GLENWOOD RESOURCE CENTER - PRELIMINARY REPORT

Description of the Facility

Glenwood Resource Center (GRC) is located in the City of Glenwood, which is in western Iowa. This facility has 231 operational beds for temporary respite admissions, emergency services, and long-term placements for individuals with intellectual or developmental disabilities. The current census is 194. GRC s' residents possess diverse abilities and functional levels and have varying intellectual abilities. The diagnoses of the facility's' residents with intellectual disabilities range from mild to profound. Some residents require more staffing supports to meet their daily needs, while others are much more independent and capable of meeting many their own needs. Many of the individuals have swallowing disorders, seizure disorders, ambulation issues, or other health care needs. A significant portion of GRC's population has medically complex issues while many other GRC's residents struggle with maladaptive behaviors, such as self-injurious behavior or aggression. A significant proportion of GRC's residents have been diagnosed as having mental illness; and, of those residents with an Axis I disorder diagnosis, virtually all had been prescribed one or more psychotropic medications.

GRC receives Medicaid funding from U.S. Department of Health and Human Services ("HHS"). For Medicaid purposes, GRC is certified to care for individuals as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). As a condition of receiving Medicaid funds as an ICF/IID, the Centers for Medicare and Medicaid Services (CMS) requires a regular survey of conditions and investigation of certain incidents reported at participating institutions. The Iowa Department of Inspection and Appeals (DIA) is the state entity that is responsible for the CMS ICF/IID surveys in Iowa. DIA has cited GRC for repeated deficiencies in Client Protections (investigations of abuse and neglect), Client Rights, Staff Training, and Active Treatment (Individual Support Plan implementation). GRC has been under a Conditional License since November 2019.

Purpose of Report

GRC is currently under investigation by the United States Department of Justice (DOJ) under the Civil Rights of Institutionalized Persons Act (CRIPA) and Title II of the Americans with Disabilities Act (ADA). Specifically, the DOJ investigation will focus on:

- Whether GRC has violated the federal rights of the residents by placing them at serious risk of harm by subjecting them to: 1) harmful and uncontrolled human subject experiments; 2) inadequate medical and nursing care, physical and nutritional management, and behavioral health care; 3) needless and harmful restraint practices; and 4) incidents causing needless physical injury; and

- Whether GRC violates the rights of residents under Title II of the ADA by not providing services to those residents in the most integrated setting appropriate to meet their needs.

The purpose of this report is to provide an independent review of GRC in light of the DOJ investigation. In addition, the Iowa Department of Human Services asked for a review of GRCs services and supports to

address the DIA conditional license concerns surrounding supervision of residents, staff training, and consistent implementation and oversight of individual program plans.

This report was developed after preliminary review and assessment of Glenwood Resource Center's (GRC's) facility systems, policies, services and supports that are in place to ensure adequate and effective treatment and supervision of individuals. This review and assessment also included a review of GRC's implementation of individual support plans (ISPs), staff training, monitoring and oversight of program implementation for individuals who lived at GRC during the designated review period (2017-2019). I visited GRC on January 9-10, 2020 and February 10-14, 2020 (DOJ on-site). A more extensive review and additional on-site visits with observation of program implementation and interactions between staff and people who live at GRC has not been possible due to COVID-19 restrictions. However, a number of teleconferences and video meetings have been conducted to obtain additional information and provide consultation.

The primary sources of written information were the Department of Justice (DOJ) Document Production Request dated 12/19/2019 and written information from GRC requested by this reviewer. I have not reviewed any official DOJ document requests received by Iowa Department of Human Services (DHS) prior or subsequent to the 12/19/2019 request. I also reviewed information obtained from GRC staff interviews conducted by DOJ experts during their February 10-14, 2020 on-site visit and from GRC staff interviews I conducted myself or by DHS administrative staff. Additional information was obtained via attendance at individual support plan (ISP) meetings and Monthly Integration Reviews. I observed residents in a variety of settings, their homes, activity areas, classrooms, workshops, and during meals while at GRC during my visit of January 9-10, 2020 and February 10-14, 2020 (DOJ on-site). I also had meetings with DHS administrative staff during my January visit to obtain background information and listen to DHS concerns.

There are a number of major issues that contributed to the current DOJ investigation into GRC polices, procedures and practices. Some of these areas of concern are outside my purview or have been assigned to other experts. My assigned areas will be discussed individually and overlapped as necessary to assure clear and concise communication of the factors involved and to provide recommendations for both immediate and ongoing improvement. The following major topic areas will be covered:

- Leadership and Supervision of GRC
- GRC Work Culture
- Medical Services (Mortality review)
- Quality Management
- Restraint Use
- Psychology Services
- Staffing and Supervision of Individuals
- Staff Training
- Implementation of Individual Support Plans (ISP)
- Habilitation and Skill Acquisition

LEADERSHIP AND SUPERVISION OF GRC:

Three (3) major issues significantly affected the leadership and supervision at GRC:

1) The State of Iowa entered into a Settlement Agreement with the Department of Justice (DOJ) on November 17, 2004 agreeing to make substantive changes in operations of each State Resource Center (Glenwood and Woodward Resource Center) to achieve targeted improvements in services and supports for individuals living at these facilities. In April 2010, GRC had been successful in demonstrating substantial compliance with the DOJ settlement agreement. Sometime after April 2010, GRC senior leadership made the decision that GRC did not have to continue to implement the policies, procedures and program changes that had been successful in demonstrating substantial compliance with the DOJ settlement agreement. It is not clear when this breakdown occurred, or who authorized it at DHS, but it is clear that these effective systems and oversight procedures deteriorated over time at GRC.

2) The second major issue that adversely affected GRC operations was the lack of effective and consistent leadership by previous Superintendents. This was compounded by the lack of effective oversight and monitoring by previous DHS leadership (Director Foxhoven and Division Director Shultz).

   The Superintendent's role is to provide overall leadership and supervision to the facility, to assure State and Federal ICF/IID rules and regulations are followed, and individuals who live at GRC are provided quality care and treatment in the least restrictive and appropriate setting to meet their needs. In order to fulfill this role, the Superintendent must provide clear and consistent guidance to the senior leadership team and establish a work culture that supports a healthy and safe environment for all employees and individuals. In addition, the Superintendent needs sufficient time on the job to establish his/her leadership style and build a cohesive team. Unfortunately, this has not been the case at GRC due to significant turnover in the Superintendent position from 2004 to the present day. The table below provides detailed information as to the frequency of this turnover by number of days/years each person held the Superintendent position.

Superintendent	Beginning Date	Ending Date	Duration in Days	Duration in Years
William Campbell	3/13/69	8/12/04	12,936	35.44
Thomas Hoogastraat	8/13/04	10/17/08	1,526	4.18
Kelly Brodie (Interim)	10/18/08	10/25/09	372	1.02
Scott Booth	10/26/09	4/15/10	171	0.47
Kelly Brodie (Interim)	4/16/10	7/11/10	86	0.24
Zvia McCormick	7/12/10	11/7/13	1,214	3.33
Kelly Brodie (Interim)	11/8/13	5/1/14	174	0.48
Gary Anders	5/2/14	2/10/17	1,015	2.78
Rick Shults/Marsha Edgington (Interim)	2/11/17	9/10/17	211	0.58
Jerry Rea (on administrative leave from 12/9/19 to 12/30/19)	9/11/17	12/9/19	819	2.24

Marsha Edgington (Interim); 5/1/20 used for days calculation	12/9/19	Present	144	0.39

As can be seen above, there has been significant turnover in the Superintendent position since 2008 with some stability during the tenure of Thomas Hoogastraat, Zvia McCormick and Gary Anders. I am not privy to the reasons why these three (3) Superintendents and other Superintendents left GRC, but those reasons may provide additional information about GRC specific issues and DHS issues that require attention. Any organization that has this kind of turnover in leadership will typically experience short- and long-term problems with continuity, communication, team process, and planning, to name a few issues. In response to such significant leadership changes, it is not unusual for department heads to develop survival strategies to assure their own departmental processes and work tasks are protected from frequent changes. Staff also may be hesitant (or resist) making any changes in policy, procedures and daily operations because once they begin to adopt new ways of doing things, new leadership changes course. The result is a silo mentality with deterioration of communication and cooperation, and lack of integration of clinical care across and between departments. Overall staff morale suffers, people frequently protect their positions and perceived status, trust issues begin to form, recruitment and retention becomes difficult and teamwork becomes disjointed. The quality of care for both staff and individuals suffers.

3) An additional issue of concern is the lack of a "deep bench" at the GRC senior leadership level. There has been turnover in key Executive Committee (EC) positions in the past 5 years: Executive Officer (currently vacant), Director of the Office of Quality Management, Director of Nursing (currently vacant), Director of Education and Training, and Assistant Superintendent of Treatment Support Services. In my discussion with the current Interim Superintendent and DHS Liaison, they expressed frustration with some members of the EC in that these EC members are extremely hesitant to initiate tasks within their purview or in coordination with other departments. This hesitancy may be the result of lack of knowledge of GRC systems and operations, their responsibilities as a leadership team, fear of change (see #2 above), poor coordination of efforts, overwhelmed by the sheer amount of work needed and learned helplessness that came about during Dr. Rea's tenure as Superintendent. Some members of the EC disagreed with the changes that Dr. Rea was implementing, but did not express their concerns to him due to fear of retaliation. Dr. Rea also fostered cliques with the EC (those that supported his efforts and those that did not) and there may be lingering trust issues within the EC leadership that affect their ability to cooperate and integrate their efforts to be a cohesive leadership team. One of the EC members did ask DHS leadership for assistance several times (via e-mails and phone) during Dr. Rea's tenure, but became frustrated by the lack of action by DHS leadership to effectively address their concerns.

GRC WORK CULTURE

In my interviews with GRC staff and in my document review of multiple staff satisfaction and supervisory effectiveness surveys, problems at GRC have been around for several years. The GRC Executive Committee (ECR) members also shared information about long-standing problems in the areas of teamwork, cooperation, communication and problem solving. The ERC members expressed significant

concern about Dr. Jerry Rea's leadership and the direction he was taking GRC as a facility. Executive Committee members described Dr. Rea as controlling and intimidating, and that he created an unhealthy work environment in which retaliation and fear were common. Executive Committee members related incidents in which verbal and written caustic exchanges among GRC staff also occurred in personal interactions outside of GRC and in social media (e.g., Twitter, Snapchat and Facebook). A number of EC members described GRC as a hostile workplace.

Dr. Rea recognized serious problems at GRC and was interested in changing the GRC leadership model and work culture using organizational behavior management principles (OBM; e.g., Stephen R. Covey). These types of significant changes require effective communication, cooperation at all levels of the organization, and time to be successful. OBM principles were frequently discussed in Executive Committee (EC) meetings and book chapters were assigned to EC members as homework. EC members were instructed to disseminate these principles to their departments and make subsequent changes in operations, policy and procedures.

EC members said that Dr. Rea wanted to refocus GRC and simplify operations. EC members used terms coined by Dr. Rea as "creative destruction" and that GRC was to "focus on less in order to accomplish more". From January 2017 to August 2018, policies and procedures were submitted to the Policy and Procedures Committee for review and approval. In August 2018, Dr. Rea decided to streamline policies and protocols and only wanted policies required by DHS and Medicaid ICF/IID rules and regulations. In addition, the Policy and Procedures Committee was disbanded in lieu of small groups of staff revising proposed policies. One group (Group 2) maintained minutes of the meetings, while the other Groups (1,3,4) did not. As a result of Dr. Rea's direction, a significant number of GRC policies, procedures and committees were eliminated. EC members were instructed to take these discontinued policies and procedures back to their respective departments and include them in their standard operations. Many EC members said most of these policies and procedures were never implemented at the departmental level because they either disagreed with the changes or weren't provided sufficient guidance to make the needed changes. In addition, EC members described the elimination of major GRC policies and procedures as causing significant confusion among employees. During my meeting with the EC in January 2020, several EC members expressed concern about the elimination of policies and other issues. When asked by me if they expressed their concern with Dr. Rea, they said it was not safe to do so.

As part of Dr. Rea's OBM leadership model, he conducted frequent staff surveys to help identify the most important GRC issues. Common troubling themes emerged from these satisfaction surveys:

- GRC work culture was consistently described as authoritarian, disrespectful, non-supportive, toxic, frustrating, retaliatory, and unfair. Staff morale described as poor.
- Residential staff felt their supervisors did not understand staff's jobs
- Upper and middle management are not good role models, and frequently do not follow behavior support plans
- Upper and middle management are over controlling of both staff and individuals
- While employees are encouraged to speak up, management is not open to constructive feedback, doesn't listen, promises not kept or retaliation occurs
- Scheduling in residential services is unfair, inconsistent and favoritism is demonstrated by residential supervisors

- Too much overtime and residential staff pulled to different homes; did not have sufficient supervision, training and support to effectively complete their assigned tasks
- Too many staff satisfaction surveys, but no action taken.

Based upon these results, Dr. Rea also asked EC members to identify the most important GRC issues that they believed would not be achieved unless it got special attention. The top six (6) identified issues were:

1) employee morale,
2) staffing/overtime,
3) lack of communication,
4) favoritism by supervisors,
5) lack of consistent implementation of rules by supervisors and leadership, specifically in residential services, and
6) lack of a person-centered process

These issues also appeared most frequently as problem areas in many staff satisfaction surveys and Supervisor Effectiveness Evaluations.

Dr. Rea borrowed a term from Stephen Covey's work entitled Wildly Important Goals (WIG) to focus attention and effort on these six (6) issues. WIG workgroups were created across campus and meetings were typically conducted 1- 2 times per month. Some WIG groups met weekly. The WIG workgroups were interdisciplinary and required significant staff time, resources and effort. A number of recommendations were made and different initiatives were implemented. However, as time progressed and issues didn't significantly improve, WIG meeting attendance diminished over time and the efforts to change the work culture and instill a person-centered process failed. Staff put in significant time and effort working on important issues for little payoff, which unfortunately exasperated staff and further contributed to lower staff morale. It is my impression that the WIG workgroups took on a life of their own and unfortunately replaced the interdisciplinary team process in addressing individual needs and supports. The essential teamwork, coordination and communication necessary to maintain daily facility operations suffered. The concerns listed above are still major issues that the current GRC administration is actively trying to address.

<u>GRC as a Research Center</u>

DHS leadership has assigned the investigation of possible research activities at GRC to other experts and law enforcement; therefore, I will not comment on those specific activities in this report. However, it is my impression from DOJ interviews of GRC staff and documents reviewed (Executive Steering Committee minutes and Glenwood Resource Center Seed Funding white paper, and Research Proposal written by Dr. Steve Taylor), that research efforts were a major focus of Dr. Rea and several departments. These activities interfered with the primary mission of GRC which was to provide quality care, support and a safe living environment to the individuals who live at GRC. In addition, research efforts were not supported by a number of EC members which further alienated EC members trust of each and cooperation on other tasks that were more critical to GRC's operations as an ICF/IID facility.

MEDICAL SERVICES

These areas are being reviewed and recommendations made by the University of Iowa physicians who have been on-site at GRC. I have not received or review their report. However, my review of the Mortality Review Committee information presents issues of concern for health services that require immediate attention.

I reviewed the following documents: GRC Mortality Review policy, Mortality Review Process Checklist, the Mortality Review Document Checklist, Mortality Review Timeline, Primary Physician Mortality Review, the Mortality Review Committee Report and the format for External Independent Physician Mortality Review. These policies and procedures are adequate to conduct a Mortality Review if followed appropriately. From my review of the twenty (20) Mortality Review Committee minutes that were part of the 12/19/2019 DOJ document request, several significant issues are of concern. The written information presented is very sparse and there is a lack of any written discussion of the critical issues. While verbal discussion may have occurred, it is odd that in all 20 mortality reviews there are no recommendations in the section entitled Recommended Plans for Corrective Actions with Assignments. Therefore, it is difficult to determine if the GRC mortality review adhered to GRC policy and procedures and provided a review of critical issues such as: past medical history, diagnoses, events leading up to the death, medications, allergies/adverse drug reactions, hospital encounters during the past year, history of key health concerns, events surrounding the death, treatment prior to transfer to the emergency room, diagnostic assessment, evaluations, and tests performed during the terminal illness (if applicable), appropriateness of medical treatment, and suggestions on how to improve medical services. The lack of sufficient documentation brings into question the sufficiency of the GRC mortality review process and the response to mortalities. My concerns are supported by the mortality reviews completed by The Columbus Organization.

The Columbus Organization has been conducting physician mortality reviews for GRC since 2009. I reviewed the Columbus mortality review report dated 1/27/20 in which nineteen (19) deaths from 6/23/19 -12/12/19 were reviewed. Their report reviewed 10 out of the 20 deaths in my sample and in seven (7) of those cases the Columbus physician provided detailed and specific recommendations for each individual case. In addition, the Columbus Mortality Review report also provided priority recommendations and additional recommendations to improve medical services and overall resident care (see the Columbus Mortality Report for details). Two major health care procedures and process issues need immediate review:

1) recognition of illness by staff and nurses and referring an individual for a medical assessment in a timelier manner; and
2) determining which clinical services can be effectivity provided by GRC and when transfer to a higher level of care is required. It is not clear that GRC Medical Services and Nursing Services reviewed this report and took the necessary actions to address the recommendations provided.

QUALITY MANAGEMENT

I reviewed the following documents: GRC Policy on Quality Management (7/19/2010 and 8/20/19), GRC Policy on Risk Management, GRC Policy on Incident Management, Quality Council Meeting Reports and Quality Council meeting minutes for 2017, 2018 and 2019, Treatment Program Administrators' (TPA) Monthly Reports for 2017, 2018 and 2019, and the Quality Indicators database. On 2/14/2020, I interviewed the Director of Quality Management to obtain additional information about the quality assurance process, staffing, and concerns.

The Quality Management (QM) policy, GRC Policy on Risk Management, and GRC Policy on Incident Management are adequate on a general basis, but facility practices are not consistent with the current GRC policies. As part of the previous DOJ settlement agreement, GRC tracked 249 quality indicators across three (3) general areas with performance measures and associated outcomes:

- Physical Health & Safety
    - Physical Health: Outcomes
    - Physical Health: Performance Measures
    - Physical Safety: Outcomes
    - Physical Safety: Performance Measures
- Emotional Wellness & Self Determination
    - Outcomes
    - Performance Measures
- Independence & Social Belonging
    - Outcomes
    - Performance Measures

Most of these 249 Quality Indicators were abandoned under the previous Superintendent (Dr. Rae). However, a wealth of information/data are still collected and presented to the Quality Council via Quality Council Meeting Reports and Treatment Program Administrator (TPA) Monthly Reports on a variety of topics including:

- Incidents and types of incident (e.g., falls, aggression, elopement, pica, etc.)
- Injuries of unknown origin
- Level of injuries
- Fractures
- Hospital admissions and emergency room visits
- Restraint use
- Investigations
- Peer-to-peer incidents
- Compliance monitoring
- Preventive maintenance
- Medication variances
- Staff injury and OSHSA reportable staff injuries

While GRC still tracks a tremendous amount of data as quality indicators, there is a lack of written evidence in the Quality Council meeting minutes of any discussion or critical analysis of the above QM indicators. The topic and discussion sections provide significant information, but the Action Needed, Responsible Party, Date Due and Date Resolved are all blank. Given this lack of information, it is not

clear that data is used to make decisions at all levels of the facility. For example, in the July 2018 Quality Council Meeting Report, thirty-seven (37) persons were listed as falling and twenty-nine (29) had an increase in falls from the previous month, however, there is no further information provided as to fall prevention efforts for these individuals or on a center-wide basis to access patterns and trends. In the same report, there was a 63% increase in the number of actual medication variances reported, but again no further information as to corrective action taken or if remediation training was provided. Similar issues were found in other Quality Council Meeting minutes for restraint, injuries of unknown origin and other critical Quality Indicators.

After review of the GRC Quality Indicators Report and other QM documents mentioned above, it is not clear that GRC has established specific departmental or center-wide or QM goals and objectives, and whether they have achieved the outcomes desired. In addition, the accuracy of some of the data in the Quality Indicators Report is also suspect. For example, on several reviewed reports the number of persons on medication for dual purposes (psychiatric diagnosis on Axis I & seizure disorder) was zero, and the number of persons requiring documented coordination between psychiatry & neurology was also zero. Information obtained from the pharmacy database and from positive behavior support plans indicate that a significant number of individuals are taking medications for dual purposes. Documented coordination between psychiatry & neurology is needed to assure appropriate clinical treatment. Moreover, it is important that accurate data is entered into the GRC Quality Indicators Report in order to make informed decisions and set reliable goals and objectives.

The Quality Council meetings are not functional in their current form. Information about the health and safety of individuals requires appropriate information, detailed review, critical thinking and careful analysis to make informed decisions and develop plans of improvement. The GRC Quality Management process does not meet current standards of care.

In my interview with the GRC QM Director, she indicated that she has had minimal training on quality management methods and analysis of quality indicator data. However, she is eager to obtain training to improve her knowledge of quality management processes and procedures. She also expressed frustration that majority of her time and her staff's time is spent conducting Type 1 investigations which leaves little time to engage in other Quality Management activities. GRC Incident Management Policy (8/20/19) defines Type 1 investigations as follows:

- All allegations of abuse.
- All serious injuries.
- All suspicious or unexpected deaths, and all deaths allegedly caused by abuse.
- All allegations of sexual abuse.
- All suspicious injuries.
- All injuries resulting from restraint.
- All suicide attempts.
- All individual sexual assaults of another individual.
- All physical assaults resulting in serious injury.
- Any physical assault when in the professional judgment of the treatment program manager, treatment program administrator or other authority, a type 1 review is deemed appropriate based on:
    - The nature of the incident,
    - The potential of harm from the incident, or

    - The prior incident frequency or history of the individuals involved.
- Other incidents as assigned by the superintendent or division administrator.
- All other incidents in which an initial type 2 incident review or clinical or interdisciplinary team review indicates a potential allegation of abuse.

Abuse and Neglect Investigations

The Office of Quality Management has four (4) full-time investigator positions but the QM Director indicated that one position is vacant most of the time. The 3 current investigators are relatively new and only began their duties in late 2019. The vacant investigator position puts additional responsibilities on the other 3 investigators and the QM Director to conduct Type 1 investigations. GRC Policy on Incident Management requires that all Type 1 investigations shall be conducted by a qualified investigator who has successfully completed competency-based training on current professional standards for conducting investigations. GRC contracts with Labor Relations Alternative, Inc. (LRA; https://lraconsultants.com/) for Investigations and Incident Management Training. LRA provides competency-based training with three (3) levels of certification: 1) Conducting Serious Incident Investigations, 2) Advanced Course in Investigations, Writing Investigative Reports, Weighing Evidence and Drawing Conclusions, and 3) Root Cause Analysis and Mortality Review.

The QM Director stated that all current investigators and herself completed certification for the basic course, but have not been recertified. The lack of recertification is problematic and violates GRC policy. The QM Director does not have an investigation manual but keeps a "tips folder" on what to look for given certain types of cases (e.g., elopement, suspicious injuries, etc.). While this is helpful, it cannot replace an investigation manual, especially for new investigators. Completing additional certification in the LAR Advanced Course in Investigations would be extremely helpful for all investigators given their responsibilities. Also given their roles and responsibilities for incident management, it would be helpful if Treatment Program Managers (TPM) and Treatment Program Administrators (TPA) receive this training.

The Department of Investigations and Appeals (DIA) is the State of Iowa survey team that determines GRC's compliance with Conditions of Participation in the Medicaid/Medicare program relative to Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID). A review of the CMS ICF/IID Deficiencies for the time period between the DIA Annual CMS survey visit in 2017 and the DIA Annual Survey visit in 2020 found that GRC had repeated deficiencies in the Conditions of Participation for Client Protections related to Investigations (Tags W153, W154 and W155). These CMS ICF/IID regulations are as follows:

- W153: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the Administrator or to other officials in accordance with State law through established procedures.
- W154: The facility must have evidence that all alleged violations are thoroughly investigated.
- W155: The facility must prevent further potential abuse while the investigation is in progress.

Repeated deficiencies in the area of Client Protections are of major concern and a more detailed analysis of the individual investigations, the investigations process and staff supervision and training are required to determine how these repeated deficiencies effect the integrity of the Abuse/Neglect investigative process and the work culture at GRC. A plan of improvement will be developed.

From January 2019 to November 2019, there were 907 Type 1 investigations (average 82 per month) as noted in Quality Council Meeting Reports. The majority of Type 1 investigations were for allegations of abuse, neglect, mistreatment and exploitation; a significant number of the allegations were for physical abuse or sexual abuse. Very few allegations were substantiated after the investigations were completed. Based upon my professional experience, the number of allegations is significantly more than typically reported at similar sized ICF/IID facilities with a similar population. Furthermore, the percentage of substantiated allegations are lower than expected. Both are of concern and require closer examination to determine their accuracy. If allegations are really this high and the percentage of founded allegations that low, then I have serious concerns about the integrity of the Abuse/Neglect investigative process and the work culture at GRC that puts individuals at risk for harm.

Another explanation that may help explain the above discrepancy between the higher than expected number of Abuse/Neglect allegations and the lower than expected substantiated allegations is the frequency of false allegations. In discussion with Interim Superintendent, Psychology staff and Director of Quality Management, there are several individuals who have made a large number of false A/N allegations in an attempt to control their environments and/or gain attention. It is important to note that these individuals have a history of untreated trauma. False allegations are a sign for help and the interdisciplinary team and psychology need to address the reasons for these false allegations and make the necessary revisions to the ISP and behavior support plan, including mental health therapy, skill building and alternative functional behaviors.

Because a significant number of false allegations may have skewed the data, it is important to obtain a more accurate picture. One avenue is to identify the false allegations and remove them from the computation of total allegations and allegations not substantiated. Removing these outliers is for computational purposes only and will assist in determining a more accurate and reliable data for allegations of abuse and neglect and substantiated findings. This suggestion is not meant to discount any allegations of abuse, neglect or exploitation made by individuals; all allegations have to be taken seriously and properly investigated. However, there needs to be a change in practice and policy that allows GRC and DIA to address proven “false allegations” in a timelier manner and as “unlikely to have occurred” (not unsubstantiated), while still ensuring a fair, equitable and reliable investigative process.

The QM Director expressed concern that discussion of allegations and investigations appear in social media (e.g., Twitter, Snapchat and Facebook). Information related to any facility investigation or complaint of alleged abuse and neglect should be shared with only those administrators or care staff who are essential to conducting and completing the investigation. Anything short of this compromises the integrity of the investigation and creates a significant risk of harm to individuals and staff. In particular, staff and individuals may be unwilling to report incidents of abuse or neglect if they perceive that investigations are not sufficiently confidential. Also, the lack of confidentiality increases staff and residents’ risk of reprisal by disgruntled persons when investigation facts are widely known across a facility. DHS and GRC must address the practice of GRC staff discussing investigations on social media to ensure the integrity of the reporting and investigative processes.

All Type 1 Investigations are uploaded directly to DIA for review and possible independent investigation. When an allegation of Abuse/Neglect is made against a staff person, GRC either removes that person from the GRC campus and puts them on administrative leave, or they reassign the staff to a different area of campus as not to have any contact with the individual. The staff member cannot return to regular duty until the investigation is completed and the allegation is not substantiated. However, DIA must give the final approval before a staff member may return to regular duty. The process of review

and approval by DIA can take time and it is not unusual for DIA final approval to take several months. I do not know the reason for this delay, but further review of the process and discussion with DIA would be helpful.

RESTRAINT USE

Data on restraint use was obtained from Quality Council meeting reports for 2017, 2018 and 2019, and from the Restraint Database for 2017-2019. Additional information on the use of restraint was gathered from DOJ interviews of psychology staff and my own additional interviews with various GRC staff. Two major events significantly altered the use of physical restraint and programmatic restraint at GRC:

- Elimination of the Mandt system and replacing it with the Crisis Interaction Training (CIT) program; and
- Implementation of programmatic restraint in response to a DIA survey finding that excessive emergency physical restraint was used with some individuals without guardian consent. In addition, DIA was concerned that frequent application of emergency restraints within short time intervals, without incorporation into a written active treatment program and behavior support plan was a violation of ICF/IID regulations.

In early 2018, Dr. Rea eliminated The Mandt System and replaced it with the Crisis Interaction Training (CIT). He based this decision on several factors:

- He felt that CIT was a more fiscally prudent alternative to Mandt.
- Based upon his previous experience with CIT in Kansas, Dr. Rea believed that CIT would reduce the use of physical restraint and reduce both staff and resident injuries.
- He believed that the use of supine restraint would be a more effective way to address serious aggressive behavior.
- Because the CIT system taught the use of supine restraint, it was a safer alternative to the Mandt system in addressing serous aggressive behavior. The Mandt System does not teach any type of prone or supine restraint.
- He had the support of the Psychology Director, several psychology staff, the Director of Training, and some of residential supervisors, who felt that Mandt was ineffective in addressing serious aggressive behavior.

According to the GRC Director of Training, in mid-February 2018 CIT trainers from Parsons Kansas provided instructor classes (train-the-trainer model) to the four (4) GRC training staff and the Residential Treatment Supervisors (RTS). The instructor classes covered 2 days. The Director of Training said that several of the GRC instructors voiced concern about CIT's lack of national recognition as a behavior management system, the lack of structure of the CIT training, and that it lacked a re-certification program. Additional concerns emerged about CITs limited focus on de-escalation techniques. In November 2018, the psychology department was so concerned that they added additional training material in pre-service orientation on de-escalation techniques. Concerns about the limitations of CIT were not taken to Dr. Rea because staff felt he was invested in the implementation of CIT and would not change his mind. CIT training for the rest of the GRC staff began March 21, 2018.

GRC has used chemical restraints, physical restraints, programmatic physical restraints, and medical restraints to address problematic behaviors that put individuals at risk for harm. Prior to April 2019, all physical restraints were classified as emergency physical restraints. During a survey DIA cited ICF/IID Tag W296-483.40(d)(1)(ii) which states that "The facility may employ physical restraint as an emergency,

but only if absolutely necessary to protect the resident or others from injury. DIA was concerned that the facility was employing emergency physical restraint to often for some individuals and without guardian consent. In addition, DIA was concerned that frequent application of emergency restraints within short time intervals, without incorporation into a written active treatment program raised serious questions about the individual's receipt of active treatment and the individual's right to be free from unnecessary restraint. As part of GRC's plan of correction, the GRC Hierarchy of Behavioral Interventions policy was revised (revised 3/19/19) to include programmatic restraint if there were three (3) instances of the use of emergency restraint within a rolling 30-day period. A number of individual's positive behavior support plans were changed to include programmatic restraint. The first documented use of supine programmatic restraint was April 26, 2019.

If physical restraint is added as an integral part of an individual's positive behavior support plan the typical intent is to clarify the specific reasons for the restraint, the type of restraint to be used (or not used for safety reasons), the severity of the behaviors to justify its usage, the risks associated with restraint use, alternatives to restraint use, specific individualized calm criterion for release from restraint, and an individualized plan towards reduction. This overall goal should lead to a less restrictive means of managing and eliminating the behavior for which the restraint is applied. These essential components of a behavior support plan that prescribe physical restraint, whether it is emergency or programmatic, was not clearly included in the revised behavior support plans.

The table below presents the physical restraint, programmatic restraint, medical restraint and chemical restraint data that was reported in the monthly Quality Council Meeting Reports and in the GRC Restraint database for 2017 thru 2019.

Type of Restraint	2017	2018	2019*
Total Emergency Physical Restraints	192	409	268
Total Programmatic Restraints	0	0	588**
Total Chemical Restraints	24	24	25
Total Medical Restraints	7	15	4
Total All Restraints	**238**	**448**	**885**
			*data was only provided up to 12/19/19
			**Began to be used in April 2019; first documented use of supine physical restraint was April 26, 2019

I will focus on the use of emergency and programmatic physical restraints given excessive use of these restrictive procedures and their potential for misuse and increased potential for serious injury to both staff and individuals. As can be seen above, the use of emergency physical restraint from 2017 to 2018 increased significantly from 192 to 409; a 113% increase. The duration of emergency physical restraints from 2017 to 2018 increased from an average of 2 minutes to an average of 6 minutes; a 200% increased. In 2017, almost 50% of the emergency restraints (95/192) were used on just 3 individuals, while one individual unfortunately experienced 28% (53/192) of the emergency restraints used for 2017. A similar pattern of use can be seen for 2018. Five (5) individuals received 79% (324/409) of the total emergency physical restraints used in 2018. In addition, one of the five (5) individuals received 50%

(204/409) of the total emergency physical restraints for all of 2018. Two (2) of the individuals who received some of the highest numbers of emergency physical restraint did so in both 2017 and 2018.

While the use of emergency physical restraint decreased from 2018 to 2019 (409 as compared to 268), the use of total physical restraint used in 2019 (emergency plus programmatic restraint) exceeded the total number of emergency restraint for both 2017 and 2018 combined (511 combined use in 2017 and 2018, as compared to 856 in 2019). Although emergency physical restraint was still used in 2019 (268 times), the unfortunate consequence of changing emergency restraint to programmatic restraint for a number of people may have provided staff an incentive to use physical restraint more frequently than ever before because it was now in the behavior support plans. In addition, because the behavior support plans had informed consent from the parent/guardian and review/approval by the Human Rights Committee, programmatic restraint did not have the same level of scrutiny as the use of emergency restraints.

Restraints are to serve only as an immediate protection from imminent harm. Minimally accepted standards dictate that restraints be employed only in the face of imminent risk of harm, when less restrictive interventions have proven unsuccessful and never as a punishment. Furthermore, restraints are to be administered in a hierarchal, graduated fashion from lesser to more restrictive measures. Individuals are to be released as soon as they have gained individualized control criteria and the imminent risk of harm is no longer present. In short, individuals are to be free from restraint except where an immediate and critical threat of harm is present.

As mentioned previously, The Mandt system was replaced by the CIT program beginning March 21, 2018. Psychology behavior support plans were ineffective is addressing serious aggressive behaviors. The CIT program was also ineffective in teaching de-escalation techniques, so staff relied upon supine restraint. Therefore, there was a significant increase in the use of emergency restraint from 2017 to 2018 (192 to 409). From January 2018 to the end of March 2018, emergency physical restraint was only used 31 times (an average of 10 times per month), while after CIT was fully operational in April 2018, emergency physical restraint was used 378 times (409-31), and average of 42 times per month.

It is clear that implementation of CIT was at least partially responsible for the increase in the use of emergency physical restraint. However, the psychology department failed to monitor use of physical restraint and make necessary systematic changes to the behavior support plans to reduce restraint use. In addition, the Interdisciplinary Teams failed to monitor and address the use of emergency restraint. These inactions raise serious questions about the Interdisciplinary Team process and the individual's receipt of active treatment. Moreover, information on use of emergency physical restraint and programmatic physical restraint was found in the Quality Council meeting reports and in the Restraint database, suggesting a system-wide failure and a serous breach of clinical responsibility on a number of levels. Clearly, GRC violated the right of individuals to be free from unnecessary restraint.

Staff Injuries as related to Use of Physical Restraint

GRC tracks injuries to staff in a database entitled Staff Injury Tracker. I reviewed the staff injury data from 2017, 2018 and 2019 to determine the total number of staff injuries due to all causes, the number of staff injuries associated with managing behaviors, the number of staff injuries associated with physical restraint, and the number of staff injuries associated with supine restraint.

Staff Injuries Reported in 2017, 2018, and 2019

Year	Total Number of Staff Injuries	Number of Staff Injuries Managing Behaviors (Percent of Total for the year)	Number of Staff Injuries Associated with Physical Restraint	Number of Staff Injuries Associated with Supine Physical Restraint
2017	267	142 (53%)	3	0
2018	233	129 (55%)	9	0
2019	318	215 (68%)	51	33
Grand Total	**818**	**486**	**63**	**33**

Total staff injuries due to all causes was similar for 2017 and 2018, whereas 2019 had the highest number of staff injuries from all causes. As noted in the table above, injuries to staff are more probable when staff are managing problematic behaviors. Across all 3 years, over 50% of total staff injuries occurred when staff were managing problematic behaviors. However, in 2019 there was approximately a 13% increase from the previous 2 years in staff injuries associated with managing problematic behaviors. In 2019, the number of staff injuries associated with the use of physical restraint increased by 466% from the previous year. In addition, 65% (33/51) of those injuries occurred when supine physical restraint was used.

Resident Injuries as related to Use of Physical Restraint

It was expected that residents' injuries related to use of physical restraint would show a similar pattern of injuries as noted for staff injuries. GRC does document resident injuries and the use of restraint but they are not in a database that allows for detailed review and critical analysis of their relationship. Data and written synopsis of resident injuries can be found in several distinct places: Treatment Program Administrator (TPA) Monthly Reports, Quality Council Monthly Reports, and in individual GRC Accident and Incident Reports. While data and written synopsis for use of physical restraint can be found in similar locations including the GRC Restraint database, none of these have sufficient information and linked data to allow for needed comparisons between resident injuries that may have occurred from use of emergency physical restraint or programmatic physical restraint. It is unusual that a facility would track such a relationship for staff, but not for residents.

BEHAVIOR SUPPORT PLAN DEVELOPMENT AND IMPLEMENTATION

Persons with developmental disabilities may engage in challenging, even harmful ("maladaptive") behaviors frequently. Examples include biting, slapping, scratching oneself or others, intentionally destroying property, or pica. The causes of these behaviors often reflect difficulty in learning effective and healthy ways of meeting one's needs and wants. Generally accepted professional practice requires that appropriate psychological interventions, such as behavior support programs and habilitation plans, be used to address significant behavior problems and assist individuals to live in more integrated settings. If facilities fail to provide adequate psychological services, individuals who may be capable of more independence are not provided skills to foster that independence. This is a lost opportunity.

Psychology Staff

The GRC Psychology Department's staff includes a Psychology Administrator/Director and six (6) Psychology positions. The current Psychology Director has training and experience in applied behavior analysis and is a Board-Certified Behavior Analyst at the Ph.D. level. However, he will retire in June 2020. Currently, one (1) Psychology position is vacant, and another psychologist will retire in August, 2020, leaving only four (4) psychologists for the entire campus. All of the psychologists have Masters degrees as required. Three (3) psychologists have education and training in applied behavior analysis; none are certified as a Board-Certified Behavior Analyst. Two (2) psychologists have education and training in mental health with skills in counseling and substance abuse. Psychologist duties include annual assessments for the ISP meetings, review of functional assessment information, writing and revising the behavior support plans, attending IDT meetings, attending monthly integrated review meetings, and providing information for psychiatric consultations. Those psychologists with a mental health background provide some individual counseling, but no group counseling at this time. Psychological evaluations, including cognitive and adaptive behavior assessment, are completed every three (3) years by community-based contract licensed Psychologists.

Psychologist Caseload

The caseload of each psychologist varies in size depending upon which houses the psychologist is assigned and the number of people living in that house. In September 2019, all 6 Psychologist positions were filled and caseloads varied between a high of 43 and a low of 13. The Psychology Director also had a caseload of 12. The generally accepted caseload ratio for a psychologist is 1:25 for ICF/IID facilities serving persons with developmental disabilities. For caseloads with a significant number of individuals with serious behavioral issues and/or mental health disorders the ratio should be cut to 1:20. The Psychology Director attempted to balance out caseloads based upon the number of behavior support plans in a home and mental health needs. In several homes, the caseload was split based upon the needs of the behavioral and mental health needs of individuals and the expertise of the psychologist. For example, in one home the assigned psychologist had all but two (2) individuals on their caseload. The remaining two (2) individuals were assigned to another psychologist because the individuals had more mental health issues, and the assigned psychologist to that home did not have a mental health background. Currently, with five (5) psychologists and based upon the number of behavior support plans, the caseloads have a range of 47 to 22, with an average caseload of 30.

When home coverage was split among psychologists, residential staff expressed concern about not knowing who the psychologist was for certain individuals. This home split also decreased continuity of clinical support in the home. In DOJ interviews, some residential staff did not know who the psychologist assigned to house was, and had not seen a psychologist for at least one (1) year. This is a serious problem and brings into question whether the psychology staff actually know the people they support.

The RTW staff said they rely upon the Psychology Assistants for information because they see them almost every day. Psychology Assistants are assigned to each home and frequently cover RTW shifts to assure adequate resident supervision and safety. Although Psychology Assistants are not supervised

clinically by the Psychologists, psychology staff depend upon them for a majority of clinical tasks. Psychology Assistants also teach staff how to implement the behavior support plans. Psychology Assistants also collect functional assessment information for program development and collect all the behavioral data and enter the information into a database for graphing. Psychology Assistants may also attend psychiatric consultations and provide behavioral data for psychotropic medication reviews. Given their major clinical role in psychology, it is critical that Psychology Assistants are clinically supervised by psychology staff and have appropriate training in applied behavior analysis. The Director of Psychology trains the Psychology Assistants, but the training package was not made available for review.

Behavior Support Plans

In the assessment of behavior support plans (BSPs), I have reviewed over twenty-five (25) BSPs, attended numerous psychology staff/peer review meetings and Behavior Management Review meetings. I have also provided consultation and feedback to every Psychologist concerning functional assessment information and BSPs. I have also interviewed residential staff about behavioral interventions and observed individuals in their homes and at GRC vocational sites. I was also present when the DOJ Psychology expert, Dr. Chan, interviewed psychology staff and residential staff and observed individuals in their homes. During those observations, individuals frequently engaged in maladaptive behaviors, but staff often failed to implement behavior support plans. When staff from one home were pulled to cover another home, pulled staff admitted they were not familiar with the individuals and did not know about the behavior support plan or any ISP goals/objectives. This brings into question the consistent implementation of behavior support plan or any ISP goals/objectives.

Generally accepted professional standards of practice provide that behavioral interventions should be: (1) based on adequate assessments of the causes and "function" (i.e., purpose) of the behavior; (2) be implemented as written; and (3) be monitored and evaluated adequately. Ineffective behavior support programs increase the likelihood that individuals engage in maladaptive behaviors, subjecting them to unnecessarily restrictive interventions and treatments.

The current GCR census is 194 people. One hundred and fifty-two (152) of the individuals have a BSP, or 78% (152/194) of the GRC population. Although some persons newly admitted to a facility might arrive with serious maladaptive behaviors, the fact that a significant number of the GRC population engages in serious maladaptive behaviors demonstrates that the facility's behavioral supports and services suffer from major deficiencies. Many of the GRC behavior support programs are ineffective and substantially depart from generally accepted professional standards. In particular, they often are not based on adequate functional assessments, are poorly crafted, and are not closely monitored, evaluated, and revised as needed.

The functional assessment is updated annually by the Psychology Assistant which may not be sufficient given possible changes in function of behaviors over time. The typical GRC functional assessment includes a brief description of the individual, psychiatric diagnosis, baseline data, behavioral history, Functional Assessment Interview (FAI; O'Neil, Horner, Albin, Sprague, Storey, & Newton, 1977), an ABC Checklist and Analysis, a scatter plot, reinforcer preference assessment (RAISD, Fisher, Piazza., Bowman & Amari, 1996), a narrative description of the results with a hypotheses about the function of the target

behavior, justification, risks, and canned statements about maintenance and generalization. In the functional assessments and BSPs I reviewed, there are significant shortcomings. FAI information is omitted from the FAI standardized tool and the assessment has been shortened considerably which makes the tool less accurate and reliable. Information about etiology is missing and there is limited differentiation between operant, environmental, social, medical and psychiatric based behaviors. Operational definitions are poor. Psychotropic medication changes and significant life events are not consistently graphed to determine their influence on treatment. Significant parts of a professional functional assessment are missing, such as observational data, naturalist functional analog information, social skills assessment, psychiatric rating scales or other standardized assessments concerning mental health issues. Trauma history, history of sexual abuse and sexually inappropriate behavior may be noted in the functional assessment information, but formal assessment is lacking. The functional assessment typically indicates that target behaviors have multiple functions, but efforts to clinically test the function of target behaviors to get a more accurate hypotheses and a potentially more effective treatment plan is lacking.

Effective behavioral interventions typically include modifying the environmental or other controlling variables to prevent maladaptive behavior from occurring. Effective behavioral interventions should also target the function of the maladaptive behavior to the maximum extent possible and focus on replacing the maladaptive behavior with a healthy alternative behavior that serves the same function. The functional assessments I reviewed typically pointed to an environmental factor or other controlling variable (as distinct from mental illness) as possible motivating variables or setting events related to the behavior. However, the psychologist frequently did not use this information to identify appropriate replacement behaviors or to attempt to modify the environmental factors or other controlling variables. If it was attempted, the effort was typically not correct. Furthermore, the identified replacement behaviors were often too broadly stated to be useful. For instance, the behavior support plan for one individual indicated that the identified replacement behavior for that individual who was identified as engaging in "socially inappropriate behavior," was to engage in "appropriate social behavior”.

Maladaptive behavior is frequently a form of communication for persons with developmental disabilities who lack the tools to communicate more conventionally. Although a complete functional assessment should address communication, a separate, reliable communication assessment by a Speech Pathologist should be routinely used to help identify the role that lack of effective communication may contribute to an individual’s maladaptive behaviors. Collaboration between Speech and Psychology in providing a coordinated effort can significantly improve the success of a behavior support plan. Moreover, addressing communication issues can have great efficacy in building essential skills and identify appropriate learning objectives and interventions. Clinical coordination between Speech and Psychology is severely lacking.

Another common contributing factor related to maladaptive behavior are medical issues, such as GERD, allergies, constipation, dental issues, acute and chronic illness and pain. Unfortunately, psychology does not routinely consider medical issues and pain in their functional assessment information. Although medical issues may be listed in the functional assessment, psychology does not consider it with their purview. Furthermore, they often failed to consult with medical or nursing staff to determine how medical issues may be related to the target behaviors. For example, a number of individuals have

contractures, spasticity, and arthritis that may cause pain. Although GRC Nursing staff use a pain assessment tool, psychology staff did not consider this assessment information. An empirically-based pain assessment tool for persons with developmental disabilities (Pain and Discomfort Scale; PADS). was shared with psychology staff to improve their understanding of a standard protocol and possible indicators of pain. This tool was also shared with nursing services.

A functional assessment identifies the particular positive or negative factors that prompt or maintain a challenging behavior for a given individual. By understanding the precursors and, separately, the purposes or "functions," of challenging behaviors, professionals can attempt to reduce or eliminate these factors' influence, and thus reduce or eliminate the challenging behaviors. In addition, functional assessments help identify possible replacement behaviors that are more appropriate and more useful in everyday life. Without such informed understanding of the cause of behaviors, attempted treatments are arbitrary and ineffective.

Trauma-Informed Care

People with intellectual and developmental disabilities (ID/DD) experience traumatic events at a much higher frequency than the non-disabled population. It has been estimated that people with ID/DD suffer 2.5 to 10 times the abuse and neglect of non-disabled peers. More than 90% of adults reported sexual abuse within their lifetime (Valenti-Hein & Schwartz, 1995). Often, they receive little or no treatment for the effects of trauma. Trauma experiences can lead to mental health problems and difficult behaviors. Trauma can have profound effects on a person and can range from environmental sensitivities (loud noises, bright lights) to behaviors like distrust of others, despair, and powerlessness. To move past trauma, individuals need an ongoing sense of safety, connections to others they can trust, and as sense of empowerment.

It is clear from review of numerous behavior support programs and discussion with various GRC clinical staff, that a significant number of individuals who live at GRC have a history of trauma; however, it is not addressed as a treatment goal. GRC does not have a current system of trauma-informed care, but must develop a comprehensive approach to trauma-informed care at both the clinical and organizational levels to be successful.

Implementation and Monitoring of Behavior Support Plans

Behavior support plans are only effective if implemented as intended (i.e., often referred to as treatment integrity). Generally, greater levels of treatment integrity are associated with better individual outcomes. To implement a behavior support plan correctly and consistently staff need to be well trained and their ability to implement the behavior support plan assessed regularly using a competency-based approach. A competence-based approach requires not only reading the plan and understanding it, but also being able to demonstrate correct implementation of the plan through role playing and asking questions. After the initial training is completed and staff have demonstrated 100% competence, staff booster training is required to ensure consistent implementation. This is especially important given the number of behavior support plans and the variety of target behaviors to decrease

and functional replacement behaviors to increase. Frequent monitoring of program implementation is critical to assess staff skills.

Teaching staff correct documentation of the behavior support plan is also required in order to determine treatment effectiveness and to alert the professional when a revision is needed. It is important that staff are trained by the professional who developed the behavior support plan. This helps ensure that the program is implemented and documented as intended, but it also helps the plan's author understand the practical aspects of the behavior support plan's implementation in different environments and with different staff.

At GRC, the psychology staff who write the behavior support plans do not directly teach the staff who are responsible for implementation. Rather, the psychology staff teach the psychological assistants and the residential/vocational supervisors, and they teach the direct support staff (i.e., Residential Treatment Worker (RTW). This train-the-trainer approach can be effective if implemented correctly, but it is also fraught with potential problems. One such problem is teaching drift. That is, the correct teaching of the behavior support plan has drifted over time and the instructor is no longer teaching correct implementation or documentation as originally intended. To combat potential teaching drift, frequent monitoring of the secondary trainer is required with booster teaching sessions to assure that the plan is taught correctly. GRC psychology staff do not frequently monitor the teaching done by psychological assistants and residential/vocational supervisors to ensure that "drift" does not occur, so it is not clear that behavior support plans are taught or implemented as intended. This train-trainer model is also used for other ISP goals/objectives, such as physical and nutritional management plans. Therefore, the train-the -trainer teaching model brings into question similar concerns for other ISP goals/objectives.

While direct care staff are to be trained to competence at their original home to correctly implement behavior support plans and other ISP goals/objectives, RTW staff are frequently temporarily assigned ("pulled") to work from one house to another to assure adequate number of staff for supervision of individuals. When staff are "pulled" into a new home, there are numerous ISP goals/objectives for each new person that must be taught and learned for correct implementation and documentation. To accomplish this, psychological assistants meet with pulled staff before the beginning of the next shift in an attempt to teach them what they need to know in the new home. This is a tremendous amount of information to be learned in a very short period of time (30 to 40 minutes). In several RTW interviews and during observations on the homes, RTW staff said they felt unprepared to correctly implement most programs and counted on the original home staff to help them.

In addition to monitoring the teaching of behavior support plans, is it important to monitor actual implementation and documentation of the behavior support plan. While the psychology department does have a monitoring system, it does not provide accurate information as to correct implementation and documentation. For example, the Psychology Director indicated in an interview with DOJ that their current system to monitor BSP implementation and documentation provided artificially high passing scores to staff. For example, if staff could tell the monitor where the BSP was located they were assigned a passing score.

Given the above information, GRC does not have an acceptable system to assess effective implementation of behavior support plans, staff's knowledge of the plan, and correct documentation to assess progress. Without the necessary teaching, monitoring and evaluation, individuals are in danger of being subjected to inadequate and unnecessarily restrictive treatments.

Psychotropic Medication Use

Weaknesses in behavioral assessments frequently create a vacuum that may be filled by inappropriate use of psychotropic medications. As of April 30, 2020, of the 194 people living at GRC, 141 individuals are prescribed psychotropic medications. About 73% (141/194) of the individuals with identified maladaptive behaviors and/or mental health diagnoses regularly receive psychotropic medications; often multiple psychotropic medications for the same diagnosed condition. See the table below. GRCs use of psychotropic medications is an unusually high. Published literature estimates that between 14-35% of people ID/DD and mental health disorders are prescribed psychotropic medication. Further detailed review of psychiatric diagnoses is required to determine if there is clinical justification for such high rates of psychotropic medication use and the number of psychotropic medications prescribed.

Psychiatric Diagnosis and Number of Psychotropic Medications Prescribed	Number of Individuals
Psychiatric Diagnosis with 0 medications	12 individuals
Psychiatric Diagnosis on only 1 medication	33 individuals
Psychiatric Diagnosis on 2 medications	60 individuals
Psychiatric Diagnosis on 3 medications	21 individuals
Psychiatric Diagnosis on 4 medications	20 individuals
Psychiatric Diagnosis on 5 medications	5 individuals
Psychiatric Diagnosis on 6 medications	2 individuals
Information obtained from the GRC Pharmacy Supervisor; April 30, 2020	

Information obtained from interviews of psychologists and from review of the BSPs, indicate that psychology staff do not have sufficient knowledge of dual diagnosis (i.e., comorbidity of intellectual disabilities and mental health disorders). Psychology staff are unfamiliar with standardized tools used to assess mental health disorders in the ID/DD population. In addition, psychology staff have little understanding of their clinical responsibility in providing input to the consulting psychiatrists in formulating psychiatric diagnoses. Too often the psychiatrist and IDT make treatment decisions based on anecdotal reports. There is also significant pressure by residential staff, supervisors and guardians to make little, if any, medication changes for fear in increasing challenging and maladaptive behaviors. To complicate matters, the collaboration between psychiatry and neurology as to single use (i.e., seizure control) or dual use medication (i.e., seizure control and mood stabilization) is weak.

Psychologists reported that they do not routinely attend psychiatric medication team meetings; Psychological Assistants may attend in their stead. Psychologists have presented information in several interviews that medications adjustments have been made but they were unaware for several days. Without a system in place to consistently exchange information between these two disciplines (neurology included), treatment altered by one specialty could destabilize treatment from the other specialty and severely compromises the quality of care that people receive.

STAFFING AND SUPERVISION OF RESIDENTIAL TREATMENT WORKERS

The GRC Interim Superintendent and DHS Liaison have indicated that GRC is budgeted for 690.5 positions; on February 17, 2020 only 643 positions were filled (most were RTW vacancies). Three hundred and thirty-six (336) Residential Treatment Workers RTWs) are funded including 28 RTW positions in the GRC waiver homes, leaving 308 RTW positions to staff GRC homes. When determining how many total RTW positions are needed to maintain adequate staffing levels a staff factor multiplier formula is typically used. The staff factor multiplier takes into account an employee's possible paid time off (sick leave, personal leave, holiday leave, etc.) to determine the actual amount of time an employee will actually be available to work. An ICF/IID industry standard staff factor multiplier is 1.8, meaning you need 1.8 RTW positions filled and budgeted to have one RTW staff available to work. When determining how many RTW positions are needed for a home, interdisciplinary teams in cooperation with facility leadership must first determine the minimum number of RTW positions needed for each shift and home in order to provide required health, safety, supervision, and active treatment. For example, based upon the needs of 12 individuals who live in Home 462 it was determined that five (5) RTW staff are needed on both AM and PM shift, while three (3) RTW staff are required for night watch shift. Given the 1.8 staff factor multiplier factor, nine (9) staff must be available on both AM and PM shift (5x 1.8 = 9 staff), while on night watch shift six (6) staff must be available (3x1.8= 5.4 staff). Always rounding up assures adequate number of staff, rounding down causes staff shortages. In addition to the above calculations, GRC leadership must also consider the number of individuals who require 1-1 staff supervision on each shift in their minimum staff coverage. Currently, 31 individuals require 1-1 staffing for behavioral issues (the majority of 1-1s) or medical issues (e.g., seizures or fall prevention). However, the original reasons for 1-1 may have changed over time and efforts are underway to determine their continued clinical necessity.

When all homes and shifts are considered and a 1.8 staffing factor is used, GRC needs 416 RTW funded positions to provide minimal RTW coverage. However, GRC currently has only 308 funded RTW positions, so they are short 108 RTW funded positions (416-308 = 108). This is a major problem and will result in significant mandatory overtime ($3.3 million in FY 2019, and predicted to be $3.8 million in FY 2020), staff burnout, and the lack of adequate and effective supports to consistently implement individual program plans. This also means that supervisors have to cover a significant number of shifts as direct support staff and don't have sufficient time to train, mentor and supervise RTW staff. Even if a 1.4 staff factor multiplier is used (not to be confused with a 1 to 4 staff to individual supervision), GRC needs 322 funded RTW positions, and in this scenario, GRC is still short 14 funded RTW positions (322-308= 14). While this may seem better, the 1.4 staff factor multiplier does not allow for a sufficient number of RTW staff for minimum coverage and to ensure adequate and effective services and supports. In addition, supervisory staff will have to work even more shifts as direct support staff to main safety minimums.

If the State of Iowa is not willing to fund the necessary RTW positions to support the current population (N=194) using a recommended 1.8 staff factor multiplier, then an alternative would be to transition a significant number of individuals (estimated at 43 individuals after discussion with the Interim Superintendent and DHS liaison) to less restrictive settings in the community that are appropriate to meet their needs. Successful community transitions take considerable time, effort and coordination with community providers and managed care organizations. In addition, significant GRC RTW staff time will be required to assure successful transitions. It is possible that a combination of increased RTW funded positions and sufficient community transitions may ease the lack of sufficient RTW staff.

However, there is still the overriding problem of RTW recruitment and retention which is a nationwide crisis.

GRC has a common practice of assigning new RTW staff to the PM shift. It is also noted that the PM shift has the most turnover. This practice has created serious problems in supervision and training of new RTW staff. Combined with the high turnover and frequently pulling staff to different homes, new RTW staff do not have enough time to learn the required tasks and individual ISP goals in one home before they are pulled to a new one; sometimes multiple times in a week. In addition, supervisors don't have enough contact to coach and mentor new RTW staff and assure they are properly trained. New RTWs should not be pulled to other homes before they complete competency-based training and adequate supervision in their originally assigned home. It is hard enough beginning a new job and learning the myriad of ISP plans and objectives for one set of individuals without being thrown into a new environment with a whole new group of individuals with their specific needs and supports.

Adequate supervision of RTWs requires sufficient numbers of well-trained supervisors on each shift who have the leadership skills to coach, teach and motivate RTW staff to carry out their jobs effectively and efficiency. Supervisors must also have adequate time with new RTW staff to train, coach and mentor them. It is not clear that either of these occur with enough frequency to be effective. Many supervisors move up from RTW positions because they have performed well in that role. However, the skills required to be an excellent RTW do not necessarily make an excellent supervisor. GRC lacks a standardized curriculum for supervisor training that teaches the skills necessary to be an effective supervisor and leader. In interviews with several new supervisors, they said they felt like they had been thrown into the deep end of the pool and asked to swim. They also felt that they did not have sufficient time with new RTW staff to teach and coach them because RTW staff were pulled to different homes so frequently. In addition, RTW turnover was so frequent on PM shift that they had a difficult time keeping up with new RTW staff to complete their needed training on individual's ISP programs, behavior support plans and home operations.

Due to direct care staffing shortages and high staff turnover rates, GRC cannot adequately identify risks and ensure residents' safety. GRC must ensure adequate staffing is available for all shifts if they are to provide residents adequate protection from harm or risk of harm. In addition, with residential supervisors working a significant number of shifts as direct support staff, there is not sufficient opportunity to mentor, coach and supervise RTW staff.

STAFF TRAINING

A telephone interview was conducted with the Director of Education and Training in early May 2020. to obtain information on staff training and development. The Training Director has a background in business and adult education and was the Dean of Continuing Education at a Community College for 27 years before she retired. She has been at GRC for two (2) years as the Director of Education and Training. The training department has four (4) full time Training Specialists, one is Nurse.

All new staff must complete 4-days of general orientation on typical topics needed to understand basic GRC operations, policies and procedures, such as Human Resources, Environmental Health and Safety, Human Rights, Active Treatment, Infection Control, HIPAA Privacy and Security, CPR/First Aid/ AED use, Incident Management and Risk Management policy, Back Injury Prevention, and basic computer use. My Learning Point (a Learning Management System) is used for on-line training.

Training staff teach the majority of the classes, but other GRC staff teach specialty sections. For example, the Director of Quality Management teaches Incident Management and Risk Management and Environmental Health and Safety is taught by the Director of Environment Services. Most policies are trained on-line and have a competency test with 100% required to pass. Staff typically have 3 chances to pass the tests in Orientation; most pass but some require additional coaching until they do pass. More critical policies (e.g., Incident Management and Risk Management) are taught in person. All staff are required to complete a competency-based DHS on-line course on the Mandatory Reporter Policy (Child and Adult, 2 hours each). The course is general and does not have specific information about intellectual and developmental disabilities. The abuse/neglect policy is taught as part of the Incident Management policy, but this course is only one hour in duration. This amount of training time is not sufficient given the importance incident management and of abuse/neglect (A/N) training for staff and the large number of A/N investigations at GRC. On a positive note, all staff are given a small abuse/neglect reporting reminder card that is attached to the employee ID.

In addition to Orientation, Residential Treatment Workers (RTW) are required to successful complete the RTW Basic Skills Curriculum. The RTW Basic Skills courses require 80% to pass for competency. These courses are focused on the knowledge, skills and abilities needed for direct client care. The Basic Skills Curriculum is currently 7 days and on Day 4 and Day 7 RTWs go to their assigned homes to work under a mentor, usually another RTW, Residential Treatment Supervisor (RTS), or psychology assistant. The purpose of the mentor is to teach skills need to be successful on the home, provide active treatment and provide documentation. The Crisis Intervention Training (CIT) course is only 4 hours and the Training Director expressed concern about CITs lack of prevention and crisis management information, and overreliance on restraint. When implemented, the Mandt course requires 2 days of trainer training with a written test and hands-on demonstration of the physical techniques for compliance. The MANDT system is committed to the concept of Positive Behavior Support, prevention, and the importance of a therapeutic relationships. Mandt will replace CIT as soon as instructor training and certification can be accomplished.

In new employee orientation, clinical staff teach classroom specialty courses, such as Nutritional Management, use of adaptive equipment, Dysphagia, G-tube/J-tube/ostomy care, mental health, communication, and Applied Behavior Analysis. There is a final test and clinical skills check for competency. Staff are provided a Physical and Nutritional Management (PNM) reference card to carry with their employee ID.

The RTW orientation training used to be 3-4 weeks, but the previous GRC Superintendent shorten the training so RTW staff could be part of coverage sooner. The new Superintendent has plans to return to 3-4 weeks of training for all residential staff who provide direct care to individuals.

A number of new policies and procedures have been developed. The Director of Education and Training, confirmed that new employees will be trained in orientation, while Supervisors will train seasoned employees and require their signature to assure completion of each training.

DIA has cited GRC several times for lack of active treatment (CMS ICF/IID Tag W249) and failure to assure residents consistently receive the necessary supports and services as directed by the Individual Support Plan (ISP). The current Superintendent has begun an initiative to increase staff training on active treatment and ISP implementation. The new ISP/Transition Planning Project has begun to address the ISP process/implementation and discharge transition issues. Activity Specialists will teach a

new 1-hour in-person active treatment course for orientation. In addition, a new 2-hour on-line person-centered planning (PCP) course developed at Woodward Resource Center will be required soon for all staff.

These efforts to increase training for staff in orientation and in annual re-training are commendable. Time will tell if they are effective in increasing staff knowledge of active treatment, person-centered support, and ISP implementation. GRC will need to address the current training process for RTW staff that are temporality assigned ("pulled") to a different home to cover a shift vacancy.

As mentioned previously, a significant number of individuals require 1-1 staffing for behavioral issues. The use of 1-1 staff provides an excellent opportunity for teaching replacement behaviors and establishing a trusting relationship with the individual. However, from interviews with RTWs and Psychologists that is not the case. One-to-one staff are used as glorified babysitters who receive no additional training on BSP implementation, replacement skill development or de-escalation techniques. This is a lost opportunity to make a significant clinical difference in someone's life.

INTERDISCIPLINARY SUPPORT PLANNING PROCESS

Information for this section was derived from attendance at (2) Interdisciplinary Support Planning (ISP) meetings with DOJ experts by either myself or DHS staff. While this is a limited sample, the Director of Social Worker confirmed that these were representative of the ISP process and ISP documents. The following are observations and concerns about the ISP meetings that were attended:

- A typed list of team members is provided at the meeting, but individual team members do not sign an attendance sheet. Therefore, there is no actual written evidence that a team member attended the ISP meeting.
- The individual did not actively participate in the ISP meeting. In one ISP meeting, the Speech Therapist reported that the individual uses an augmentative communication and enjoys using it to communicate, but the device was not brought to the meeting.
- Team members read their reports or provided summaries but there was no discussion, integration or collaboration of ISP goals and objectives. Team members did not have access to each other's reports prior to the meeting that could have facilitated this process.
- There was a significant lack of a person-centered process during the meeting. While there was some discussion of preferences and likes, most of the meeting concentrated on deficits instead of strengths. There was a definite focus on what was important FOR the person, and little discussion about what was important TO the person. In addition, there was also not a pre-meeting of the IDT to review issues and come prepared to discuss them at the ISP meeting.
- One individual was over 70 years of age and is prescribed four (4) psychotropic medications. There was no discussion about her psychiatric diagnoses or possible medication side effects.
- An RTW was in the ISP meeting but did not participate in the discussion. It is not known whether the RTW knew the individual, or was just an available person to bring the individual to the ISP meeting. While the Residential Treatment Supervisor provided information about home life, there was not a family group leader (RTW) who is an assigned as an advocate for the individual, a staff who is most knowledgeable about the person and can talk directly about the person's life, wishes and dreams for the future.

- Discussion about discharge and transition to a less restrictive setting and barriers to possible community placement was inadequate. Teams operated as if they must either recommend or not recommend community placement. By taking this all-or-nothing approach, these teams failed to consider many options that are available to an individual. If a guardian was against possible discharge, the discussion ended without review of possible options. There was no attempt to educate the individuals' family or guardians on available community options, facilitating visits to different community settings (i.e., group home, independent apartment living, or adult foster placement (sponsored homes), or consulting with providers regarding the services available within the community.
- It was obvious that the interdisciplinary teams lacked sufficient knowledge of the community placement options available to individuals. As a result, individuals, their families and guardians are denied opportunities to learn of supports and services that would enable individuals to live in the most integrated settings appropriate to their individual needs.

The ISP document contained a significant amount of detailed information about the individual which demonstrated excellent knowledge of the person. However, the focus was on the health and safety of the individual at GRC, and did not have goals/objectives that were important to the person's interests, consideration of goals/objectives about potential discharge or transition, or education of family members of possible community options. Parts of the ISP demonstrated the use of person-centered language and process, but I was told by several IDT members that what looked good on paper was not really daily practice.

In order to provide a more detailed review of the ISP process and ISP documents, attendance at additional ISP meetings for individuals with varied needs and supports is required.

HABILITATION AND SKILL ACQUISITION

Cognitive and adaptive behavior assessments are done before admission, to validate individuals' qualification for ICF admission, and updated every 3 years to determine any changes in cognition and adaptive skills. In combination with other assessments, like psychology, vocational and communication, there should be a concerted effort to address relevant factors in determining the individual's ability to learn new skills and to develop basic skill-acquisition programs. This is of significant concern because of the ICF/IID requirement of continuous active treatment. Assessments should focus on individuals' strengths, rather than individuals' deficits, and how those strengths can be used in a community setting. Goals for skill-acquisition should be functional and closely related to lowering barriers to independence and increasing individuals' safety. In addition, an important part of habilitation is learning and using skills in community environment in which those skills are useful and functional and will help in living a successful life outside of GRC.

Skill-acquisition programs in behavior support plans are severely lacking. As for the implementation of the skill-acquisition programs that currently exist, I found little guidance to staff as to how such programs should be taught. It appears that direct support staff are left to create their own teaching strategies, with poor success. The only written guidance to staff found in BSPs are vague statements about encouragement. The behavior plans say nothing about which teaching strategies to use or avoid with the individuals based upon assessment of their skills.

A significant part of habilitation and active treatment is the provision of vocational services. GRC provides individuals with activities and opportunities to work on campus at several sites. For some individuals these are meaningful activities and opportunities for personally satisfying paid work. For other individuals, vocational opportunities, both on campus and in the community, are limited mostly due to staff resources and lack of jobs that individuals find interesting. Providing individuals with meaningful activities and opportunities for personally satisfying work strengthens their skills of independent living and powerfully motivates appropriate behaviors. Vocational staff have expressed frustration about providing opportunities for meaningful activities and work at GRC because they have to depend mostly on residential staff to transport people to the work and leisure locations and getting them to the location on time. Frequent RTW staff shortages and vacancies in Activity Aides are a common reason for not assisting individuals to take advantage of opportunities both on and off-campus.

In DOJ interviews, a significant number of RTWs indicated that most individuals only leave GRC campus to take part in community outings about 1-2 times per month. While some favorite individuals without challenging behaviors leave campus more often (3-4 times per month). In addition, several RTW staff said their Activity Aide position was vacant, so they could not leave campus. Supervisors need to make attendance at vocational and leisure opportunities a priority. Planning trips off-campus don't require an Activity Aide; residential supervisors need to take the initiative to increase opportunities for off-campus activities and assure attendance at on-campus activities and work. Holding staff accountable and monitoring performance will be necessary to assure success. Increased community work options also need to be considered and vocational staff need to develop creative parentship with community businesses to increase opportunities for satisfying and productive paid work. Generally accepted professional standards recognize that everyone deserves a meaningful life filled with opportunities for fun, personal growth and individual satisfaction.

Respectively Submitted by:

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