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**PART I**  
**GENERAL PROVISIONS**

A. This Settlement Agreement (the “Agreement”) is entered into between the United States of America (the “United States”) and the State of Texas and the Texas Department of Aging and Disability Services (“DADS”), on behalf of each of its state mental retardation facilities, Abilene State School, Austin State School, Brenham State School, Corpus Christi State School, Denton State School, El Paso State Center, Lubbock State School, Lufkin State School, Mexia State School, Richmond State School, San Angelo State School, and San Antonio State School, and the Texas Department of State Health Services (“DSHS”), on behalf of the ICF/MR component of Rio Grande State Center and on behalf of any additional state mental retardation facility. The state schools and state centers, as well as any additional state mental retardation facility, may be collectively referred to in this Agreement as “the Facilities” and may be individually referred to as “Facility.” In this Agreement, the “Parties” means the United States and the State of Texas, defined as all components of the executive branch of State government and not including the legislative and judicial branches (the “State”).

B. This Agreement resolves the investigations of the Facilities (the “investigations”) conducted by the United States Department of Justice (“DOJ”), pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”), 42 U.S.C. §1997.

C. This Agreement addresses the remedial measures identified by DOJ in its December 11, 2006 letter to the State regarding the investigation of Lubbock State School and in the December 1, 2008 letter regarding the investigations of the other twelve Facilities. The December 11, 2006 and the December 1, 2008 letters will be collectively referred to in this Agreement as the “Findings Letters.” This Agreement does not serve as an admission by the State that remedial measures are necessary to meet the constitutional or statutory rights of individuals with mental retardation residing at the Facilities (the “individuals”).

D. Nothing in this Agreement shall be construed as an acknowledgement, admission, or evidence of liability of the State under CRIPA, the Constitution or federal or state law, and nothing in this Agreement may be used as evidence of liability in the investigations or in any civil or criminal proceeding.

E. The State has at all times denied that conditions at the Facilities violate the constitutional or federal statutory rights of individuals.

F. The United States recognizes that its Findings Letters notifying the State of Texas of the results of its investigations focused primarily on conditions that the United States believed to violate federal law and did not discuss improvements reported to have been made at the Facilities since the United States investigated those Facilities.

G. This Agreement represents a voluntary effort by the State to meet the concerns identified by DOJ in the Findings Letters and to avoid costly, adversarial and protracted litigation.

H. This Agreement is enforceable only by the Parties hereto. This Agreement is binding upon the Parties, by and through their officials, agents, employees, and successors. No person or entity is intended to be a third party beneficiary of the provisions of this Agreement for any purpose, and accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Agreement or any civil, criminal, or administrative action. Furthermore, this Agreement does not authorize, nor shall it be construed to authorize, access to State documents by persons or entities not a Party to this Agreement.

I. This Agreement is expressly conditioned on obtaining subsequent approval by the Texas Legislature in accordance with Texas Civil Practice and Remedies Code, Chapter 111. The pendency of such approval shall not delay implementation of this Agreement. The State will continue to implement its obligations under this Agreement for the term of this Agreement unless the State files with the court, by no later than June 30, 2009, proof that the necessary final approval required by Texas Civil Practice and Remedies Code, Chapter 111 has not been obtained.

J. Pursuant to Federal Rule of Civil Procedure 41(a) (“Rule 41(a)”), the Parties agree to file in the United States District Court, this Agreement, together with a Complaint, a Joint Rule 41(a) Motion for Voluntary Dismissal to dismiss the Complaint upon the appointment of the Monitor pursuant to Section III.E, and the proposed order.

## **PART II** **IMPROVEMENT PLAN**

### **A. Definitions**

#### **1. Competency-Based Training**

Competency-based training means 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 that he or she can use such knowledge or skills effectively in the circumstances for which they are required.

#### **2. Restraint**

- a. Chemical Restraint. Chemical restraint means any drug that is prescribed or administered to sedate an individual, or temporarily restrict an individual’s freedom of movement, for the purpose of managing the individual’s behavior.

- b. Mechanical Restraint. Mechanical restraint means 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 any device used to achieve functional body position or proper balance or to prevent injury due to involuntary movement.
- c. Medical Restraint. 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 but not limited to, dental) procedure, or is only necessary for protection during the time that a medical or dental condition exists, for the purpose of preventing an individual from inhibiting or undoing medical or dental treatment. Medical restraint includes pre-treatment sedation.
- d. Physical Restraint. Physical restraint is any manual method that restricts freedom of movement or normal access to one's body, 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, positioning 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 challenging behavior is prevented; holding an individual, without the use of force, to calm, or comfort, or hand-holding to escort an individual from one area to another; and response interruption used to interrupt an individual's behavior, using Facility-approved techniques.
- e. Crisis Intervention. Crisis intervention is the use of restraints: a) in response to an immediate safety situation that places the individual or others at serious threat of violence or injury if no intervention occurs; and that results either from an occurrence that could not have been anticipated or from incomplete treatment (i.e., current treatment that has not eliminated the risk of future occurrences of the behavior); and applies b) only after less restrictive measures have been determined to be ineffective or not feasible.
- f. Prone Restraint. Prone restraint means any physical or mechanical restraint that places the individual in a face-down position. Prone restraint does not include brief physical holding of an individual who, during an incident of physical restraint, rolls into a prone or supine position, when staff restore the individual to a standing, sitting, or side-lying position as soon as possible.

### **3. Positive Behavior Support Plan (“PBSP”)**

A Positive Behavior Support Plan (“PBSP”) is a comprehensive, individualized plan that contains intervention strategies designed to modify the environment, teach or increase adaptive skills, and reduce or prevent the occurrence of target behaviors through interventions that build on the individual’s strengths and preferences and that exclude aversive or punishment contingencies. The PBSP 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 to acquire or increase replacement behaviors that are selected on the basis of an accurate structural assessment (i.e., an assessment of the antecedents of behaviors) and functional assessment (i.e., an assessment of the consequences of behaviors), and specific implementation procedures from such training; and
- c. Target behavior reduction strategies, based on accurate structural and functional assessments, and specific implementation procedures for such strategies.

### **4. Individual Support Plan (“ISP”)**

An 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; is developed by the individual’s interdisciplinary team (“IDT”) through comprehensive assessments of the individual; reflects, to the fullest extent practicable, the individual’s preferences, strengths, needs and desires; and includes methods to track and document progress toward identified goals and objectives.

### **5. Consistent With Current, Generally Accepted Professional Standards of Care**

A qualified professional’s decision that does not so substantially depart from contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such judgment, practice, or standards. The Parties have endeavored in this Agreement to set out specific substantive requirements consistent with current, generally accepted professional standards of care. Except as otherwise specifically provided in this Agreement, the standard for assessing compliance with the substantive provisions of this Agreement shall be whether the Facilities’ practices are consistent with current, generally accepted professional standards of care.

**6. Legally Authorized Representative (“LAR”)**

A person authorized by law to act on behalf of an individual with regard to a matter described in this Agreement, who may include a parent, guardian, or managing conservator of a minor, or a guardian of an adult.

**7. Exploitation**

The illegal or improper act or process of using an individual or the resources of an individual for monetary or personal benefit, profit, or gain.

**8. Effective Date**

The Effective Date hereof is the date this Agreement is filed with the Court.

**B. Introduction**

As part of an overall service delivery system, each Facility shall provide care and treatment to individuals in order to support and strengthen the individual’s ability to function, to grow and develop in ways benefiting quality of life, to attain self-help and social skills, to minimize regression or loss of skills, and to provide for reasonable safety, security and freedom from undue bodily restraint, where possible.

**C. Protection from Harm - Restraints**

Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.

1. Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities’ policies shall be used.
2. Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.
3. Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A



restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.

4. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. 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.
5. Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face-to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.
6. Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and 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. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.
7. Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:
  - a. review the individual's adaptive skills and biological, medical, psychosocial factors;
  - b. review possibly contributing environmental conditions;

- c. review or perform structural assessments of the behavior provoking restraints;
  - d. review or perform functional assessments of the behavior provoking restraints;
  - e. develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as 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 the individual's ISP;
  - f. 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
  - g. as necessary, assess and revise the PBSP.
8. Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.

**D. Protection From Harm - Abuse, Neglect, and Incident Management**

Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.

- 1. Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.
- 2. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility 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 but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or

that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility 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, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well-supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.
- 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 of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.
- e. Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR 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 individuals' rights, including information about how to exercise such rights and how to report violations of such rights.
- g. Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.
- h. Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.

- i. Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.
3. Commencing within six months of the Effective Date hereof and with full implementation within one year, 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 Facility residents. Such policies and procedures shall:
  - a. Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.
  - b. Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.
  - 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 each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.
  - f. Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; 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; 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; the investigator's findings; and the investigator's reasons for his/her conclusions.

- g. 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.
  - h. Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.
  - i. Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.
  - j. 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.
4. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: 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.
5. 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 individual, each Facility 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. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.

#### **E. Quality Assurance**

Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:

1. Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.
2. Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.
3. Disseminate corrective action plans to all entities responsible for their implementation.
4. Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.
5. Modify corrective action plans, as necessary, to ensure their effectiveness.

**F. Integrated Protections, Services, Treatments, and Supports**

Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:

**1. Interdisciplinary Teams**

Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:

- a. Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.
- b. Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.
- c. Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.

- d. Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.
- e. Develop each ISP in accordance with the Americans with Disabilities Act (“ADA”), 42 U.S.C. § 12132 et seq., and the United States Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999).

## **2. Integrated ISPs**

Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:

- a. Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:
  - 1) Addresses, in a manner building on the individual’s preferences and strengths, each individual’s prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;
  - 2) Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;
  - 3) Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;
  - 4) Identifies the methods for implementation, time frames for completion, and the staff responsible;
  - 5) Provides interventions, strategies, and supports that effectively address the individual’s needs for services and supports and are practical and functional at the Facility and in community settings; and
  - 6) Identifies 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 individual’s progress, the person(s)

responsible for the data collection, and the person(s) responsible for the data review.

- b. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.
- c. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.
- d. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.
- e. No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency-based training when the plans are revised.
- f. Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.
- g. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.



## **G. Integrated Clinical Services**

Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.

1. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.
2. Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.

## **H. Minimum Common Elements of Clinical Care**

Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:

1. Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.
2. Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
3. Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.
4. Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.
5. Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.

6. Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.

7. Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.

### **I. At-Risk Individuals**

Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:

1. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.

2. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at-risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.

3. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.

### **J. Psychiatric Care and Services**

Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:

1. Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.

2. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.

3. Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.
4. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used 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 pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.
5. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.
6. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.
7. Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.
8. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.
9. Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through

behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.

10. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.

11. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility-level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.

12. Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.

13. Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.

14. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.

15. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.

#### **K. Psychological Care and Services**

Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.

1. Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.
2. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.
3. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.
4. Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.
5. Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.
6. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.

7. Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.
8. By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.
9. By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.
10. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.
11. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.
12. Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.
13. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.

#### **L. Medical Care**

1. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves

receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.

2. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.

3. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.

4. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.

#### **M. Nursing Care**

Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:

1. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.

2. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.

3. Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health

status. Nursing interventions shall be implemented promptly after they are developed or revised.

4. Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.

5. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.

6. Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.

#### **N. Pharmacy Services and Safe Medication Practices**

Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:

1. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.

2. Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.

3. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to



associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.

4. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.

5. Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.

6. Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.

7. Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.

8. Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.

#### **O. Minimum Common Elements of Physical and Nutritional Management**

1. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech

pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.

2. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.

3. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.

4. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.

5. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.

6. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.

7. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.

8. Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.

**P. Physical and Occupational Therapy**

Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:

1. By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.

2. Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.

3. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.

4. Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.

## **Q. Dental Services**

1. Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.
2. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.

## **R. Communication**

Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:

1. Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.
2. Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.
3. Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.

4. Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.

**S. Habilitation, Training, Education, and Skill Acquisition Programs**

Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.

1. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.

2. Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.

3. Within three years of the Effective Date hereof, each Facility 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 individual's needs. Such programs shall:

- a. Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and
- b. Include to the degree practicable training opportunities in community settings.

**T. Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs**

**1. Planning for Movement, Transition, and Discharge**

a. Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage

and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.

- b. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:
  - 1) The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.
  - 2) The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.
  - 3) Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.
- c. When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:
  - 1) Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.

- 2) Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.
  - 3) Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.
- d. Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.
  - e. Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.
  - f. Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.
  - g. Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.
  - h. Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community

Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.

## **2. Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**

- a. Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.
- b. The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90<sup>th</sup> day following the move date.

## **3. Alleged Offenders**

The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.

## **4. Alternate Discharges**

Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:



- a. individuals who move out of state;
- b. individuals discharged at the expiration of an emergency admission;
- c. individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;
- d. individuals receiving respite services at the Facility for a maximum period of 60 days;
- e. individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;
- f. individuals discharged pursuant to a court order vacating the commitment order.

**U. Consent**

1. Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual’s health or welfare and an LAR to render such a decision (“individuals lacking LARs”) and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.

2. Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.

**V. Recordkeeping and General Plan Implementation**

1. Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.

2. Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.

3. Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.

4. Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.

### **PART III** **MONITORING AND ENFORCEMENT**

A. Compliance. Except as otherwise stated above, each Facility shall be in substantial compliance with all of the terms of this Agreement within one year from the Effective Date of this Agreement. In this Agreement, the phrase “commencing within [specified time period] of the Effective Date hereof and with full implementation by [specified time period]” means taking objectively measurable steps such that full implementation of the specific requirement at issue will be achieved by the specific deadline for full implementation, if not sooner. As to each such provision, and for each Facility, the State shall begin taking such objectively measurable steps no later than the commencement date specified in that provision, and shall continue implementation steps such that full implementation, on schedule, can reasonably be expected.

B. Dissemination of Agreement. Upon the Effective Date, the State shall ensure that all current and future staff understand the terms of this Agreement, to the extent necessary to carry out their job duties and responsibilities, and implement the terms of this Agreement.

C. Contact Person. The State shall appoint a person who shall devote sufficient time and resources to oversee compliance with this Agreement and to serve as the State’s point of contact.

D. Substantial Compliance. “Substantial Compliance” with each and every substantive provision of this Agreement, as defined in Section III.J, for a period of one year shall fully satisfy the Agreement. Noncompliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, shall not constitute failure to maintain substantial compliance. At the same time, temporary

compliance during a period of otherwise sustained noncompliance shall not constitute substantial compliance. For purposes of Sections III.Q and R, a Facility has achieved substantial compliance with a substantive provision when that provision has been implemented for the individuals residing, or placed from, that Facility.

E. Monitor. The Parties jointly agree to appoint an expert or experts to monitor the Facilities' implementation of this Agreement (the "Monitor"). Given the number of Facilities, the Parties anticipate that responsibilities for monitoring the Facilities shall be divided among a number of experts. The Parties shall identify the experts serving as Monitor, and their specific responsibilities, in a submittal to the Court made within ninety (90) days of the Effective Date of the Agreement. If the Parties are unable to agree upon a Monitor, each Party shall submit two names for each Monitor position, along with resumes or curricula vitae and cost proposals, to the Court, and the Court shall appoint the Monitor from among the names submitted. The State shall pay all reasonable costs and expenses incurred by the Monitor, in accordance with the Texas Prompt Payment Act, in the course of carrying out his/her duties under this Agreement. The Monitor shall have full authority to assess, review, and report independently on the Facility's implementation of and compliance with the provisions of the Agreement and may offer recommendations to aid the Facility in achieving compliance. The Monitor may be terminated only for good cause and only with prior notice to an agreement by the Parties. No Party, nor any employee or agent of any Party, shall have any supervisory authority over the Monitor's activities, reports, findings, or recommendations. In the event that the Monitor is unable to serve or continue serving as the Monitor, or in the event that the Parties for any reason agree to discontinue the use of the Monitor, the Parties shall meet or otherwise confer within thirty (30) days of being notified of the incapacity or the decision to discontinue use of the Monitor, to select a new Monitor. If the Parties are unable to agree upon a selection, each Party shall submit two names for each Monitor position, along with resumes or curricula vitae and cost proposals, to the Court and the Court shall appoint the Monitor from among the names submitted.

1. Except as required or authorized by the terms of this Agreement, or as authorized by a Court order, or by joint written agreement of the Parties, the Monitor (and members of the Monitoring Team, as set forth in Section F below) shall not: issue public statements (at a conference or otherwise) or make findings with regard to any act or omission of the State or its Facilities, agents, representatives or employees, or disclose to any person or entity, other than the Court or the Parties, any confidential information provided to the Monitor in the course of his or her duties in this case, as set forth in Section S herein below.

2. Any press statement made by the Monitor or members of the Monitoring Team regarding his/her employment or related to his/her responsibilities as Monitor in this case must first be approved in writing by both Parties.

3. The Monitor and members of the Monitoring Team shall not testify in any other litigation or proceeding with regard to any act or omission of the State or any of its agents, representatives, or employees, related to this case. The Monitor and members of

the Monitoring Team may testify in any case brought by any Party in this case regarding the implementation, enforcement, or dissolution of the Agreement.

4. Reports issued by the Monitor and members of the Monitoring Team shall not be admissible against the State in any proceeding other than a proceeding to enforce this Agreement.

5. Unless such conflict is waived by the Parties, the Monitor and members of the Monitoring Team shall not accept employment or provide consulting services that would present a conflict of interest with the Monitor's responsibilities under the Agreement, including being retained (on a paid or unpaid basis) by any current or future litigant or claimant, or such litigant's or claimant's attorney, in connection with a claim or suit against the State or its departments, officers, agents, or employees.

6. Neither the Monitor nor any person or entity hired or otherwise retained by the Monitor to assist in furthering any provision of the Agreement shall be liable for any claim, lawsuit, or demand relating to the Monitor's performance under the terms of this Agreement. This paragraph does not apply to any proceeding before a court related to performance of contracts or subcontracts for monitoring the Agreement.

F. Monitoring Team. The Parties agree that the Monitor may use consultants to assist the Monitor. These experts shall work under the direction of the Monitor, assist the Monitor in monitoring the Facilities' compliance with this Agreement, and, together with the Monitor, shall be referred to as the Monitoring Team. The Monitor and the Parties will agree upon which particular consultant(s) the Monitor shall use to assist the Monitor in his duties as Monitor. The State shall pay all reasonable fees and expenses incurred by members of the Monitoring Team in the course of carrying out their duties under this Agreement, in accordance with the Texas Prompt Payment Act. No Party, nor any employee or agent of any Party, shall have any supervisory authority over the Monitoring Team's activities, reports, findings, or recommendations.

G. Monitoring Team Access. The Monitoring Team shall have full and complete access to the Facilities to which the team is assigned, including all of the Facility's buildings and facilities, staff, individuals served (subject to the individual's right to refuse), individuals' records, and documentation relating to the issues addressed in this Agreement, except where covered by attorney work product protections or attorney-client privilege. Each Facility's Superintendent shall direct all employees to cooperate fully with the Monitoring Team assigned to that Facility. The Monitoring Teams shall be permitted to initiate and receive ex parte communications with the Parties.

H. Monitoring Team Visits. By the later of six months from the Effective Date this Agreement or six months from the Parties' identification to the Court of experts serving as Monitor pursuant to Section E, the Monitor shall conduct a "baseline" evaluation of the Facilities to which the Monitor is assigned to determine the Facility's compliance with the terms of this Agreement. This baseline evaluation is intended to inform the Parties and the Monitor of the status of compliance with the Agreement. The Monitor

shall produce a written report to the Parties with regard to the Facility's compliance with particular provisions of the Agreement as soon as practicable, but at least within 60 days of this visit. Thereafter, the Monitoring Team shall visit each Facility to which the Monitor is assigned no less frequently than every six months following the baseline evaluation.

I. Status and Facility Reports. At the conclusion of each Monitoring Team visit, the Monitor shall notify the Facility verbally of his or her preliminary impressions regarding noncompliance with identified areas of the Agreement. At its discretion, DOJ may be present for any such briefings. Further, following each Monitoring Team visit, the Monitor shall provide the Parties with Status Reports describing the steps taken by the Facility to which the Monitor is assigned to implement this Agreement and evaluating the extent to which the Facility has complied with the requirements of the Agreement. The Monitor's Status Reports shall be issued within 45 days of each visit, unless the Parties agree otherwise. For each requirement of Part II of this Agreement, the report shall specify: (1) the steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance; (2) whether the relevant policies and procedures are consistent with the requirements of the Agreement; (3) the self-assessment steps the Facility undertook to assess compliance and the results thereof; (4) the level of compliance, i.e., "noncompliance" or "substantial compliance"; and (5) the Monitor's recommendations, if any, to facilitate or sustain compliance. Drafts of the Monitor's Status Reports shall be provided to the Parties at least ten business days prior to issuance of the Status Reports. Additionally, the Parties shall have access to all written and oral briefings and reports provided by members of the Monitoring Team to the Monitor. To facilitate each Monitor's visit to a Facility, no later than fourteen calendar days before each visit, the State shall provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with this Agreement. Notwithstanding the foregoing, if a Monitor's Status Report is delayed, the Monitor's subsequent visit shall occur no earlier than 60 days from the report's issuance.

J. Monitoring Exit Criteria. When a Facility achieves substantial compliance with any substantive provision(s) of this Agreement for one year, no further monitoring or reporting of that Facility shall be required on that provision. For purposes of this Agreement, a substantive provision is a provision identified by a capital letter in Part II of this Agreement.

K. Monitoring Team Budget. The State shall provide each Monitoring Team with a budget sufficient to allow the team to carry out the responsibilities described in this Agreement.

L. DOJ Access. DOJ and its consultants shall have unrestricted access to and shall, upon request, receive copies of any documents, records, and databases under the State's control relating to the implementation of this Agreement, except where covered by attorney work product protections or attorney-client privilege. The State shall provide any requested documents, records, and databases to DOJ as soon as possible, but no later than within 30 business days of the request, subject to a reasonable extension agreed

upon by the Parties based on the volume of documents requested or the difficulty in producing the requested information. DOJ and its consultants shall have unrestricted access to all of the Facility's buildings and facilities, staff, individuals served at the Facility (subject to the individual's right to refuse), individuals' records, and documentation relating to the issues addressed in this Agreement. The Facilities' Superintendents shall direct all employees to cooperate fully with DOJ and its consultants. DOJ agrees to provide the State with reasonable notice of any visit or inspection, although the Parties agree that no notice shall be required in an emergency situation where the life, immediate health, or immediate safety of an individual is at issue.

M. Clinical Reviews.

1. Peer Review. Notwithstanding any other provision in this Agreement, access to and use of Peer Review Records by the Monitor, Monitoring Teams, and DOJ shall be limited to assessing the quality assurance aspects of the peer review process.
2. Clinical Death Review. The State shall notify the Monitor and DOJ immediately upon the death of any current Facility resident, including any individual who died following transfer due to medical condition from a Facility to a medical facility.

N. Implementation Plan. Within one hundred twenty (120) days of the Effective Date of this Agreement, the State shall develop an Implementation Plan addressing each of the substantive provisions of this Agreement, as defined in Section III.J., above, to guide the specific tasks necessary to reach compliance with this Agreement and to foster implementation of sustainable quality assurance measures. The State may update the Implementation Plan as the State deems appropriate. Upon request by the State, the Monitor shall provide the State with technical assistance with regard to the Implementation Plan. The Implementation Plan shall not be used to assess the State's compliance with any part of this Agreement.

O. Consistency of Monitoring. The experts appointed as Monitor shall collectively serve as a "Monitoring Panel." The Monitoring Panel shall seek to ensure a consistent methodology in determining compliance and substantial compliance with the provisions of this Agreement. If either Party or member of the Monitoring Panel requests that the Monitoring Panel resolve an apparent inconsistency in the methodology used to assess compliance with any provision of this Agreement, the Monitoring Panel shall confer and issue a written decision addressing the claimed inconsistency within 30 days of the request. The decision of a majority of the Monitoring Panel shall control as to the monitoring methodology, unless the Parties appoint a Coordinating Monitor who is charged with overseeing the Monitoring Panel and ensuring the consistency and adequacy of Monitoring, in which case, the Coordinating Monitor's decision shall control.

P. Dispute Resolution and Enforcement. The Parties intend to pursue a collaborative approach to resolve disputes that may arise in the implementation of this

Agreement regarding an alleged failure of a Party to comply with a provision of this Agreement or the meaning of a provision of this Agreement. If a dispute arises between the Parties regarding an alleged failure of a Party to comply with a provision of this Agreement or the meaning of a provision of this Agreement, the Parties agree to attempt first to resolve the dispute through discussion between the Parties. If the Parties reach a resolution that varies from the Agreement herein, the resolution shall be reduced to writing, signed, and filed with the Court for approval. If the Parties are unable to resolve the dispute through discussion, either Party may, at its discretion, seek a judicial determination of the alleged noncompliance or dispute after providing the other Party with 30 days' written notice of its intent to seek such a determination. This 30-day period shall not be necessary where DOJ believes conditions or practices pose an immediate and serious threat to the life, health, or safety of the individuals served at a Facility. During this 30-day period, the Parties shall continue discussions to attempt to resolve outstanding differences. At the end of this 30-day period, either Party may, without further notice, seek a judicial determination. Except where DOJ believes conditions or practices pose an immediate and serious threat to the life, health, or safety of the other individuals served at a Facility, DOJ shall not initiate contempt proceedings for an alleged failure to fulfill an obligation under this Agreement without first having obtained an order for specific performance of the obligation and having notified the State of the intent to initiate contempt proceedings.

Q. Termination. The Court shall retain jurisdiction to enforce the terms of this Agreement for the duration of the Agreement. Except as provided herein, the Agreement will terminate five years after the Effective Date hereof. The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year. Within 60 days prior to the fourth anniversary of the Effective Date, the Monitor shall provide the Parties and the Court an assessment of the status of compliance with each substantive provision of this Agreement as to each Facility ("Four-Year Report"). For purposes of this Four-Year Report, the Monitor may use the most recent Facility status reports, prepared pursuant to III.I hereof, if such reports were issued within the previous 90 days. Any dispute between the Parties regarding the Monitor's assessment of the status of compliance in the Four-Year Report will be resolved in accordance with Section III.P. For each Facility, the Court's jurisdiction shall terminate after five years as to any substantive provision with which the Facility has been in substantial compliance for at least one year. Thereafter, as to each Facility, the Court shall retain jurisdiction over any remaining substantive provision identified in the Four-Year Report, or as otherwise agreed by the Parties, or as ordered by the Court pursuant to III.P as to which the Facility has not achieved substantial compliance for at least one year, until the Facility has been in substantial compliance with that provision for at least one year. After substantial compliance with any remaining substantive provisions of this Agreement for a period of one year, the DOJ and the State will file a joint motion to terminate the Agreement.

R. Early Termination. Notwithstanding Section III.Q, above, this Agreement may be terminated for any Facility once the Facility reaches substantial compliance with all

substantive provisions as defined in Section III.J., above, of this Agreement and sustains substantial compliance with all provisions for one year thereafter. After a Facility has reached substantial compliance with all substantive provisions of this Agreement for a period of one year, the DOJ and the State will file a joint motion to terminate the Agreement as to that Facility.

S. Confidentiality. The Parties agree that any records or confidential information produced pursuant to this Agreement may be shared only with the following: (1) the Court, including public submissions and filings, in a proceeding to enforce the terms of this Agreement, and only in such proceeding; (2) any expert(s) or consultant(s) selected or retained by the Parties pursuant to this Agreement; (3) all counsel of record in this matter; (4) the Monitor, Monitoring Team, and any staff and clerical personnel working with the Monitoring Team; (5) staff and clerical personnel involved in the preparation and review of the submissions and reports for counsel of record; (6) State employees responsible for implementation of this Agreement; and (7) United States and other governmental officials, as necessary, in order to carry out law enforcement responsibilities. All Parties shall be responsible for maintaining the confidentiality of records and information in their possession. Submissions to the Court that contain identifying information of clients (such as their full name, address, or social security number) shall be filed with the Court using pseudonyms or initials.

1. No Monitor is a state or local agency or an agent thereof, and accordingly the records maintained by the Monitor shall not be deemed public records subject to public inspection.
2. Subject to Section S.5, below, the Parties and the Monitor shall redact or otherwise obscure confidential information that clearly identifies an individual served by the Facility, and shall substitute a pseudonym, birth date, and/or other code, in any document that they cause to be made available to the public.
3. The United States shall adhere to the requirements of Federal law, including the Freedom of Information Act (“FOIA”), 5 U.S.C. § 552. In the event of a request pursuant to FOIA for records containing confidential information, the United States agrees to assert all applicable exemptions in protecting any such confidential information, including 5 U.S.C. § 552(b)(7)(A), (b)(6), (b)(7C), and (b)(7)(D).
4. The State shall adhere to the requirements of state and Federal law. In the event of a request pursuant to FOIA or state law for records containing confidential information, the Parties and Monitor agree to assert all applicable exemptions in protecting the confidentiality of information contained therein.
5. The Parties and the Monitor shall provide to one another records in unredacted form.
6. Notwithstanding the foregoing, all documents, records, photographs, and videotapes and any information in such documents, records, photographs, and videotapes



may be shared with state and federal departments and agencies for official governmental purposes.

T. Successors. This Agreement shall be binding on all successors, assignees, employees, agents, and all those working for or on behalf of the State.

U. Challenges. The Parties agree to defend the provisions of this Agreement. The Parties shall notify each other of any court or administrative challenge to this Agreement. In the event any provision of the Agreement is challenged in any local or state court, removal to federal court shall be sought.

V. Waiver. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision therein shall not be construed as a waiver of its right to enforce other deadlines or provisions of this Agreement. In the event any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.

W. Unforeseen Delay. If any unforeseen circumstance occurs that causes a failure to timely carry out any requirements of this Agreement, the State shall notify the DOJ in writing within 30 calendar days of the time that the State becomes aware of the unforeseen circumstance and its impact on the State's ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. The State shall implement all reasonable measures to avoid or minimize any such failure.

X. Notice. "Notice" under this Agreement shall be provided by courier or overnight delivery and shall be provided, at DOJ, to Shanetta Y. Cutlar, Chief, U.S. Department of Justice, Civil Rights Division, Special Litigation Section, 601 D St., N.W., Washington, DC 20004 and, at the State, to James C. Todd, Assistant Attorney General, Office of the Attorney General, General Litigation Division – 019, 300 W. 15<sup>th</sup> Street, 11<sup>th</sup> Floor, Austin, Texas 78701. Either Party may name another individual to receive notice by written notice to the other Party.

Y. Non-Retaliation. The State agrees that it shall not retaliate against any person because that person has filed or may file a complaint, provided information or assistance, or participated in any other manner in an investigation or proceeding relating to this Agreement.

Z. Modification. Any modification of this Agreement shall be executed in writing by representatives for the State and the United States and filed with the Court for its approval.

AA. Integration. This Agreement shall constitute the entire integrated agreement of the Parties. With the exception of DOJ's Findings Letters referenced in paragraph I.C of this Agreement, any DOJ technical assistance recommendations regarding the issues

raised therein, and any document to which the Parties mutually agree to govern the Monitor's assessment of compliance, no prior drafts or prior or contemporaneous communications, oral or written, will be relevant or admissible for purposes of determining the meaning of any provisions in this Agreement or in any other proceeding.

BB. Right to Withdraw. Each Party reserves the right to withdraw consent to this Agreement in the event that the Rule 41(a) dismissal is not granted by the Court on the express terms agreed to by the Parties. Modification of the Parties to this Agreement would be a material change to the Agreement.

CC. Costs. All Parties shall bear their own costs, including attorney fees.

DD. Subheadings. All subheadings in this Agreement are written for convenience of locating individual provisions. If questions arise as to the meanings of individual provisions, the Parties shall follow the text of each provision.

WHEREFORE, the Parties to this action having agreed to the provisions in the Agreement set forth above, this Agreement is hereby entered this \_\_\_\_\_ day of \_\_\_\_\_, 2009.

FOR THE UNITED STATES:

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Acting United States Attorney  
Western District of Texas

*/s/ Daniel M. Castillo*

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FOR THE STATE OF TEXAS:

*/s/ Adelaide Horn*

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Commissioner  
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DAVID L. LAKEY  
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Texas Department of State Health  
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*/s/ Linda Hinshaw*

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LINDA HINSHAW  
Superintendent  
Abilene State School

*/s/ Dave Ptomey*

---

DAVE PTOMEY  
Acting Superintendent  
Austin State School

*/s/ Robert Ham*

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ROBERT HAM  
Superintendent  
Brenham State School

*/s/ Iva Benson*

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**IVA BENSON**  
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Corpus Christi State School

*/s/ Nancy Condon*

---

**NANCY CONDON**  
Superintendent  
Denton State School

*/s/ Tony Ochoa*

---

**TONY OCHOA**  
Superintendent  
El Paso State Center

*/s/ Kristin Weems*

---

**KRISTIN WEEMS**  
Acting Superintendent  
Lubbock State School

*/s/ Gale Wasson*

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**GALE WASSON**  
Superintendent  
Lufkin State School

*/s/ Bill Lowry*

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**BILL LOWRY, PH.D.**  
Superintendent  
Mexia State School

*/s/ Al Barrera*

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AL BARRERA  
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Richmond State School

*/s/ Sonia Hernandez-Keeble*

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SONIA HERNANDEZ-KEEBLE  
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# **Appendix A:**

## **Restraint Documentation Guidelines**



Restraint Documentation Guidelines for State Mental Retardation Facilities  
November 2008

1. As soon as possible, after any restraint procedure is initiated, staff begins documentation of the restraint episode, using the Restraint Checklist. Specific information documented on the Restraint Checklist includes:
  - a. Date and time restraint was begun;
  - b. Location of the restraint;
  - c. Brief description of the events leading to the restraint, including what was happening prior to the change in the individual's behavior that led to the use of restraint;
  - d. Interventions/ actions taken by staff, to de-escalate the situation and/or calm the individual, prior to use of restraint (This may not always be applicable to a medical restraint.);
  - e. The specific reason(s) for the use of restraint;
  - f. Method and type (e.g., medical, dental, crisis intervention) of restraint;
  - g. Names of staff involved in the restraint episode;
  - h. Observations of the individual and actions taken by staff while the individual was in restraint:
    - Observations are documented every 15 minutes and at release;
    - Any specific behaviors of the individual that required continuing restraint;
    - Care provided by staff during restraint, such as opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan;
  - i. Level of supervision provided during the restraint episode;
  - j. Date and time the individual was released from restraint;
  - k. Results of the assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects.
2. Staff trained in the application and assessment of restraint document a face-to-face assessment of the individual that is conducted as soon as possible, but no later than 15 minutes from the start of the restraint, to review the application and consequence of restraint.
3. Upon being informed of the use of restraint, a licensed health care professional documents the physician's order for the restraint in the individual's record, if a physician's order is needed.
4. A licensed health care professional documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for medical restraint pursuant to a physician's order. If, in an extraordinary situation, the physician orders an alternative monitoring schedule, the vital signs and mental status checks are documented according to the alternative schedule. For an individual subject to restraint away from a State Mental Retardation Facility, a licensed health care professional documents vital signs and mental status of the individual within thirty minutes of the individual's return to the State Mental Retardation Facility. In each instance of a medical restraint, the schedule and type of monitoring that is specified by the physician determines frequency of documentation.
5. At shift change, for a restraint applied as a crisis intervention, staff going off duty documents a review of the status of the individual with staff who is coming on duty. Documentation includes time the restraint was initiated; the individual's current physical, emotional, and behavioral condition; medications administered during the restraint if any; and type of care needed.
6. Following termination of a restraint applied as a crisis intervention, a restraint monitor documents a debriefing on the Restraint Debriefing form.

7. Prior to administration of a chemical restraint, the licensed health care professional contacts the psychologist, who assesses whether less intrusive interventions are available and whether conditions for administration of a chemical restraint have been met. The psychologist documents this assessment on the Administration of Chemical Restraint Consult form.

**Appendix B:**  
**Psychiatric Evaluations/Assessments**

## **STATE MENTAL RETARDATION FACILITIES**

### **Psychiatric Evaluations/Assessments**

- I. Identifying information
  - a. Name, age, gender, ethnicity, housing, marital status
- II. History of Present Illness
  - a. Name, age, gender, ethnicity, housing, marital status
  - b. Behavioral concerns: antecedents, frequency, intensity, duration
  - c. Substance use
  - d. Suicidal/homicidal ideation
  - e. Current medications, pattern of use, efficacy
  - f. Psychiatric symptoms
  - g. Neuro-vegetative symptoms
- III. Past Psychiatric History
  - a. Inpatient treatment
  - b. Outpatient treatment
  - c. Medication history
  - d. Previous diagnosis
  - e. Trauma history
  - f. History of self-injury, suicide, aggression to others
- IV. Family History
  - a. Psychiatric disorders
  - b. Medical disorders, especially diabetes, cardiovascular disease, CVA, HTN
  - c. Neurological syndromes
- V. Substance Use History
  - a. Alcohol: first drink, DUI, blackouts, current pattern
  - b. Drugs of abuse, including IVDU
  - c. Tobacco
  - d. Caffeine
- VI. Medical History
  - a. Active conditions
  - b. Past history
  - c. Current medications
  - d. Allergies
  - e. Diet
  - f. Exercise habits
- VII. Developmental History
  - a. Prenatal and birth history
  - b. Early development
  - c. Family relationships
  - d. Educational history
- VIII. Social History
  - a. Relationship history (marriage, partner, children)
  - b. Work history
  - c. Legal history
  - d. Sexual history
- IX. Physical Examination
  - a. Pertinent positives and negatives
  - b. Neurological findings

- X. Labs
  - a. Urine drug screen
  - b. Pertinent positives and negatives
- XI. Mental Status Examination
  - a. General observations
    - i. Appearance (jewelry, scars, tattoos)
    - ii. Behavior (eye contact/calm/agitated, psychomotor slowing/pressure/agitation)
    - iii. Speech
    - iv. Cooperativeness
  - b. Thinking
    - i. Thought process (logical, goal-directed, loose, tangential, circumstantial, over inclusive)
    - ii. Thought content (preoccupations, delusions, suicidal ideation, homicidal ideation)
    - iii. Perception (auditory, tactile, visual, olfactory, gustatory hallucinations)
  - c. Emotion
    - i. Affect
    - ii. Mood
  - d. Cognition
    - i. Orientation
    - ii. Attention and concentration
    - iii. Memory
    - iv. Insight
    - v. Judgment
- XII. Diagnostic Assessment (five axes)
  - i. Clinically justifiable diagnoses are provided for each individual. All diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review.
  - ii. The documented justification of diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist).
  - iii. Differential diagnoses, “deferred,” or “rule-out” diagnoses, and a diagnoses as listed as “NOS” (“Not Otherwise Specified”) are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner.
  - iv. If the determination is “no diagnoses” this is considered to be clinically justified and documented.
- XIII. Bio-Psycho-Social-Spiritual Formulation (Case Formulation)

Case Formulation consists of the following sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan:

  - a. Review and integration of information from the disciplinary assessments;
  - b. Identification of important factors, in a biological psychological social and spiritual hierarchy, that affect the individual's condition, functional abilities, and quality of life;
  - c. Creation of clinically based predictions about the individual's needs; and
  - d. Design of integrated treatment, habilitation, and enrichment interventions, through the interdisciplinary treatment process, to meet the individual's needs.
- XIV. Treatment Recommendations
  - a. Pharmacological intervention
  - b. Non-pharmacological intervention

## **Appendix C: Post-Move Monitoring Checklist**

## POST-MOVE MONITORING CHECKLIST

Name of individual:	Name of staff performing this checklist (print):			
Residential Provider:	Signature of staff completing this form:			
Home Address:	Date of visit: Circle one: <b>1-7 days</b> <b>8-45 days</b> <b>46-90 days</b>			
Home Phone Number:	Name & phone # of Case Manager/ QMRP:			
Date individual moved into home:	Name & phone # of Residential Provider contact person:			
<p><b>Instructions:</b> Complete the checklist to assess whether supports called for in the Community Living Discharge Plan (CLDP) are in place. “Yes” = supports identified in the CLDP are in place; “No” = identified supports are not in place; “N/A” = not a support identified in the CLDP.</p> <p><b>NOTE: All “No” responses must include a narrative on the attached page explaining why the support is not in place.</b></p>				
		<b>Yes</b>	<b>No</b>	<b>N/A</b>
1	Identified essential supports, per CLDP, in place? (List all items mentioned in CLDP Section IV Item D 1.)			
2	Identified non-essential supports, per CLDP, in place? (List all items mentioned in CLDP Section IV Item D 2.)			
3	Has the support plan been updated? (If so, enter date meeting held or date meeting scheduled)			
4	Have there been any changes in medication? (If so, list medications changed, date of change and reason for change)			
5	Does the provider have documentation to confirm staff have been trained on:			

## POST-MOVE MONITORING CHECKLIST

	a. individual's medical needs?			
	b. individual's dietary/nutritional needs?			
	c. individual's personal hygiene needs?			
	d. mobility needs?			
	e. individual's behavioral considerations and/or psychiatric needs/symptoms?			
	f. individual's communication needs?			
	g. individual's adaptive aids?			
6	Personal belongings in the home and available to the individual?			
7	Home generally clean and in good repair?			
8	Do the individual's records indicate the individual has remained free of injury/illness?			
9	Do the individual's records indicate any behavioral incidents, and, if so, were the incidents effectively managed?			
10	Has there been a change in home, provider or Case Manager/QMRP?			
11	Does the individual express satisfaction with his/her new life, or, if individual is unable to indicate, does the individual's LAR or primary correspondent indicate individual is satisfied with his/her new life?			
12	Were the medical and other specialty provider appointments kept, consistent with the individual's CLPD and/or the individual's support plan, as applicable?			

### ACTION/FOLLOW-UP FOR ANY ITEMS MARKED "NO"

Item number	ACTION TAKEN	DATE AND RESPONSE TO ACTION TAKEN



## **Appendix D: Recordkeeping Practices**

# State Mental Retardation Facilities - Communication Process

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## Recordkeeping Practices

### DATE

11/12/2008

### APPLIES TO

All Departments

### CONTACT PERSONS

Director of Quality Enhancement  
Assistant Superintendent of Programs

### REFERENCES

Completing Individual Profile Sheets  
Ensuring the Availability and Use of Individual Notebooks  
Texas Department of Aging and Disability Services Records Retention Schedule

### DEFINITIONS

**Active Record** - a record pertaining to an individual residing at a State Mental Retardation Facility that is maintained within the individual's living residence. These records include documents stored in residential areas to communicate the care, treatment, and training of an individual that are used for effective individual habilitation planning and implementation and for protection of the legal rights of the individual, the facility and facility staff, as well as computerized documents accessible to the Personal Support Team.

**Approved Abbreviation List** - a list of approved abbreviations and symbols that may be used in the individual client records.

**Falsification** - knowingly, recklessly, or intentionally entering, failing to enter, altering, or deleting data so that the documentation provided is untrue and intended to deceive.

**Inaccurate Recordkeeping Practices** - activities undertaken to document or record data either incorrectly or in a manner that does not comply with approved record keeping procedures, when there is no intent to deceive.

**Individual Notebooks** - A portion of the Active Record that accompanies the individual to ensure more reliable delivery of services and, when possible, immediate documentation of significant events.

**Master Record** - a record pertaining to an individual currently or formerly residing at a State Mental Retardation Facility that includes current and/or historical information.

**Overflow Folder** - a file, such as microfilm, for each individual that contains the documents that are purged from the Active Record and that will be sent to the Medical Records Department for long term storage.

**Record Maintenance Guidelines** - a list of the order in which approved forms are filed in the record and the schedule by which documents shall be removed to the Overflow Folder.

# State Mental Retardation Facilities - Communication Process

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## Recordkeeping Practices

### GENERAL INFORMATION

1. The record is to be legible, accurate, current and complete.
2. Each entry in the record is to be dated with the month, day, and year.
3. Entries which may occur more than one time during the same day are to include the time of day, as well as the date.
4. All entries that are not typewritten should be made with a non-erasable ballpoint pen (black recommended).
5. Each entry must be authenticated by the signature (first and last name) and identification or job title of the person making the entry. If initials only are required on a form, such as a Medication Administration Record Sheet, a signature legend must be on the document and used by all who make entries on the page for identification purposes.
6. Individual records shall not contain pages with gaps of space between data entries. Unused portions of the page shall be marked through with a large "X" or a line shall be drawn through single blank lines.
7. Entries in the record shall be written in a chronological format. If there is an occasion when documentation is impossible, (e.g., a record that is temporarily unavailable; or the service to an individual cannot be interrupted), the words "late entry" shall be placed in the margin beside the documentation of the event, which shall be completed as soon as possible. The date shall indicate the day on which it should have been written. If it is the same day but out of time sequence, the time shall be referenced.
8. In situations in which one person is authorized to sign for another person (i.e., in his/her absence as "designee," etc.), the person signing will sign the other person's name and then write "by" and sign his/her own name. The use of signature stamps is forbidden.
9. Records are to be organized in a manner providing ready access to information relevant to the individual's status and to the supports and services he/she receives. The record organization will follow the Record Maintenance Guidelines.

### FILING

1. The File Clerk or designee shall be responsible for filing and removing completed documents according to the Record Maintenance Guidelines for Active Records.
2. The Residential Coordinator or designee shall be responsible for filing and removing completed documents according to the Record Maintenance Guidelines for Individual Notebooks. Persons responsible for documents in the Individual Notebooks are responsible to check and make sure the most recent information is in these notebooks and that the Residential Coordinator gets updates and revisions as they occur.
3. Active Records will include records needed by the personal support team members in order to provide services and supports in one record as well as individual notebooks, and computerized records, such as Injury Reports.
4. The File Clerk or designee will file any document that is received that is designated as a priority

# State Mental Retardation Facilities - Communication Process

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## Recordkeeping Practices

document within one working day of its completion after checking to ensure that the responsible team member has reviewed the document prior to filing as needed.

5. The File Clerk or designee is responsible to copy these documents and distribute as needed.
6. If the File Clerk or designee determines that an Active Record is overloaded after purging according to the Record Maintenance Guidelines, the File Clerk or designee shall divide the record into additional volumes, labeling each with A, B, C, etc. The volumes shall be filed so that all remain a part of a complete record.
7. Overflow documents are sent to the Medical Records Department by the File Clerk or designee so that historical records can be maintained/microfilmed according to state retention schedules.

## SECURITY OF RECORDS

1. Only authorized persons with a need to know may view the individual's record. The individual is always authorized to view his/her record.
2. Parts of the Active Record may not be removed for any reason by any staff member other than to be copied when necessary, then replaced immediately, or for purposes of purging the record according to the schedule.
3. Documents purged from the record should, in general, be sent to the Records Department to determine need for retention, type and length of storage needed.
4. The Records Department will arrange for confidential shredding of any documents no longer needed in hard copy after ensuring the microfilmed copies of records to be maintained are legible/copied correctly.
5. Personal support team (interdisciplinary team) members are responsible to arrange for confidential shredding of any drafts or copies of records kept in the Active Record when the drafts or copies are no longer needed.
6. Access to computerized records will be protected through security access to the site and/or passwords.

## UNIFIED RECORD

1. All documents should be kept in the Active Record, Master Record and/or Individual Notebook.
2. Medical Progress Notes must be integrated, including entries from at least Physicians, Physician Assistants, Psychiatrists, Dentist, Nurses, and Therapists.
3. Professional staff may maintain additional copies of records for use in their support for each individual but details, diagnosis, assessments, plans of care and treatment must be entered into the Active Record or given to the File Clerk or designee for filing.

## FALSIFICATION OF RECORDS

1. Falsification of individuals' records is prohibited. Examples of falsification include but are not limited to those listed below:
  - a. A staff member intentionally creates and documents program implementation within an individual record, although the program was not actually provided.
  - b. At the end of a reporting period, an individual demonstrates more progress than projected on a specific program objective. This discovery is made when the staff member is reviewing the

# State Mental Retardation Facilities - Communication Process

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## Recordkeeping Practices

- data sheet prior to making a progress entry. Since such progress will require that an IDT meeting be held to develop a new program, the staff member alters the data entries to reflect less progress. This results in no new program being initiated.
- c. A staff member discovers that an individual has an injury. Rather than reporting and documenting the discovery of the injury, the staff member deliberately takes no action. This failure to document an event is an act of falsification since the record entry for the shift does not accurately reflect a known event.
  - d. An observation note is entered in an individual's record, which documents several toileting accidents during the shift. Later, because it is perceived that this entry will reflect negatively on unit staff, the entry is deleted from the record.
  - e. Entries are made prior to administering a service, e.g., meals or medications.
2. Supervisors shall provide ongoing supervision to staff that enter documentation into individual records in order to facilitate the highest degree of integrity of individual records.
  3. It shall be the responsibility of each supervisor to intervene and stop falsification practices when such are identified. If it is determined that falsification of individual records is occurring or that supervisory staff are encouraging, knowingly permitting, or directing such practices, the supervisor engaging in such practices is subject to disciplinary action up to and including dismissal from employment.
  4. In confirmed allegations of falsification of records, the employee(s) responsible for the falsification shall be subject to disciplinary action up to and including dismissal from employment.

### **QUALITY ENHANCEMENT**

1. Quality assurance procedures shall include random review of the unified record of at least 5 individuals every month.
2. Problems noted during these random audits will be monitored to ensure that adequate corrective action is taken to limit possible reoccurrence.

### **EXCEPTIONS**

Exceptions to this policy may be made with justification and approval by the Superintendent.