the State to implement the terms of this Agreement.

288. The Parties agree that, as of the Effective Date of this Agreement, litigation is not "reasonably foreseeable" concerning the matters described in this Agreement. To the extent that any Party previously implemented a litigation hold to preserve documents, electronically stored information, or things related to the matters described in this Agreement, the Party is no longer required to maintain such a litigation hold. Nothing in this paragraph relieves any Party of any other obligations imposed by this Agreement, including the document creation and retention requirements described herein.

289. The State shall not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the United States' investigation or the Monitor's activities related to this Agreement. The State shall implement reasonable procedures to detect and prevent any acts of retaliation. The State shall timely and thoroughly investigate any allegations of retaliation in violation of this Agreement and take any necessary corrective actions identified through such investigations.

290. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein will not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.

291. The Parties shall promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof.

292. The Parties represent and acknowledge this Agreement is the result of extensive, thorough, and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of the allegations set forth in the Department of Justice's CRIPA Notice dated December 22, 2020. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of a Party is duly authorized to enter into this Agreement and to bind that Party to the terms and conditions of this Agreement.

293. This Agreement may be executed in counterparts, each of which will be deemed an original, and the counterparts will together constitute one and the same Agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.

294. The performance of this Agreement shall begin immediately upon the Effective Date.

295. The State shall maintain sufficient records and data to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Monitor and the United States for inspection and copying on a reasonable basis. All requests for documents shall allow a 30-day period for production, except where the Monitor or the United States has a reasonable belief that a member of the Target Population faces a risk of immediate and serious harm. Such action is not intended, and shall not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with such information. Other than to carry out the express functions as set forth herein, both the United States and the Monitor shall hold such information in strict confidence to the greatest extent possible.

296. "Notice" under this Agreement shall be provided by email to the signatories below or their successors.

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FOR THE UNITED STATES:

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So ordered this _____ day of _____, _____.

_____
United States District Court Judge