United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: March 20-24, 2017

Date of Report: June 9, 2017

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Mexia SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

This review was originally scheduled for January 2017, but due to severe storm damage that occurred in the few days prior to the scheduled review, the parties and the Monitors agreed to postpone it until March 2017.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twelve of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included two outcomes: outcome 5 related to restraint, and outcome 9 related to abuse, neglect, and incident management.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Restraint

Four indicators were moved to the category of requiring less oversight, primarily regarding usage of approved restraint and the completion of restraint documentation. The overall use of crisis intervention restraint at Mexia SSLC remained about the same as at the time of the last review, and remained at the second highest in the state. That being said, the usage of crisis intervention chemical restraint was very low (only two occurrences) and crisis intervention mechanical restraint and protective mechanical restraint for self-injurious behavior were not used at all. Given the high rate of physical restraint, the operation of the restraint reduction committee should be changed to involve analysis of data and participation from attendees.

Efforts are needed to initiate timely nurse monitoring of restraints, document vital signs and reassess as needed, describe individuals' behaviors when documenting mental status, and clearly document injuries and other negative health effects.

Abuse, Neglect, and Incident Management

Mexia SSLC conducted a lot of investigations; about 800 in the Tier 1 document request six-month period. The incident management department was well organized and managed. Criteria were met for all investigations for indicator 1 regarding there being supports in place to reduce the likelihood of the incident. This was good progress since the last review. Overall, staff

were knowledgeable about abuse and neglect identification and reporting and individuals and LARs were educated about this topic. The quality of investigations was good and they were begun and completed within required timelines. Recommendations were made and implemented in a timely manner. Some attention needs to paid to meeting reporting requirements and documenting re-assignment of alleged perpetrators. Perhaps a quality assurance check of some sort would be helpful to the incident management department.

A prevailing problem at Mexia SSLC was individual-to-individual aggressive actions (called peer-to-peer aggression at Mexia SSLC and most other SSLCs, too). There were frequent occurrences of this type of aggression at Mexia SSLC (reported to be more than 100 per month). Most of these caused no injury or minor/non-serious injures. Some, however, caused serious injuries, such as a broken nose (about three per month). More comments from the Monitoring Team are provided under abuse neglect indicator 1. The Monitoring Team requests a monthly update from the State regarding Mexia SSLC activities being implemented to reduce the likelihood of peer-to-peer aggression, data on occurrences of peer-to-peer aggression, and analysis of the data.

Other
IDTs were not attending to the requirements regarding pretreatment chemical restraint.

Restraint

<table>
<tr><td colspan="12">Outcome 1- Restraint use decreases at the facility and for individuals.</td></tr>
<tr><td colspan="3">Summary: The overall usage of crisis intervention restraint remained about the same as during the last review, and also remained the second highest in the state when adjusting for census. On the other hand, the average duration of a physical restraint decreased compared with the previous review, there were but two usages of crisis intervention chemical restraint, and no usage of crisis intervention mechanical restraint or protective mechanical restraint for self-injurious behavior. This was all very good to see. The restraint reduction committee met regularly, but needed to be revised so that there would be analysis of data and discussion among attendees. These two indicators will remain in active monitoring.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>611</td><td>613</td><td>609</td><td>436</td><td>935</td><td>994</td><td>715</td><td>816</td><td>339</td></tr>
<tr><td>1</td><td>There has been an overall decrease in, or ongoing low usage of, restraints at the facility.</td><td>67%
8/12</td><td colspan="9">This is a facility indicator.</td></tr>
<tr><td>2</td><td>There has been an overall decrease in, or ongoing low usage of, restraints for the individual.</td><td>78%
7/9</td><td>0/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>1/1</td><td>0/1</td><td>1/1</td></tr>
<tr><td colspan="12">Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (May 2016 through January 2017) were reviewed. The</td></tr>
</table>

overall usage of crisis intervention restraint remained about the same as during the last review, and also remained the second highest in the state when adjusting for census. The use of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because almost all of the crisis intervention restraints were physical restraints. The average duration of a physical restraint, however, decreased compared with the previous review to the point where the facility's average duration was the fourth lowest in the state. This was good to see. There were two occurrences of crisis intervention chemical restraint over the nine-month period. This was also good to see, especially given the varied psychiatric needs of many of the individuals. There were no occurrences of crisis intervention mechanical restraint, and no individuals had protective mechanical restraint for self-injurious behavior (PMR-SIB).

The number of injuries that occurred during restraint was low. The number of individuals for whom crisis intervention restraint was used each month remained the same as last review, that is, about 20 per month. The facility, however, highlighted about a dozen individuals who no longer had any occurrences of crisis intervention restraint.

The use of restraint for medical procedures was low. The graph showing non-chemical restraints for medical reasons reflected the use of abdominal binders for six individuals. These were being reassessed for determination if a more appropriate classification would be as protective/supportive devices (i.e., DADS policy #55). The graph showing the use of pretreatment chemical sedation was zero, but the tier 1 document I.17 showed 16 occurrences, all for invasive procedures, such as colonoscopy. Thus, the use of restraint for medical procedures at Mexia SSLC was low, but the facility's data sets did not line up.

The use of restraint for dental procedures was zero for non-chemical restraints. For chemical restraints, no occurrences were on the graph, but the tier 1 document I.17 and tier 2 document I.K showed that there were 87 usages of TIVA sedation in the past year. No individuals were receiving any formal/structured interventions to reduce future likelihood of needing TIVA, however, many informal supports were used and IDTs worked to avoid the need for TIVA (as was the case for many years at Mexia SSLC), though implementation was usually not documented anywhere (also see pretreatment sedation section below in this domain section of the report).

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (i.e., duration of physical restraint, use of crisis intervention chemical and mechanical restraints, injuries during restraint, protective mechanical restraint for self-injurious behavior, the use of non-chemical or chemical restraint for medical procedures, and the use of non-chemical restraint for dental procedures).

The Center's restraint reduction committee met each month and during the week of the onsite review. A good set of data was presented, including most of the 12 sets discussed in this indicator as well as the other indicators of this section. In addition, the committee reviewed general campus data regarding some variables that can affect the occurrence of those behaviors that can lead to crisis intervention restraint, such as engagement in activities on campus, and the number of community activities. The minutes and the Monitoring Team's observation of the meeting, however, did not demonstrate any discussion of these data, trends, actions that might be taken, and so forth. The committee (and meeting format) would benefit from some guidance from facility management regarding data analysis, development of actions, and follow-up protocols. In addition to the restraint reduction committee, restraint data were reviewed at the newly formed executive safety committee and the long-time occurring QAQI Council.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. Of these, all six received crisis intervention physical restraints (Individual #611, Individual #613, Individual #609, Individual #436, Individual #935, Individual #816). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six (Individual #613, Individual #609, Individual #436, Individual #935).

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

Summary: When crisis restraint was used, it was an approved type of restraint, and terminated when no longer needed. This was the case for this review and the two previous reviews. Therefore, indicators 3, 4, and 6 will be moved to the category of requiring less oversight. There were occurrences, though infrequent, of misapplication of restraint, such as in contraindication to orders, or before using a less intrusive form of intervention. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	816			
3	There was no evidence of prone restraint used.	100% 10/10	1/1	2/2	1/1	1/1	2/2	3/3			
4	The restraint was a method approved in facility policy.	100% 10/10	1/1	2/2	1/1	1/1	2/2	3/3			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	90% 9/10	1/1	2/2	0/1	1/1	2/2	3/3			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 9/9	1/1	1/1	1/1	1/1	2/2	3/3			
7	There was no injury to the individual as a result of implementation of the restraint.	90% 9/10	1/1	1/2	1/1	1/1	2/2	3/3			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	90% 9/10	1/1	2/2	0/1	1/1	2/2	3/3			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	0/1	Not rated	Not rated	Not rated	Not rated	0/3			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	90% 9/10	1/1	2/2	0/1	1/1	2/2	3/3			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	90% 9/10	1/1	1/2	1/1	1/1	2/2	3/3			

Comments:

The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #611, Individual #613, Individual #609, Individual #436, Individual #935, Individual #816). Of these, all 10 were crisis intervention physical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For Individual #609 9/15/16, the documentation reported that restraint was implemented when he began scratching himself with a pen. Without additional information, it was impossible to conclude this represented an immediate and serious risk.

6. For Individual #613 5/25/16, the last entry for activity was released per provider orders. This occurred when RN arrived and knew that Individual #613 was not to be in a horizontal restraint. She directed the staff to do a release. Once the restraint was released, no further restraint was necessary.

7. For Individual #613 5/25/16, the restraint checklist noted no injury, but the face to face assessment form noted a bruise to his shoulder. The face to face assessment noted that staff secured his upper body and the daily unit meeting minutes noted a bruise to his left shoulder from peer to peer aggression. More clarity was needed to state that the injury did not result from the restraint.

8 and 10. For Individual #609 9/15/16, there was no documentation that staff attempted a physical hold before moving to a more restrictive restraint. A physical hold would seem to have been an appropriate first step for the behavior described.

9. Because criterion for indicator #2 was met for four of the six individuals, this indicator was not scored for them. For Individual #611 and Individual #816, of the relevant sub-indicators, the PBSP was more than a year old and/or was not being implemented reliably.

11. The restraint used for Individual #613 5/25/16 was in contraindication to his plan. Although it was initiated, other facility staff (i.e., RN) observed the implementation and intervened to end the restraint. It was good, however, to see that restraint contraindications were now in every ISP.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

Summary: This indicator showed good improvement since the last review. With sustained high performance it might be move to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	816			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 3/3	Unable to rate	1/1	1/1	Not rated	Not rated	1/1			

Comments:
12. Because criteria for indicators 2-11 were met for Individual #436 and Individual #935, this indicator was not scored for them. Staff were unable to be interviewed for Individual #611, but staff who worked directly with the other three individuals were very familiar

with restraint requirements and answered the Monitoring Team's questions correctly.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Face to face assessments were completed for all cases. With sustained high performance, this indicator might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	816			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 10/10	1/1	2/2	1/1	1/1	2/2	3/3			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Since the last review, the Center's scores essentially remained the same. Efforts are needed to initiate timely nurse monitoring of restraints, document vital signs and reassess as needed, describe individuals' behaviors when documenting mental status, and clearly document injuries and other negative health effects. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	816			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	50% 5/10	0/1	1/2	0/1	1/1	0/2	3/3			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 5/10	0/1	1/2	0/1	1/1	0/2	3/3			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 5/10	0/1	1/2	0/1	1/1	0/2	3/3			
Comments: The crisis intervention restraints reviewed included those for: Individual #611 on 10/31/16 at 7:05 p.m.; Individual #613 on 5/25/16 at 7:33 p.m., and 6/29/16 at 10:57 a.m.; Individual #609 on 9/15/16 at 7:30 p.m.; Individual #436 on 10/22/16 at 8:48 a.m.; Individual #935 on 7/13/16 at 9:01 p.m., and 10/22/16 at 6:44 a.m.; and Individual #816 on 6/7/16 at 6:30 p.m., 10/4/16 at 9:51 a.m., and 11/3/16 at 4:02 a.m.											

a. For six of the 10 restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint, and monitored vital signs, which is one of the sub-indicators for Indicator a. The exceptions were for Individual #611 on 10/31/16 at 7:05 p.m., Individual #613 on 6/29/16 at 10:57 a.m., Individual #609 on 9/15/16 at 7:30 p.m., and Individual #935 on 10/22/16 at 6:44 a.m. Some examples of problems noted included:

- For Individual #611 on 10/31/16 at 7:05 p.m., documentation showed the time the nurse arrived, but provided no information about the individual's vital signs or mental status, or a nursing assessment for injuries.
- For Individual #609, the Flowsheet, dated 9/15/16, included conflicting times for notification of the nurse (i.e., 7:30 p.m. and 1:00 p.m.). Individual #609's diastolic blood pressure was elevated, but documentation did not show that the nurse conducted further assessments to determine if it remained elevated or was stable. Similarly, the individual's temperature was noted to be low, but the nurse did not conduct a follow-up assessment. An integrated progress note was not found with a description of the individual's behaviors or mental status.
- For Individual #935 on 10/22/16, the records provided no information about vital signs. The nursing progress notes indicated the individual refused vital signs, but the respiration rate does not require the individual's cooperation.

Nursing staff documented and monitored mental status of the individuals for five of the 10 restraints. In some instances, no mental status assessment was documented (e.g., Individual #611 on 10/31/16 at 7:05 p.m., Individual #613 on 6/29/16 at 10:57 a.m., Individual #609 on 9/15/16 at 7:30 p.m., and Individual #935 on 10/22/16 at 6:44 a.m.), and in other instances, a sufficient description was not provided of the individual's mental status (e.g., "awake and alert") (e.g., Individual #935 on 7/13/16 at 9:01 p.m.).

b. and c. Sometimes, sufficient documentation was not available to determine whether or not nursing staff conducted the assessments necessary to determine whether or not the individual sustained an injury, and/or experienced other negative health effects (e.g., Individual #611 on 10/31/16 at 7:05 p.m., Individual #613 on 6/29/16 at 10:57 a.m., and Individual #935 on 10/22/16 at 6:44 a.m.).

As noted above, Individual #609's diastolic blood pressure was elevated, but documentation did not show that the nurse conducted further assessments to determine if it remained elevated or was stable. Similarly, the individual's temperature was noted to be low, but the nurse did not conduct a follow-up assessment.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Summary: Documentation was completed correctly for all restraints for this review and the two previous reviews, with one exception of one item (nursing notation) on two restraints in July 2015. This indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	816			
15	Restraint was documented in compliance with Appendix A.	100% 10/10	1/1	2/2	1/1	1/1	2/2	3/3			

Comments:

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	816			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	70% 7/10	1/1	2/2	1/1	1/1	1/2	1/3			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	67% 4/6	1/1	2/2	N/A	N/A	N/A	1/3			

Comments:

16. Overall, at Mexia SSLC, there were frequent reviews of supports by IDTs. Seven of the restraints met criteria for these indicators. The three that didn't are described below:

- For Individual #935 10/22/16, his history of abuse, medical issues possibly affecting his behavior, refusing medications, and unstable psychiatric condition were all mentioned in the ISPA as variables that contributed to the need for crisis intervention restraint, however, no action plans to address these variables were developed (or implemented).
- For Individual #816 10/4/16, IDT review when there were more than three crisis intervention restraints in any rolling 30 day period did not adequately address these restraints (also see outcome and indicators in domain #3).
- For Individual #816 11/3/16, the information typically found in the restraint checklist or face to face assessment, instead was found in the unit and IMRT meeting minutes. Some general recommendations were made, but there was no specific discussion regarding the relationship between various antecedent and consequent variables and Individual #816's restraint and his behavior.

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary:			Individuals:								
#	Indicator	Overall Score									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A									
48	Multiple medications were not used during chemical restraint.	N/A									
49	Psychiatry follow-up occurred following chemical restraint.	N/A									

Comments:

47-49. There were only two crisis intervention chemical restraints in the last 10 months, which was good to see. Neither involved any of the individuals reviewed by the Monitoring Team.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Mexia SSLC conducted a lot of investigations; about 800 in the Tier 1 document request six-month period. The incident management department was well organized and managed. Criteria were met for all investigations, a very good accomplishment. Moreover, this showed progress since the last review. This important indicator will remain in active monitoring. Also, please see the comments below regarding individual-to-individual aggression.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		

Comments:

The Monitoring Team reviewed 10 investigations that occurred for seven individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, six unconfirmed). The other three were for facility investigations of discovered laceration injuries and suicidal actions. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #611, UIR 0106, DFPS 44902526, unconfirmed allegation of neglect, 10/19/16
- Individual #613, UIR 7538, DFPS 44658832, unconfirmed allegation of physical abuse, 8/18/16
- Individual #609, UIR 0121, DFPS 44913278, unconfirmed allegation of neglect, 10/24/16
- Individual #609, UIR 7090, suicidal actions, date unknown
- Individual #436, UIR 0170, DFPS 44965505, unconfirmed allegation of physical abuse, 11/13/16
- Individual #935, UIR 0128, DFPS 44916256, unconfirmed allegation of physical abuse, 11/25/16
- Individual #935, UIR 7096, serious injury sutures, determined, 5/7/16
- Individual #994, UIR 7563, DFPS 44707209, unconfirmed allegation of neglect, 8/31/16
- Individual #994, UIR 0168, other, date unknown
- Individual #715, UIR 7271, DFPS 44475245, confirmed allegation of neglect, 6/29/16

1. For all 10 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all investigations, criminal background checks and duty to report forms were completed. In fact, for all of the investigations, all four of the above sub-indicators were met. This was very good to see and demonstrated the facility's regularly occurring review of individual trends, past occurrences, data, and programming. For the most part, IDTs met often and revised supports.

Even so, a prevailing problem at Mexia SSLC was individual-to-individual aggressive actions (called peer-to-peer aggression at Mexia SSLC and most other SSLCs, too). There were frequent occurrences of this type of aggression at Mexia SSLC (reported to be more than 100 per month). Most of these caused no injury or minor/non-serious injures. Some, however, caused serious injuries, such as a broken nose (about three per month). The rate of occurrence was high for the past year or so. The Monitoring Team has some observations and comments:

- This is not new news to the facility's senior management or to its incident management department. Various work groups were already focusing on peer-to-peer aggression, as well as on variables that set the occasion for this type of aggression, such as cigarette purchasing not being available after 3:00 pm.
- Other relatively new activities were occurring, such as the executive safety committee, improving their database, and reviewing data every Friday.
- Peer aggression was also addressed via individual behavior support plans, service objectives, counseling assignments, increased staffing levels of supervision, and so forth (as noted above in this indicator).
- Peer-to-peer aggression data and activities focused upon observed physical aggression. But we also know that there are other types of aggression that occur, such as verbal threats and other types of behaviors that might be generally categorized as bullying. Even physical aggression that does not cause injury can cause other types of emotional stress, retaliatory actions, and escape behaviors. Indeed, many of the individuals living at Mexia SSLC were ordered there because of these types of aggressive and assaultive behaviors in the community.
- Protection from harm requires that individuals be protected from all types of harm. Consider that there are many protocols and requirements in place to reduce the likelihood of abuse by staff members, such as repeated staff training, mandated reporting requirements, video cameras, data reviews, facility action plans, etc. Also consider that there are no facility/system-wide protocols in place to reduce the likelihood of peer-to-peer aggression and bullying and to set the expectation and culture that peer-to-peer aggression is not tolerated. The Monitoring Team spoke with the QA director and the Facility director about this at various times during the onsite week and they were committed to addressing this campus-wide.
- A set of data should be created that provides a good picture of the occurrence of peer-to-peer aggression, such as frequency, type, effect, etc., in the same general type of way that the facility already drills down with its data related to allegations, confirmations, injuries, and restraint usage (e.g., the list of 12 data sets in restraint indicator 1 above).
- The Monitoring Team requests a monthly update from the State regarding Mexia SSLC activities being implemented to reduce the likelihood of peer-to-peer aggression, data on occurrences of peer-to-peer aggression, and analysis of the data.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.	
Summary: Performance was about the same as during the last review for this indicator. It is possible that clarifications in the UIR regarding reporting might be improved if there was an additional quality assurance check of this aspect of the	Individuals:

UIRs before final submission. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	611	613	609	436	935	994	715		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	40% 4/10	0/1	0/1	0/2	1/1	2/2	1/2	0/1		

Comments:

2. The Monitoring Team rated four of the investigations as being reported correctly. The others were rated as being reported late or improperly. All were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #611, UIR 0106: Per the DFPS report, the incident occurred at 8:38 pm and was reported to them at 8:47 pm. Per the UIR, the incident occurred at 8:00 pm and was reported to facility (by DFPS) at 9:30 pm. Per the UIR, the incident was reported to the facility director/designee at 9:43 pm (page 8) or 9:30 pm (page 14). These conflicting data entries were not resolved and made it impossible to determine whether or not it was reported to the facility director/designee within one hour. This case involved the merging of several cases, which might have contributed to the various data entries.
- Individual #613, UIR 7538: The UIR, on page 3 stated that during anger management class, Individual #613 stated that the alleged perpetrator slapped him. This would have started the one-hour time requirement, but the entry did not have a date/time. The facility was notified by DFPS of the allegation at 12:13 pm (page 8) and answered yes to the reported-within-one-hour item, but without reference to date/time that Individual #613 made his allegation. On page 9, there was a statement referring to Individual #613 reporting a false allegation, but later a behavioral health services staff member was identified as the reporter.
- Individual #609, UIR 0121: Per the UIR (page 12), this was acknowledged as a late report.
- Individual #609, UIR 7090: This was a complicated case that included a facility investigation of a suicidal behavior and an unconfirmed allegation of verbal abuse. With regard to the former, the UIR had conflicting information about the occurrence of the event, that is, either on 5/5/16 or 5/6/16. Therefore, the correct reporting of this incident could not be determined.
- Individual #994, UIR 7563: Per DFPS, the incident occurred on 8/30/16 at 8:25 pm and was reported to them at 7:44 am on 8/31/16 by another individual. The UIR did not provide any explanation as to why any of the staff onsite did not immediately report.
- Individual #715, UIR 7271: Per the DFPS report and the UIR, the incident occurred the evening of 6/28/16 and wasn't reported until almost noon the next day. From both reports it was clear that evening staff knew, or should have known, that supervision had not occurred properly.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.	
Summary: All three indicators scored 100% for this review and the previous two	Individuals:

reviews with the exception of indicator 4 at the last review. Therefore, indicators 3 and 5 will be moved to the category of requiring less oversight. With sustained high performance, indicator 4 might be moved to the category of requiring less oversight after the next review.											
#	Indicator	Overall Score	611	613	609	436	935	994	715		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 3/3	1/1	Not rated	1/1	Not rated	1/1	Not rated	Not rated		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
Comments: 3. Because indicator #1 was met for all, this indicator would usually not be scored for them. But because of the performance in indicator 2 (above) regarding reporting, the Monitoring scored this indicator for some of the individuals. All staff were able to answer all of the Monitoring Team's questions.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: This indicator will remain in active monitoring. This type of information might also be part of a final quality assurance-type review of investigation documentation before it is finalized (similar to as noted in the summary to outcome 2, indicator 2, above).			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	80% 8/10	0/1	1/1	1/2	1/1	2/2	2/2	1/1		
Comments: For Individual #611 UIR 0106, it was unclear as to when the alleged perpetrators were put into no contact status with individuals. To be specific, the report said that the alleged perpetrators should be placed in this status. Further, two staff were noted to have been placed in this status, but neither were listed as alleged perpetrators in the DFPS report. All in all, the UIR did not clearly describe these details, thus, making it impossible to validate that all alleged perpetrators were immediately removed from client contact. For Individual #609 UIR 0121, staff was placed on 30-minute monitoring on another home. Rationale for this was not provided.											

Outcome 5– Staff cooperate with investigations.											
Summary: With sustained high performance, this indicator might move to the category of requiring less oversight after next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		
7	Facility staff cooperated with the investigation.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: All three indicators scored at 100% for this review. This was the case for indicator 8 for the last two reviews, too, and it will be moved to the category of requiring less oversight. With sustained high performance, indicators 9 and 10 might be to the category of less oversight after the next review, too.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
Comments:											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Investigations commenced and were completed within the required timeframes for all investigations for this review and for the past two reviews, too. Therefore, indicators 11 and 12 will be moved to the category of requiring less oversight. Supervisory review might add additional focus on reporting timelines. Indicator 13 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		

11	Commenced within 24 hours of being reported.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	40% 4/10	0/1	0/1	0/2	1/1	2/2	1/2	0/1		

Comments:
13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.

Summary: Performance was slightly lower for indicator 14 and much improved for indicator 15 compared with the previous review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	86% 6/7	0/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	86% 6/7	1/1	1/1	1/1	1/1	1/1	1/1	0/1		

Comments:
14. For Individual #611, the review for one month rather than the required six months.

15. Individual #715 had a superficial laceration to his upper eyelid just under the eyebrow that should have had a non-serious injury investigation completed.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: These three indicators were at 100% performance for this review and the two previous reviews, too, with one exception in July 2015. All three will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	1/1	1/1	2/2	1/1	2/2	2/2	1/1		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	1/1		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 7/7	1/1	1/1	N/A	1/1	2/2	1/1	1/1		
Comments:											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 19-23. Regular collection and presentation of investigation-related data occurred at Mexia SSLC and had been occurring for many											

years. Identification of patterns or trends that require action was not occurring to meet criteria. Recent activities, such as the initiation of the executive safety council, may set the occasion (and expectation) for this to occur. One example is peer-to-peer aggression, which is discussed under indicator 1 above.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A									
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. and b. Based on documentation the Center submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had dental pre-treatment sedation.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on documentation the Center submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: This outcome and its indicators require some attention from the facility. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	935	994	816	339					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/4	0/1	0/1	0/1	0/1					

2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	0% 0/4	0/1	0/1	0/1	0/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/4	0/1	0/1	0/1	0/1					
4	Action plans were implemented.	25% 1/4	0/1	0/1	1/1	0/1					
5	If implemented, progress was monitored.	0% 0/4	0/1	0/1	0/1	0/1					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/4	0/1	0/1	0/1	0/1					

Comments:
1-6. This outcome and its indicators applied to Individual #935, Individual #994, Individual #816, and Individual #339.

Individual #935 had general anesthesia for an off campus medical procedure on 7/7/16. No information was documented in his ISP, ISPAs, or ISP preparation document concerning this procedure.

Individual #994 had general anesthesia for an off campus dental procedure on 2/19/16. No information was documented in his ISP, ISPAs, or ISP preparation document concerning this procedure.

Individual #816 had general anesthesia for an off campus dental procedure on 4/5/16. A 3/30/16 ISPA discussed a toothbrushing program to address toothbrushing refusals, however, no additional information concerning his PTCR procedure was documented in his ISP, ISPAs, or ISP preparation document.

Individual #339 had general anesthesia for an off campus dental procedure on 3/3/16. No information was documented in his ISP, ISPAs, or ISP preparation document concerning this procedure.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.												
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:									
#	Indicator	Overall										

		Score									
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	Not Rated (N/R)									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	N/R									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	N/R									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	N/R									
e.	Recommendations are followed through to closure.	N/R									

Comments: Due to the change in dates for the Mexia SSLC review, the physician on the Monitoring Team was not able to participate in the onsite portion of the review. As a result, the Monitoring Team was unable to conduct a full review of the deaths, so these indicators were not rated.

Based on documentation the State provided, since the last review, three individuals died. The causes of death were listed as:

- Individual #38 - pseudomonal pneumonia, acute-on-chronic respiratory insufficiency, and urinary tract infection at the age of 71;
- Individual #518 – cardiac arrest, and chronic coccygeal ulcer pilonidal cyst at the age of 58; and
- Individual #407 – aspiration pneumonia, and anoxic encephalopathy at the age of 46.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	ADRs are reported immediately.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2						0/1	0/1		
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the	0%						0/1	0/1		

	ADR.	0/2										
d.	Reportable ADRs are sent to MedWatch.	N/A						N/A	N/A			
Comments: a. through d. Both individuals had ADRs related to an increase in increase in serum creatinine. The Center did not submit the ADR Report form that included the required information for reporting suspected ADRs.												

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: These indicators will remain in active oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	67% 2/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	67% 2/3

Comments: a. and b. In the six months prior to the review, Mexia SSLC completed three DUEs, including:

- On 6/9/16, a DUE on Geodon, and on 12/2/16, a DUE on Abilify. For these DUEs, the Clinical Pharmacist submitted a concise report that included drug background information. The study objectives, methodology, results, and recommendations were documented. The Pharmacy and Therapeutics (P&T) Committee meeting minutes summarized the presentation and provided action steps to address the recommendations. Subsequent minutes addressed follow-up for some of the recommendations. The P&T chair should consider development of an action plan format that specifies the corrective actions, person responsible, and target completion dates.
- On 9/30/16, a DUE on Xarelto. One individual receiving this medication was identified. It was later determined that the individual received Eliquis and not Xarelto. There appeared to be little benefit derived from completing a DUE with a sample size of one. Physician requests for educational and prescribing information can be met through other mechanisms.

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Eighteen of these indicators, in psychiatry, psychology/behavioral health, medical, dental, communication, and skill acquisition had sustained high performance scores and will be moved the category of requiring less oversight. This included one entire outcome: outcome 7 in psychology/behavioral health.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Assessments

For the individuals' risks reviewed, few of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

For this review and the previous two reviews, Medical Department staff completed the annual medical assessments in a timely manner. As a result, the related indicators will be placed in the category requiring less oversight.

To improve the quality of medical assessments, the Center should focus on the few aspects that the Monitoring Team has highlighted in the last few reports as needing improvement. More specifically, the Medical Department should focus on ensuring medical assessments, as appropriate, describe childhood illnesses, and include plans of care for each active medical problem.

For this review and the previous two reviews, Dental Department staff generally completed the dental exams and summaries in a timely manner. As a result, the related indicators will be placed in the category requiring less oversight. Continued work was needed to improve the quality of the exams and summaries, though.

Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

The quality of PNMT assessments varied. However, overall, problems were noted with regard to the thoroughness of the assessments of individuals' physical status, the minimal recommendations offered, and the lack of recommendations for measurable goals/objectives, as well as indicators and thresholds. The Center should focus on improving the quality of these assessments.

The timeliness as well as the quality of OT/PT assessments should be areas of focus.

Individuals reviewed generally had timely communication assessments or updates, which was consistent with findings for the past two reviews. As a result, two related indicators will receive less oversight from the Monitoring Team. However, the quality of these assessments was still a concern, and the Center should focus on making improvements.

The IDT considered what assessments the individual needed for almost all individuals, but for about half they did not arrange for, and obtain, them prior to the IDT meeting.

All individuals had a CPE, but many of the components of a CPE were not included. Similarly, annual psychiatry updates were done, but most were missing some components.

All individuals had current behavioral health and functional assessments, but the content of many functional assessments needed improvement.

FSAs, PSIs, and vocational assessments were current for all individuals, but were often not made available to the IDT prior to the ISP.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but there was much progress. All six ISPs, for instance, included at least one goal that met criteria, and one ISP had goals that met criteria in four of the six areas. Further, about half of these goals were written in measurable terms. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. The criteria used to monitor the set of action plans that would support achievement of the personal goals (ISP outcome 3) needed additional attention.

ISPs were revised annually, but not implemented in a timely manner for all individuals. Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken.

In psychiatry, there should be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status. The goals need to be

measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review. It was encouraging to see some discussion about psychiatry goals occurring during psychiatry-related meetings.

The psychiatry department had done a good job of improving their consent documentation, such as including medication side effects in the consent forms.

Individuals who needed a PBSP had one and, when so, there were relevant goals that were measurable. Ensuring reliable and valid data was not at criteria and performance had decreased since the last review.

Counseling services were regularly available, were provided to individuals, and documentation met criteria.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

All individuals had SAPs and almost half had reliable and valid data collected.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included at least one goal that met criteria, and one ISP had goals that met criteria in four of the six areas. This was very good progress since the last review. About half of these 12 goals were written in measurable terms, also demonstrating good progress. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	609	436	935	175	1			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	4/6	2/6	2/6	1/6	1/6	2/5			
2	The personal goals are measurable.	0%	3/6	1/6	1/6	0/6	0/6	2/5			

		0/6									
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #935, Individual #609, Individual #436, Individual #611, Individual #175, Individual #1). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Mexia SSLC campus.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. None of the six individuals had individualized goals in all six areas, therefore, none had a comprehensive set of goals that met criterion.

For these six individuals, however, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 12 of 35 personal goals met criterion for this indicator. This was an improvement from the past review when only two of 36 goals met criterion. Goals that met criterion included:

- Individual #935's goal for employment/day.
- Individual #609's goals for leisure/recreation, employment, and living options.
- Individual #436's goals for leisure/recreation and relationships.
- Individual #611's goal for leisure/recreation, greater independence, and living options.
- Individual #175's goal for leisure/recreation.
- Individual #1's goals for greater independence and living options.

Individual #935's IDT met on 2/28/17 for his annual ISP meeting. Although, not used for scoring in this review, the newest ISP (still in draft format) included much better goals than did his last ISP, that is, personal goals that were based on his preferences and offered increased opportunities to learn new skills.

Although IDTs had created the above goals (ones that were more individualized and based on known preferences), few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #935's recreation/leisure, relationship, greater independence, and living option goals were not aspirational and/or did not address the need for skill building based on his assessments. For example, his recreation/leisure goal to watch TV did

not support opportunities to learn new skills.

- Individual #609's relationship, greater independence, and health care goals did not support skill building based on assessed needs.
- Individual #436's employment/day, greater independence, living option, and health related goals were not individualized and/or based on his preferences and assessments. For example, his employment goal to be employed at a job of his choice was not individualized based on his preferences or an adequate assessment.
- Individual #611's IDT did not identify the need for an employment/day goal. He was enrolled in school, but the IDT failed to integrate his school goals into his ISP.
- Although, Individual #175's assessments identified many areas where she could gain skills, her ISP did not include goals for relationships, day programming, or greater independence. Her living option goal was to continue living on home M6. This goal was not aspirational in nature.
- Individual #1's ISP did not include an employment/day goal. Documentation and onsite observations indicated that he was not engaged in meaningful programming during the day. He did not have a relationship goal and his recreation/leisure goal was to visit area parks, which he already had the opportunity to do.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Only seven of the 13 personal goals that met criterion for indicator 1 also met criterion for measurability. Those that were measurable were:

- Individual #609's recreation/leisure goal.
- Individual #436's relationship goal.
- Individual #611's recreation/leisure, living option, and independence goals.
- Individual #436's independence, and living option goals.

Examples of goals that were not measurable included:

- Individual #935's goal to achieve routine supervision and work at the library had multiple outcomes.
- Individual #609's living option goal stated that he wanted to live in an apartment in Austin. It was not written with a specific behavioral objection that could be measured.
- Individual #436's leisure goal stated that he will participate in karaoke. The IDT will need to specify what level of participation is required to successfully achieve this goal or what skills he will learn.
- Individual #175's leisure goal to use her foot switch to activate her radio was discontinued and replaced with a goal to use leisure equipment independently. This goal was not specific enough to ensure consistent implementation or measure her level of progress.
- Individual #1's recreation/leisure goal to go to a park to enjoy being outside was not measurable.

3. For the seven goals that were determined to be measurable, none had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. As noted throughout this report, it was not possible to determine if ISP supports and services were being consistently implemented or determine the status of goals due to the lack of data and documentation provided by the facility. It appeared that few goals were consistently implemented.

The facility reported that QIDPs and other team members would soon be participating in additional training offered by the state office on ISP development. The training will be focused on assessments, SAP development and implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. That being said, six of the 11 indicators showed some improvement since the last review (and two showed a decrease). A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	609	436	935	175	1			
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	2/6	0/6	0/6	1/6	1/5			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	33% 2/6	0/1	1/1	0/1	0/1	1/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	1/1	1/1	1/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	50% 3/6	1/1	1/1	1/1	0/1	0/1	0/1			

17	ISP action plans were developed to address any identified barriers to achieving goals.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	1/6	2/6	0/6	0/6	2/5			

Comments:

8. Many personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

For the 12 personal goals that met criterion under indicator 1, six had action plans that were likely to lead to the accomplishment of the goal. These were:

- Individual #609's action plans to support his relationship and living option goals.
- Individual #611's action plans to support his independence and recreation goals.
- Individual #175's leisure/recreation goal.
- Individual #1's independence goal.

Examples of action plans that did not support achievement of the goal included:

- Individual #935's action plan to support his employment goal stated what staff would do, not what Individual #935 would need to do to seek employment.
- Individual #611's action plans to support his living option goal were not measurable (decrease in target behaviors and participate in group home tours).
- Individual #1 only had one action plan to support his living option goal to move into the community. It stated that "the team will reconvene once Individual #1's medical and psychiatric are stable with no concerns to community transition."

9. Preferences and opportunities for choice were not routinely integrated in the individuals' ISP action plans. Individuals were generally able to participate in preferred activities, however, action plans did not provide individual's opportunities to make choices and have some control over their day.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for four individuals. Two action plans were identified that clearly supported decision-making skills. Those were Individual #609's action plan to learn to balance his checkbook and Individual #175's action plan to use a foot switch to activate her music.

The facility's self-advocacy group met during the onsite review week and was observed by the Monitoring Team. Eighteen individuals attended, the most observed at a Mexia SSLC self-advocacy group meeting in many years. The individuals participated and were interested in the topics presented by the human rights officer (who led the meeting). Following the meeting, the Monitoring Team talked with the human rights officer and made a number of suggestions that might result in greater attendance, and more involvement from individuals who do attend. The suggestions were primarily about ways to support the group to learn how to make decisions. That is, to identify problems (or needs), generate possible solutions, choose/vote on a solution, develop a plan of action, and re-visit the plan to see how it turned out. Perhaps the group might even play a role in addressing peer-to-peer aggression (discussed in incident

management indicator 1 in domain 1).

11. Five individuals did not have action plans to support greater independence in any meaningful way. Individual #175's action plan to use a switch to activate her music should lead to greater independence.

- Individual #935 had action plans for budgeting that would lead to greater independence, however, his other action plans were focused on compliance rather than skill building.
- Individual #609's greater independence action plans focused on compliance with his behavioral goals rather than skill building.
- Individual #436 had a greater independence goal to learn to cook, however, his FSA indicated that he could cook independently.
- Individual #611 had a reading SAP, however, his FSA indicated that he could read. Another SAP to identify signs was not functional because he could already read.
- Individual #1 had one SAP for turning on his TV that would have minimally offered him greater independence. His FSA indicated that he could have benefited from training in other areas to increase his independence.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. In most cases, IDTs did not have updated assessments and data available for review prior to the ISP meeting to adequately determine risk ratings. Examples where strategies were not integrated in the ISP included:

- Individual #935's ISP did not include action plans to reduce his risk of injury from peer-to-peer aggression. His diagnosis of hypothyroidism was not addressed in his IHCP. Monthly reviews indicated that he frequently missed many of his medication doses, including medication for seizures. The team did not address the risk associated with his missed medications other than his psychotropic medication.
- Individual #609's ISP did not integrate behavioral strategies into his action plans.
- Individual #436's ISP did not clearly address his significant weight loss over the previous year.
- Individual #1's ISP did not integrate strategies to address his risk for falls into action plans and services and supports.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated in ISPs. In particular, psychiatry and medical supports were rarely integrated into support plans developed by other disciplines. In addition to the examples provided in indicators 11 and 12 above:

- Behavior supports were not integrated with nutritional recommendations to address Individual #609's diagnosis of diabetes. It was not evident that psychiatry had adequate input into his ISP.
- Individual #611's educational goals were not adequately integrated into his ISP. Communication and weight loss strategies were included in his ISP, however, not integrated into other action plans.
- Individual #175's positioning supports were not integrated throughout her day. Her day habilitation schedule conflicted with her PNMP supports for repositioning.
- Individual #1's behavioral supports were not integrated into supports to address his dental risks. There was no integration of communication and behavioral supports to address his frequent program refusals.

14. Meaningful and substantial community integration was absent from the ISPs. Individual #935 had a goal to seek community employment, however, action plans did not support his goal. Individual #611 attended school in the community.

15. Three of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. The facility had developed new program options that offered greater opportunities to attend programming based on preferences for some individuals. Individual #175 and Individual #1 attended day programs on the home. Their options were very limited for skill building and employment was not even considered. Individual #611 attended school in the community. Individual #609 and Individual #436 were offered a variety of skill building and employment opportunities based on their preferences. Individual #935 had a goal to work in the community, however, action plans were unlikely to lead to community employment.

16. Three of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. ISPs and observations did not support that Individual #935, Individual #175, and Individual #1 had opportunities to spend a majority of their day engaged in functional or meaningful activities. Individual #935 had a goal for community employment, however, there were no specific plans for day programming until he was employed in the community. Individual #175 and Individual #1 spent a majority of their day on the home with little interaction and minimal opportunities for skill building.

17. IDTs were doing a better job of addressing barriers to achieving goals. Four of six ISPs addressed barriers. Individual #175 and Individual #1's ISP did not adequately address barriers to achieving goals and learning new skills.

18. Some action plans described detail about data collection and review, however, overall, ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and, as noted above, in many cases, skill acquisition plans were not clearly written to ensure consistent training would occur.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: Criterion was met for some indicators for some individuals, and the scores for six indicators improved from the time of the last review (and none decreased), but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are ensuring all team member opinions are included, defining obstacles, and ensuring all individuals receive relevant education about community living options. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	609	436	935	175	1			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for	100%	N/A	N/A	N/A	N/A	N/A	N/A			

	where to live was described and this preference appeared to have been determined in an adequate manner.	1/1									
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 3/6	0/1	0/1	1/1	1/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	20% 1/5	0/1	0/1	1/1	N/A	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Five of six ISPs included a description of the individual's preference and how that was determined. The exception was Individual #175's ISP. Her ISP noted that her preference was unknown but she appeared to like her current home. It was later noted that she might like to live in a smaller environment. Individual #175 had lived at the facility for many years. Her ISP should reflect what staff that work closely with her know about her preferences.

20. The annual ISP for Individual #615 was observed by the Monitoring Team. He thoroughly described where he wanted to live.

21. None of the ISPs met criterion for this indicator. Input by psychiatry was missing from five of the six ISPs. For Individual #175, her medical assessment was not available to the IDT prior to the ISP and her behavioral assessment did not include a recommendation for living options.

22. Five of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

- Individual #611's statement regarding living options did not include his or his LAR's living option preferences.

23. Five of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #175 and her LAR have not visited a group home in the community since 2013. It was not evident that they were aware of current living options.

24. Three of five ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

- Individual #609's ISP identified LAR choice as a barrier to referral, however, the discipline members identified behavior as the greatest barrier.
- Individual #611's IDT identified his behavior as a barrier, however, they did not describe specific behavior that would be a barrier to community placement.
- Individual #175's ISP identified LAR choice as a barrier, however, unspecified medical issues were also identified by team members as a barrier in discipline assessments.

25. At the ISP for Individual #615, obstacles to his referral to transition were discussed by all team members, one by one.

26. One of the six individuals (Individual #609) had individualized, measurable action plans to address obstacles to referral or transition, if referred. For the most part, goals were not measureable.

27. At the ISP for Individual #615, a plan was put in place for the IDT to meet and to set criteria for referral.

28. One of four ISPs (Individual #436's) included specific action plans to educate individuals on living options. Individual #935 and Individual #609 had lived in the community and were familiar with living options, however, it was not clear that Individual #609's LAR was familiar with this living options in the community.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were revised annually, but not implemented in a timely manner for all individuals. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	609	436	935	175	1			
30	The ISP was revised at least annually.	100% 5/5	1/1	N/A	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if	33%	0/1	0/1	0/1	0/1	1/1	1/1			

	indicated.	2/6									
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were developed on a timely basis.

32. Documentation was not submitted that would support that all action plans were implemented on a timely basis for four of six ISPs. Examples in which timeliness criteria were not documented included:

- For Individual #935, the Monitoring Team was not able to confirm implementation of the ISP within 30 days (by 4/31/16) due to the lack of data. According to his ISP Preparation document (dated 11/28/16), his leisure goal to purchase a TV and relationship goal to reconnect with his family had not been implemented.
- Individual #609's monthly review documentation did not support implementation of his action plans for work, going out to eat, or shopping within 30 days of ISP development.
- There were not sufficient data available to determine if Individual #436's action plans were implemented within 30 days of ISP development.
- Individual #611's November 2016 QIDP monthly review indicated that his action plans to go fishing, go to church in the community, go shopping, and go to the movies with a friend were not implemented within 30 days of ISP development.

33. Five of six individuals participated in their ISP meetings. Individual #1 did not attend his annual ISP meeting.

34. Only one individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. For three individuals, there was no psychiatry participation in the planning process (Individual #935, Individual #609, Individual #611). Overall, participation was good at annual ISP meetings. QIDPs were knowledgeable regarding supports and services included in the ISP, however, it was not evident that team members actively reviewed, monitored, and revised supports in a timely manner.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Scores, and performance, for both indicators improved compared with the last review. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	609	436	935	175	1			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			

	to the annual meeting.										
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for five of six individuals.

- For Individual #1, the IDT did not consider the need for further assessing his preferences and interests. An updated vocational assessment was not considered, even though, his last assessment did not identify possible work skills or interest.

36. Three of six IDTs did not arrange for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #436, QIDP assessment submission data indicated that his psychiatry, FSA, and vocational assessments were not submitted in time for team review prior to his annual ISP meeting.
- Individual #175's QIDP assessment submission data indicated that her medical and vision assessments were not submitted prior to her ISP for team review.
- Individual #1's PSI and vocational assessments were not adequate for determining his preferences and interest. Consequently, the IDT was unable to develop a plan for meaningful day programming.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.

Summary: Progress was not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	609	436	935	175	1			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

37. IDTs met often in response to incidents and medical issues and less frequently to review progress or revise supports and services. When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. QIDPs should include documentation of any action taken to address barriers to ISP implementation. Reliable and valid data were often not available to guide decision-making. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional

assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment or assess the efficacy of revised supports. For example,

- Although Individual #935's IDT met often to review support and progress towards goals, the status of supports and follow-up to recommendations were not well documented. For example, the IDT met often to discuss program refusals. ISPAs documented recommendations that included a new incentive program, a request to meet with his physicians to discuss a possible change in medication schedule, and a trial at a new job. Subsequent ISPAs do not document implementation or status of recommendations.
- Individual #609's action plans to support his relationship and employment goals had not been consistently implemented and no progress was made towards achieving his goals. It was not evident that his team had met to discuss barriers to implementation and progress.
- Individual #1's IDT met to discuss program refusals and falls. The IDT made various recommendations including a referral to habilitation therapy for an updated assessment and a change in programming. The QIDP did not document the status or efficacy of recommendations. Program refusals were documented from July through December 2016. The team did not take action to address the program refusals until December 2016.

38. QIDPs recently began using the IRIS system to populate monthly reviews of services. There was still quite a bit of inconsistency in how this information was being used. There had also been a big turnover in QIDP staff over the past year. This contributed to the inconsistency in documentation and review. For the most part when interviewed, the QIDPs were knowledgeable about supports and services included in the ISP. Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed.

Outcome 1 – Individuals at-risk conditions are properly identified.

Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #609 – dental, and diabetes; Individual #935 – cardiac disease, and weight; Individual #281 – respiratory compromise, and infections; Individual #1 – gastrointestinal (GI) problems, and skin integrity; Individual #175 – aspiration, and seizures; Individual #595 –

circulatory, and falls; Individual #407 – respiratory compromise, and infections; Individual #444 – constipation/bowel obstruction, and hypothermia; and Individual #519 – fractures, and other: metabolic syndrome].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #407 – respiratory compromise, and Individual #519 – fractures.

b. It was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some discussion about psychiatry goals occurring during psychiatry-related meetings. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

In other words, much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, goals that focused on the individual's psychiatric disorder and monitored progress via what have come to be called psychiatric indicators. Documentation revealed some attempts by psychiatry to identify psychiatric symptoms for monitoring. Providers will need to ensure that the symptoms identified are consistent within each document and are shared with other IDT members.

To reiterate, there should be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status. The goals need to be measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

This beginning identification of psychiatric symptoms was good to see. Psychiatric providers attended some ISP meetings and indicated a goal to increase the number of meetings attended. This sets the occasion for the presentation and discussion of psychiatric indicators and psychiatry-related personal goals.

In addition to collecting data regarding problematic behaviors, some assessment instruments were being utilized, specifically the BPRS (Brief Psychiatric Rating Scale). This scale provided information regarding symptoms experienced at the time of the administration of the scale. In some cases, prior to the implementation of IRIS, there was a comparative review of successive scales included in the psychiatric documents.

Psychiatric progress notes for quarterly clinical encounters did not routinely document review of available data. There were concerns on the part of both the Monitoring Team and facility staff regarding the validity and integrity of data.

During the QAQI Council meeting that occurred during the week of the onsite review and that was attended by the Monitoring Team, the psychiatry department presented its quarterly data. The data followed the psychiatry outcomes and indicators in the Monitoring Team's tool and monitoring reports. This was good to see. However, the scores presented were different (for the most part higher) than what the Monitoring Team has found in recent reports (see pages 36-41 of the QAQI report). It might be helpful to include Monitoring Team scores along with facility self-scores, along with the reasons why indicators did not (or did) meet criteria in the monitoring report.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: All individuals had a CPE and this indicator (12) will be moved to the category of requiring less oversight. The other four indicators will remain in active monitoring. Older CPEs need to be updated and put into Appendix B format (indicator 13). All of the many components of a CPE, as detailed in the Monitoring Team's criteria need to be included in the CPE (indicator 14). Other documentation needs attention in order to meet criteria, too (indicators 15 and 16).			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339

12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	40% 2/5	1/1	0/1	0/1	N/A	1/1	N/A	0/1	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1

Comments:
12-13. CPEs were completed for all individuals. The CPE regarding Individual #339 was performed in 1994 and was not formatted as per Appendix B.

14. The Monitoring Team looks for 14 components in the CPE. One evaluation was complete and addressed all of the required elements (Individual #935). The remaining evaluations lacked from one to 10 required elements. Eight evaluations lacked a sufficient bio-psycho-social formulation. One evaluation, regarding Individual #611, lacked one required element. Five evaluations, regarding Individual #613, Individual #609, Individual #994, Individual #715 and Individual #816, lacked two required elements. One evaluation, regarding Individual #436, lacked four required elements. One evaluation, regarding Individual #339, lacked 10 required elements.

15. For the five individuals admitted since 1/1/14, one individual, Individual #935, had an initial psychiatric evaluation performed within 30 days of admission and a note from nursing and primary care on the date of admission. Individual #613 and Individual #609 did not have nursing notes on the date of admission. Individual #715 did not have a note from primary care on the date of admission.

16. There were five individuals whose documentation revealed inconsistent diagnoses: Individual #611, Individual #609, Individual #994, Individual #816, and Individual #339.

Outcome 5 – Individuals' status and treatment are reviewed annually.	
Summary: Performance remained about the same as compared with the last review for all five indicators of this outcome, all of which will remain in active monitoring. Additional focus on the details of the criteria for these indicators may result in improved scoring at the time of the next review.	Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
17	Status and treatment document was updated within past 12 months.	88% 7/8	1/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. Eight individuals required annual evaluations. Seven were done. Individual #715 had not had an annual evaluation performed, but should have.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the annual evaluations met full criteria. Evaluations were missing one to 13 required elements. The most common missing elements were derivation of symptoms and psychological assessment or behavioral health assessment. In the evaluations regarding Individual #994 and Individual #816, there was no mention of the prescribed medication in the annual evaluation. In addition, Individual #935 has history of seizure disorder, diabetes, hyperlipidemia, and thrombocytopenia. There was no discussion regarding the effects of prescribed psychotropic medications on these conditions. Individual #994 has a history of an irregular heartbeat, abnormal EKG, and complaints of chest pains. The effects of the prescribed psychotropic medication on these conditions were not discussed in the annual evaluation.

21. There was a need for improvement with regard to the consistent documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: This indicator will remain in active monitoring and will be reviewed at the next review.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	provided.										

Comments:
22. None of the individuals selected by the Monitoring Team had a PSP, though other individuals at the facility did have PSPs.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Three indicators showed good improvement from the last review, resulting in 100% scores (indicators 28, 29, 32). With sustained high performance, they might be moved to the category of requiring less oversight after the next review. Some of the content requires additional focus in order to meet the criteria for indicators 30 and 31. All five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	44% 4/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. The facility had done a good job of improving their consent documentation, such as including medication side effects in the consent forms. Side effects were categorized as common, serious but rare, and very serious but rare.

30-31. Four individuals had an individualized risk versus benefit discussion in the consent documentation. Alternate and non-pharmacological interventions were not individualized.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Individuals who needed a PBSP had one and when so, there were relevant goals and they were measurable. This was the case for all of the individuals this review and the last two reviews, too (with one exception regarding measurability at the last review). Given this sustained high performance, these	Individuals:

three indicators (1, 2, 3) will be moved to the category of requiring less oversight. Ensuring that goals were based upon assessment and had reliable and valid data were not at criteria and performance had decreased since the last review. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 13/13	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	67% 6/9	1/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, 13 required a PBSP (nine individuals reviewed by the behavioral health Monitoring Team and four individuals reviewed by the physical health Monitoring Team). All 13 of those individuals had PBSPs.

4. Individual #994 and Individual #609 had target behaviors in their PBSPs that were not included in their functional assessments. Individual #613 had a target behavior (self-injurious behavior, SIB) in his most recent progress note that was not addressed in his functional assessment.

5. Individual #816 and Individual #715 had interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that their data were reliable. The remaining individuals with PBSPs did not have either IOA or data collection timeliness measures in the last six months (e.g., Individual #613), or the last assessment of IOA or DCT was below 80% (e.g., Individual #339). In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with PBSPs have regular IOA and data collection measures. Additionally, if the levels of DCT or IOA fall below 80%, staff should be retrained and reassessed as soon as possible.

Ensuring reliability of PBSP data should be a priority area for improvement for the Mexia SSLC behavioral health services department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: All individuals had current behavioral health and functional assessments (indicators 10 and 11). This was an improvement from the last review and with sustained high performance, these indicators might move to the category of requiring less oversight after the next review. More attention needs to be paid to the content of the functional assessments (indicator 12). All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
Comments: 12. Individual #613 and Individual #715 had complete functional assessments. Individual #611, Individual #436, Individual #994, Individual #816, and Individual #339's functional assessments were rated incomplete because there were no clear summary statements based on the hypothesized antecedent and consequent conditions that affected their target behaviors. Individual #935's functional assessment was rated as incomplete because it did not identify antecedents for each target behavior. Individual #609's functional assessment did not include a direct assessment.											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: All three indicators showed decreased performance compared with the last review. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	44% 4/9	1/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	67% 6/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
Comments: 13. There was documentation that the PBSP was implemented within 14 days of attaining consents for Individual #715, Individual #935, Individual #436, and Individual #611.											

14. The PBSP was written in the last year for all individuals except for Individual #816 (PBSP dated 11/6/15). Individual #613 and Individual #436's PBSPs were written within the last year, however, they did not include targets or replacements included in the most recent progress note and, therefore, were not scored as current.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Individual #613, Individual #935, Individual #715, and Individual #339's PBSPs were rated as having all 13 components. Individual #436 and Individual #816's PBSP was rated as incomplete because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or possible. Individual #609 and Individual #994's PBSPs contained target behaviors not found in their functional assessments, and Individual #611's PBSP was not clearly based on the results of the functional assessment.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: Counseling services are regularly available and provided to individuals and documentation met criteria. This has been the case for this review and the past two reviews, too, all of which had scores of 100% for both indicators. Both indicators will be move to the category of requiring less oversight. Moreover, the facility reported that attendance at individual and group counseling to be 95%.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
24-25. Individual #611, Individual #613, Individual #609, Individual #436, Individual #935, Individual #994, Individual #715, and Individual #816 received counseling services at the time of the onsite review. All eight treatment plans and progress notes were judged to be complete.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 78%, Round 10 – 89%, and Round 11 - 89%), Indicators a and b will move to the category requiring less oversight. Indicator c will be assessed once the ISPs reviewed integrate the revised periodic assessment process.

Individuals:

#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (N/R)									

Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: To improve the quality of medical assessments, the Center should focus on the few aspects that the Monitoring Team has highlighted in the last few reports as needing improvement. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 89% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 - 94% for Indicator 3.b), Indicator b will move to the category requiring less oversight. Indicator c will be assessed once the ISPs reviewed integrate the revised periodic assessment process.

Individuals:

#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual receives quality AMA.	22% 2/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and complete physical exams with vital signs. Most, but not all included pre-natal histories, family history, pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe

childhood illnesses, and include plans of care for each active medical problem, when appropriate.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for most of the diagnoses reviewed. The exception was for Individual #281 for whom the diagnosis of serous otitis media was not consistent with the findings.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #609 – diabetes, and cardiac disease; Individual #935 – osteoporosis, and seizures; Individual #281 – other: hypertension, and other: hypothyroidism; Individual #1 – gastrointestinal (GI) problems, and osteoporosis; Individual #175 – respiratory compromise, and other: hypothyroidism/adrenal insufficiency; Individual #595 – other: renal disease, and diabetes; Individual #407 – constipation/bowel obstruction, and diabetes; Individual #444 – aspiration, and GI problems; and Individual #519 – GI problems, and cardiac disease]. The one sufficiently addressed in the individual's ISP/IHCP was for Individual #519 – GI problems.

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental examinations (Round 9 – 100%, Individuals:

Round 10 – 100%, and Round 11 - 100%) and dental summaries (Round 9 – 100%, Round 10 – 100%, and Round 11 - 89%), Indicator a will move to the category requiring less oversight. The Center needs to focus on the quality of dental exams and summaries.

#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	88% 7/8	N/A	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. It was positive for the individuals reviewed that dental exams and summaries were generally completed timely.

b. It was positive that four individuals' dental exams included all of the necessary components (one of these individuals was edentulous – Individual #444). It was also positive that all of the dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A description of periodontal condition;
- An odontogram:
- A summary of the number of teeth present/missing;
- Caries risk;
- Periodontal risk;
- Specific treatment provided; and
- The recall frequency.

Most included:

- An oral cancer screening;
- Sedation use; and
- A treatment plan.

Moving forward, the Facility should focus on ensuring dental exams include, as applicable:

- Periodontal charting.

c. On a positive note, all of the dental summaries addressed the following components:

- Effectiveness of sedation use, if applicable;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations; and
- Treatment plan, including the recall frequency.

Most included:

- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Recommendations related to the need for desensitization or another plan; and
- A description of the treatment provided.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.

Summary: Due to an issue with IRIS, full physical assessments were not documented for a number of individuals (e.g., missing information in relation to weight, neurological assessment, skin assessment, etc.). This was unfortunate, because the Center had achieved scores of 100% for these indicators for the past two reviews. If this issue is corrected by the time of the next review and the Center maintains the timeliness and quality of these assessments, Indicator a likely will move to the category requiring less oversight. The remaining indicators require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive	75%	N/A	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1

	nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	6/8									
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	44% 4/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	33% 6/18	0/2	0/2	1/2	0/2	0/2	0/2	2/2	1/2	2/2

Comments: a. Due largely to issue with IRIS, nurses had not documented full physical assessments for a number of individuals (e.g., missing information in relation to weight, neurological assessment, skin assessment, etc.). The Center had achieved scores of 100% for these indicators for the past two reviews. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead. If this issue is corrected by the time of the next review, this indicator likely will move to the category requiring less oversight.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #609 – dental, and diabetes; Individual #935 – cardiac disease, and weight; Individual #281 – respiratory compromise, and infections; Individual #1 – GI problems, and skin integrity; Individual #175 – aspiration, and seizures; Individual #595 – circulatory, and falls; Individual #407 – respiratory compromise, and infections; Individual #444 – constipation/bowel obstruction, and hypothermia; and Individual #519 – fractures, and other: metabolic syndrome).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 10/18/16 at 5:01 p.m., Individual #609 had an Accu-Chek reading of 50, which was low. The individual stated: "I am going to eat a snack right now." Staff gave him Glucerna, but he refused to have his insulin rechecked. The nurse did not document corresponding vital signs in IView or state in an IPN whether or not they were attempted. Nor did the nurse document additional assessment of his signs and symptoms, given the low blood sugar reading. At 8:00 p.m., another blood sugar reading of 173 resulted in the nurse notifying the physician.
- A medical IPN, dated 8/4/16, indicated that Individual #1 fell and hit the back of his head. It did not appear that nurses

completed the required neurological checklist.

- On 6/9/16, Individual #595 experienced an adverse drug reaction and the physician discontinued Clozapine. On 6/10/16, a new medication order was initiated. This placed the individual at risk for a rapid onset of elevated blood pressure. Nursing assessments were not found for the adverse drug reaction and/or the change in medication.
- In November 2016, an ISPA for Individual #444 indicated that she lost 17 pounds and was not eating. However, nursing assessments did not address constipation, review of bowel records, or intake and output.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. IHCPs reviewed were missing the necessary components. This is an area on which the Center needs to focus.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.	
Summary: Since the last review, the Center's scores had essentially remained	Individuals:

unchanged. In addition to ensuring that individuals are appropriately referred to the PNMT and the PNMT reviews/assesses them, the PNMT should focus on improving the quality of its assessments. These indicators will remain in active oversight.											
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	40% 2/5	N/A	0/1	0/1	0/1	N/A	N/A	1/1	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	25% 1/4		0/1	0/1	N/A			0/1	1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	25% 1/4		0/1	0/1	N/A			0/1	1/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	60% 3/5		0/1	1/1	0/1			1/1	1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	25% 1/4		0/1	0/1	N/A			0/1	1/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/5		0/1	0/1	0/1			0/1	0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2		N/A	N/A	0/1			N/A	0/1	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4		0/1	0/1	N/A			0/1	0/1	
Comments: a. through d., and f. For the five individuals that should have been referred to and/or reviewed by the PNMT: • In May 2015 and August 2015, Individual #935 met criteria for referral to the PNMT with no evidence of referral at those times. On 3/31/16, he was finally referred after a 41-pound weight loss in the previous year (i.e., monthly weights of 166, 160, 158, 158, 152, 143, 144, 149, 136, 136, 136, 130, and 125). Moreover, no IDT discussion was found of his continuing to maintain a											

lower weight through 11/15/16, with then a big jump in weight as of 11/27/16 (i.e., from 127.2 on 11/15/16 to 144 on 11/27/16, according to the three-month weight record submitted). In response to the Monitoring Team's request for a copy of any PNMT assessment, the Center did not submit Individual #935's assessment. As discussed during the onsite review, although Center staff later produced an assessment, this resulted in negative scores.

- Individual #281 experienced multiple pneumonias, and on 5/16/16 was seen at the hospital and diagnosed with right lower lobe pneumonia secondary to hiatal hernia/GERD with aspiration. The PNMT did not conduct a review until 7/27/16, at which time they decided to complete a "focused" PNMT assessment. The date of referral could not be determined from the assessment or PNMT meeting minutes. On 8/26/16, the assessment was completed. Although the Registered Dietician (RD) was listed as a team member, it was not possible to discern whether the RD actively contributed to the content of the assessment.
- The PNMT should have at least reviewed Individual #1. He experienced an increasing number of falls, including one in each August and September 2016, two in October 2016, one in November 2016, two in December 2016, four in January 2017, and four in February 2017. In other words, in the last six months, he had 15 falls with 10 of those in the last three months.
- On 7/13/16, Individual #407's IDT referred him to the PNMT, due to high risk of aspiration according to ISPA meeting documentation on that date, but the first notes from the PNMT were dated 8/18/16. PNMT documentation cited aspiration pneumonia as the presenting problem. Although a full list of members of the PNMT was provided, it was not possible to determine if all team members participated in the assessment process.
- Individual #444 was hospitalized twice in two months for pneumonia (August and September 2016) with a PNMT assessment completed on 10/1/16, although meeting minutes stated that it was finalized on 10/18/16. According to her PNMT assessment, a pulmonologist, who consulted in 2013, stated that he suspected "chronic micro-aspiration with some interstitial lung disease" and that she was "at risk for developing recurrent viral and bacterial pneumonias." On 11/16/16, she was subsequently hospitalized again. At an ISPA meeting held on that date, team members reported that she had lost 17 pounds since September. In the PNMT meeting minutes, there was no specific reference to her current weights at the time of each review or the total amount of weight loss, although there was reference to meal refusals. It was not clear what action was taken as PNMT meeting minutes were submitted only through 12/1/16. A gastroenterology (GI) consult was pending to assist in identifying the cause of her meal refusals. According to ISPA documentation on 11/29/16, the guardian would not consider PEG-tube placement. Although a full list of members of the PNMT was provided, it was not possible to determine if all team members participated in the assessment process. The PNMT did not conduct a review when the additional issue of weight loss and meal refusals emerged. Even though the IDT reported weight loss since September, the completed assessment submitted reported that she had gained weight and did not identify any concern for loss or meal refusals.

h. As noted above, the assessment for one individual was not submitted in response to the Monitoring Team's document request. For the three other assessments, the following provide some examples of problems noted:

- Individual #281's PNMT assessment identified progression of thoracic kyphosis as the primary etiology for the pneumonias with chronic dysphagia and other mitigating concerns. However, no data was presented to support progression of kyphosis other than photos and the therapist's familiarity with the individual. The assessment indicated that the option selected to address needed changes in seating was "in Lieu of Acti-back," because it was unavailable. The assessment did not clarify why if this was preferable, it was not made available to him. The assessment also did not report any data from oximeter studies (per meeting minutes only) to assess angle changes in seated position. No evidence was found of discussion related to the potential

risks associated with changes in alignment for him. Also lacking were recommendations for measurable goals/objectives, as well as indicators and thresholds.

- For Individual #407, the assessment did not include a complete assessment of current physical status. It offered few recommendations for the IDT other than to follow up on consults and consider moving him to a facility with 24-hour respiratory therapy. It identified no measurable outcomes or clinical indicators.
- Although additional work was needed, 444's PNMT assessment showed improvement in comparison with the others reviewed. For example, it included valuable information and data, as well as analysis, and recommended a number of actions to be taken. It was of concern, however, that during the assessment process, the IDT reported meal refusals and weight loss since September, but the PNMT did not address this issue, nor did the PNMT complete a subsequent review or assessment of the weight loss as a new issue as she was on the PNMT's existing caseload at the time. The Monitoring Team was concerned with the PNMT's use of "focused assessment," and that they stated that they focused on the reason for referral only. This resulted in a lack of inclusion of related or correlated conditions that the team should address in a comprehensive manner to fully meet the individual's PNM needs. In addition, the PNMT listed Individual #444's medications and general side effects, but did not address whether she might be experiencing any of these and the relevance to the conditions contributing to her PNM concerns. Also lacking were recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.

Summary: It was good to see some improvement with regard to the quality of PNMPs. The Center should continue to make strides in this area. Overall, though, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	12% 2/17	1/2	0/1	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	24% 4/17	1/2	0/1	1/2	0/2	0/2	0/2	0/2	1/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	63% 5/8	0/1	N/A	1/1	0/1	1/1	1/1	0/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	12% 2/17	1/2	0/1	0/2	0/2	0/2	0/2	0/2	1/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	18% 3/17	1/2	0/1	0/2	0/2	0/2	0/2	0/2	1/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	29% 5/17	1/2	0/1	1/2	0/2	1/2	0/2	0/2	1/2	1/2

g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	47% 8/17	0/2	0/1	1/2	1/2	2/2	0/2	1/2	1/2	2/2

Comments: The Monitoring Team reviewed 17 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: weight, and constipation/bowel obstruction for Individual #609; weight for Individual #935; aspiration, and fractures for Individual #281; choking, and falls for Individual #1; aspiration, and fractures for Individual #175; choking, and falls for Individual #595; aspiration, and fractures for Individual #407; aspiration, and fractures for Individual #444; and weight, and GI problems for Individual #519.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were the IHCPs for constipation/bowel obstruction for Individual #609, and fractures for Individual #444.

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the individuals' risks were for constipation/bowel obstruction for Individual #609, fractures for Individual #281, fractures for Individual #444, and weight for Individual #519.

c. Eight of the nine individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #281, Individual #175, Individual #595, Individual #444, and Individual #519 included all of the necessary components to meet the individuals' needs, which was good to see.

Problems varied across the remaining PNMPs and/or Dining Plans. For example, a full set of triggers was not identified for Individual #476 and Individual #407; Individual #476's PNMP did not address precautions related to his fall risk, even though he was independent with ambulation; and communication skills and/or strategies for staff were not defined for Individual #609 and Individual #476.

d. The IHCPs that identified the necessary PNM action steps were those for constipation/bowel obstruction for Individual #609, and fractures for Individual #444.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for constipation/bowel obstruction for Individual #609, fractures for Individual #444, and weight for Individual #519.

f. The IHCPs that identified triggers and actions to take should they occur were those for constipation/bowel obstruction for Individual #609, fractures for Individual #281, aspiration for Individual #175, fractures for Individual #444, and weight for Individual #519.

g. The IHCPs reviewed that defined PNMP monitoring included those for fractures for Individual #281; falls for Individual #1; aspiration, and fractures for Individual #175; fractures for Individual #407; fractures for Individual #444; and weight, and GI problems for Individual #519.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	1/1	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1					0/1		N/A		
Comments: a. Individual #407's IDT documented clinical justification for enteral nutrition, and determined he was not a candidate for progressing along the continuum to oral intake. Such documentation was not found for Individual #175.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Improvement is needed with regard to the timeliness as well as the quality of OT/PT assessment. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1

	assessment is completed in accordance with the individual's needs.										
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	0% 0/4	0/1	0/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/6	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A

Comments: a. through c. Two of the nine individuals reviewed received timely OT/PT assessments and/or reassessments, including assessments based on changes of status. The following are examples of concerns noted:

- The screening for Individual #609 should have identified the need for a comprehensive assessment secondary to diabetes and obesity, but did not. It also did not address medications, or provide status updates to medical risks, such as diabetes and weight.
- For Individual #935, the 2015 screening indicated that he should have an assessment in 2016, but it did not appear this occurred.
- No screening and/or assessment was submitted for Individual #281, or Individual #444.
- For Individual #1, an addendum to the OT/PT assessment that contained key information was not completed until the day of his ISP meeting.
- Individual #595 was receiving formal OT services, so he should have received an assessment/update as opposed to a screening.

d. As noted above, Individual #609 and Individual #935 should have had comprehensive assessments, but did not. The Monitoring Team reviewed the comprehensive OT/PT assessment for Individual #519. The following summarizes some of the problems noted:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: Although the assessment identified what was described as pertinent to habilitation therapy services, it did not discuss the relevance to the individual's OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services: Although to a certain extent, the assessment reviewed whether or not there were barriers from an OT/PT perspective to the individual being involved in activities of his choosing, the assessors did not, for example, discuss ways to build upon his current skills and preferences to involve him in an exercise program;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: The assessors provided general side effect information, but did not discuss whether or not medication side effects were potentially impacting functional motor performance and/or supports;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: The assessment discussed the individual's significant obesity, but offered no discussion of an exercise program to address this. The assessment stated that he needed improved independence in self-help, mobility, and environmental control, but did not sufficiently address how or why, or make recommendations in this regard; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, the assessment addressed, as applicable:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

e. As noted above, no assessment was submitted for Individual #281, Individual #595, or Individual #444. For the three assessments the Monitoring Team reviewed, the following summaries some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: The updates did not discuss specific impact of diagnoses, medical history, or current health status on the individuals' OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services: The only exception was Individual # 175's assessment that discussed use of her foot (a strength) to activate a switch;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The assessments

discussed the effectiveness of supports to address risks (although as discussed below, thorough analysis/justification was not consistently found), but did not sufficiently provide rationale for the recommended risk levels;

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For all three individuals, the updates provided limited discussion of the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: A limited description was provided for Individual #476, and Individual #175's assessment did not discuss hand skills or her level of participation in activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): Information was missing for Individual #476's diabetic shoes;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: Individual #476's experienced four falls, but it was unclear how this compared to the previous year. Individual #175's update provided no comparison to previous assessments. Individual #407's update indicated he met his previous year's goals, but did not state what the goals were specifically;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Rationale was not provided for the effectiveness of Individual #175's supports. In addition, Individual #476's assessment indicated supports were effective despite the fact that he fell four times (e.g., were diabetic shoes effective), no analysis was provided to justify that the ergonomic pillow and wedge were effective in addressing his sleep disturbance, and no information was provided about the effectiveness of the sensory assessment recommendations to address rectal digging and fecal smearing;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, justification was not provided for not developing OT/PT supports to address identified needs; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Recommendations that should have been made to address individuals' needs were not. The only exception was for Individual #175.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	75% 6/8	1/1	N/A	0/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	40% 2/5	N/A	0/1	0/1	1/1	N/A	1/1	N/A	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	33% 1/3	0/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: c. and d. Examples of concerns noted included:

- For Individual #609, the OT/PT made recommendations for programs/interventions outside of the ISP meeting, but no ISPAs were found to discuss these with the IDT and make decisions about implementation.
- For some individuals, assessments were not submitted, so it was not clear whether or not the individuals required OT/PT strategies or interventions.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely communication assessments/updates (Round 9 – 88%, Round 10 – 100%, and Round 11 - 100%), and the type of assessment that met their needs (Round 9 – 88%, Round 10 – 100%, and Round 11 - 89%), Indicators a and b will move to the category of requiring less oversight. Quality of the communication assessments and updates continued to be areas on which the Center needed to focus. All of the remaining indicators will remain under active oversight.

Individuals:

#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results	N/A	N/A								

	show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 7/7	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/3	0/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	N/A	0/1	0/1	0/1	N/A	0/1	N/A	N/A

Comments: a. and b. Overall, individuals received timely communication assessments or screenings. The following provides information about problems noted:

- Based on Individual #1's records, he received a "baseline" communication assessment in 2010. This assessment did not clearly state whether or not he needed another comprehensive assessment or an update, and/or the timing for such a review. The Center provided a copy of an update for 2016, with no rationale as to why a new comprehensive assessment had not been considered.

c. The following concerns were noted with the screenings reviewed:

- Although a number of the components of Individual #609's screening provided valuable information, the Speech Language

Pathologist (SLP) had not addressed diagnoses or medications.

- Individual #935's screening did not include a recommendation for the timeframe for the next screening or assessment.
- For Individual #595, the SLP did not address medications and their impact on communication, did not address vision, and did not include recommendations in the screening. Although the SLP identified that communication had an impact on the individual's target behaviors, no recommendations were included for further assessment, and the screening included very limited discussion of Individual #595's functional communication skills.

d. The following describes some of the concerns with the two assessments:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Although Individual #519's assessment addressed medical diagnoses in relation to their impact on his participation in communication supports and services, it did not address them in relation to their impact on his communication skills;
- The individual's preferences and strengths are used in the development of communication supports and services: assessments need to do more than list individuals' preferences and strengths;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Individual #444's assessment listed general side effects, but did not address whether or not side effects potentially impacted her communication skills. Although Individual #519's assessment addressed medications in relation to their impact on his participation in communication supports and services, it did not address them in relation to their impact on his communication skills;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Individual #444's assessment contained incomplete descriptions of her functional communication, as well as how others should communicate with her. Individual #519's assessment did not discuss the impact of his communication deficits on behavioral concerns;
- A comparative analysis of current communication function with previous assessments: Without thorough assessment of Individual #444's functional performance, the comparative analysis was incomplete;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Neither assessment provided a sufficient rationale for not recommending AAC, EC, or language-based supports;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: No evidence of this was found for either individual; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that complete assessments were not provided of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, as applicable, the assessments included:

- The effectiveness of current supports, including monitoring findings. This was not applicable for Individual #519.

e. The following summaries examples of concerns noted with regard to the required components of communication updates:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status,

including relevance of impact on communication: The assessments for Individual #1, Individual #175, and Individual #407 did not address the impact of these factors on the individuals' communication skills (e.g., provided general issues related to diagnoses without discussing potential or realized impact on individual's communication abilities);

- The individual's preferences and strengths are used in the development of communication supports and services: Individual #407's assessment listed them, but did not incorporate them into services or supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Individual #407 and Individual #281's updates were missing specific discussion about the impact of medications on the individual's communication skills;
- The effectiveness of current supports, including monitoring findings: Although Individual #1's update indicated the SLP was completing monitoring, results were not discussed;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Three of the four updates (i.e., the exception was Individual #175) did not demonstrate sufficient assessment in functional settings of the individuals' potential to use AAC or EC devices, and/or provide clear clinical justification for not recommending it; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that complete assessments were not provided of the communication needs of the individuals reviewed, it was unclear whether or not the assessments included a full set of recommendations to address the individuals' needs.

On a positive note, the four updates reviewed did include:

- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	56% 5/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/5	N/A	N/A	0/1	0/1	0/1	N/A	0/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy	17%	N/A	N/A	0/1	0/1	1/1	0/1	0/1	0/1	N/A

	interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	1/6									
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: b. At times, ISPs indicated individuals would use their Communication Dictionaries (e.g., Individual #444, and Individual #281), which showed a lack of understanding of how they are used (i.e., staff use them, not the individual). In other instances, although a box was checked in the ISP, no IDT discussion related to a review of the Communication Dictionary was documented (e.g., Individual #407, and Individual #1).											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: All individuals had SAPs, as has been the case for the two previous reviews, too. Therefore, indicator 1 will be moved to the category of requiring less oversight. With sustained high performance (indicator 2) and with increased performance (indicators 3 and 4), these indicators might move to the category of requiring less oversight after the next review. Almost half of the SAPs had reliable and valid data collected. This was an improvement from the last two reviews and showed good progress. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 26/26	3/3	3/3	3/3	3/3	2/2	3/3	3/3	3/3	3/3
3	The individual's SAPs were based on assessment results.	88% 23/26	2/3	3/3	3/3	2/3	2/2	2/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	88% 23/26	2/3	3/3	3/3	2/3	2/2	2/3	3/3	3/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	42% 11/26	2/3	2/3	1/3	2/3	1/2	1/3	2/3	0/3	0/3
Comments: 1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were only two SAPs available for review for Individual #935, for a total of 26 SAPs for this review.											

3. Eighty-eight percent of the SAPs were based on assessment results. Individual #994's identification of community signs SAP, Individual #436's cooking SAP, and Individual #611's reading SAP were scored as not based on assessment results because their FSAs indicated they could independently complete the skills being taught in the SAPs.

4. Eighty-eight percent of the SAPs were practical and functional (e.g., Individual #613's counting change SAP). The SAPs that were judged not to be practical or functional represented skills that the individual already possessed (see indicator #3). If an individual possesses the skill, it is not a functional SAP.

5. The Monitoring Team was encouraged to find that 14 of the 26 SAPs had interobserver agreement (IOA) measures to assess reliability. Eleven of those 14 SAPs had IOA scores demonstrating that the data were reliable. When IOA scores are below the established goal levels (e.g., Individual #339's operate a vibrator, apply deodorant, operate a radio SAPs), staff should be retrained and another assessment should be conducted as soon as possible with that individual to demonstrate that they are now reliably scoring the data.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

Summary: FSAs, PSIs, and vocational assessments were current for all individuals for this review and for the last two reviews, too. Therefore, indicator 10 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring. With additional attention, scores for both could improve.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:
10-12. All individuals had current FSAs, PSIs, and vocational assessments (if appropriate).

11. Individual #715, Individual #994, Individual #935, and Individual #613's PSIs, and Individual #436's FSA and vocational assessment were not, however, available to the IDT at least 10 days prior to their ISP.

12. Individual #935's FSA did not include recommendations for SAPs.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Seventeen of these, in restraint, psychiatry, psychology/behavioral health, medical, pharmacy dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This included one full outcome: psychiatry outcome 1.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Regarding when there were more than three crisis intervention restraints in any rolling 30-day period, Mexia SSLC completed met criteria for one of the individuals, showing that there is capability to meet criteria for all individuals.

In psychiatry, without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Regarding PBSPs, one individual who had reliable data was making progress. The others were not making progress and/or there were not any reliable data to make that determination. Goals were not updated based upon progress or lack of progress.

In behavioral health, progress notes, graphs, and data presentations met criteria. Criteria for content and occurrence of internal and external peer reviews were met.

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, some improvement was noted with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as for pre- and post-hospitalization assessments. However, ongoing concerns were noted in relation to nursing staff's assessments on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development

of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. On a positive note, over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff. As a result, the related indicator will move to the category requiring less oversight.

Interim psychiatry clinics were held when requested and documentation contained the relevant information. Neurology consultations were not occurring as needed.

Implementation of Plans

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

For the non-Facility consultations reviewed, the PCPs did not consistently review consultations and indicate agreement or disagreement, do so in a timely manner, and/or write an IPN that included necessary components. On a positive note, PCPs did order agreed-upon recommendations.

The Center also needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

On a positive note, at preventative visits, Dental Department staff provided tooth-brushing instruction to the individuals reviewed and/or their staff. This finding was consistent with the previous two reviews, so this indicator will be placed in the

category requiring less oversight. The Center should focus on ensuring individuals receive necessary prophylactic dental care, x-rays, and fluoride treatment, as appropriate.

Based on the individuals reviewed, Mexia SSLC Pharmacy Department was completing Quarterly Drug Regimen Reviews (QDRRs) timely, and practitioners generally reviewed them timely. As a result, two related indicators will be placed in the category requiring less oversight. The Center should focus on improving the quality of the QDRRs.

Adaptive equipment was generally clean and in good working order. The indicator related to working order will be moved to the category requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (close to 35% of 37 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Quarterly psychiatry reviews were done timely for most individuals, but a review of documentation and observation by the Monitoring Team found some missing components.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: Mexia SSLC completed these important indicators for one of the individuals (Individual #613), showing that the behavioral health services department and IDTs have the capability of meeting criteria for all individuals and should be by now. For the other two individuals in this review, partial completion was evident, such as discussing the variables, but not taking action (or indicating that action wasn't necessary). Therefore, these indicators will remain in active monitoring. Three indicators, however, were at 100% for all three individuals and for all individuals for the previous two reviews, too. These are indicators 24, 25, and 27, which will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	613	935	816							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10	33% 1/3	1/1	0/1	0/1							

	business days of the fourth restraint.										
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3	1/1	0/1	0/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3	1/1	0/1	0/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	33% 1/3	1/1	0/1	0/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	33% 1/3	1/1	0/1	0/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/3	0/1	0/1	0/1						
29	If the individual was placed in crisis intervention restraint more than	67%	1/1	0/1	1/1						

	three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	2/3									

Comments:
18-29. This outcome and its indicators applied to Individual #613, Individual #935, and Individual #816.

18. Individual #613 had his fourth restraint in 30 days on 6/14/16, and his ISPA met on 6/24/16 to address these restraints.

Individual #816 had his fourth restraint in 30 days on 11/13/16, however, his ISPA meeting to discuss these restraints did not occur until 12/6/16. Similarly, Individual #935 had an ISPA to discuss more than three restraints in 30 days on 6/1/16, however, his fourth restraint in 30 days occurred on 5/7/16.

20. Individual #613's ISPA following more than three restraints in 30 days reflected a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, and included action (e.g., referral to psychiatric clinic) to address these potential contributing variables.

Individual #935's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, however, no action to address these potential contributing variables. Individual #816's ISPA to address more than three restraints in 30 days documented some general recommendations concerning his psychiatric instability, however, no specific adaptive skills, or biological, medical, and/or psychosocial issues that potentially contributed to his restraints, were documented as discussed.

21. Individual #613's ISPA hypothesized that loud noises and chaotic environments contributed to his restraints. Additionally, his ISP suggested that staff be instructed to remove him from those situations to address this contributing environmental issue.

Individual #935's ISPA identified the presence of young female staff as a setting event for his dangerous behaviors that provoke restraint, however, no plans to address this variable contributing to his restraints was reflected in Individual #935's ISPA. Individual #816's ISPA did not address this variable.

22. Individual #613's ISPA minutes included a discussion of potential antecedent conditions that contributed to his restraints, and actions to address those antecedent conditions.

Individual #935's ISPA documented a discussion among the IDT that demands and instigating peers were antecedents to restraint, however, no actions to address these contributing antecedents were found in his ISPA. Although general recommendations to modify antecedents suggested that antecedents contributed to Individual #816's restraints, no specific antecedents were hypothesized to contribute to his restraints.

23. Individual #613's ISPA included a discussion of potential maintaining variables, and action to address them.

Individual #935's ISPA reflected a discussion of potential maintaining variables (e.g., escaping demands), however, there were no

documented plans of how to address these issues in the future. Individual #816's ISPA did not discuss the potential role of maintaining variables on the dangerous behaviors that provoke his restraints.

28. At the time of the review, none of the individuals had integrity data demonstrating that their PBSPs were implemented as written.

29. Individual #935's ISPA did not document that his IDT reviewed his PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Reiss screens were conducted at Mexia SSLC for some time now. Further, Reiss screens are regularly conducted for all individuals not already receiving psychiatric services. Therefore, these three indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 175	444	407						
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	1/1	1/1	1/1						
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A						
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A						

Comments:
1-3. Of the 16 individuals reviewed by both Monitoring Teams, three individuals were not receiving psychiatric services. The three individuals, Individual #175, Individual #444, and Individual #407were assessed utilizing the Reiss screen. All three scored below the threshold for referral for psychiatric services. No change of status issues required implementation of another Reiss screen.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
8	The individual is making progress and/or maintaining stability.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms (which was the case for seven of the nine individuals), changes to the treatment plan (i.e., medication adjustments or recommendations for behavioral supports) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	67% 6/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
23. The psychiatric documentation did not consistently reference the behavioral health target behaviors. While the functional assessments generally included information regarding the individual's psychiatric diagnosis, there was no discussion of the effects of said diagnosis on the target behaviors.

24. There was documentation of the psychiatrist's review of the PBSP in clinical documentation generated by nursing or the QIDP during psychiatry clinic for some, but not all, of the individuals.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Summary: All three indicators did not meet criteria and all three scored lower than during the last review due, perhaps in part, to the need to identify a consulting

Individuals:

neurologist. They will remain in active monitoring.											
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	33% 1/3	N/A	N/A	N/A	1/1	0/1	N/A	N/A	0/1	N/A
26	Frequency was at least annual.	0% 0/3	N/A	N/A	N/A	0/1	0/1	N/A	N/A	0/1	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 1/3	N/A	N/A	N/A	1/1	0/1	N/A	N/A	0/1	N/A

Comments:
25 and 27. These indicators applied to three individuals and criteria were met for one of them. In the case of Individual #816, the last neurology consultation was dated 12/11/15. Documents provided conflicting information regarding the medication prescribed to address seizures. Neurology indicated that Topamax was prescribed for seizures while psychiatry indicated that Trileptal was being jointly utilized.

26. None of the three individuals met the annual criterion. Apparently, there was a vacancy in the consulting neurology position.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Performance remained about the same as during the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	1/1	N/A

Comments:
33. There were delays in the completion of quarterly evaluations for Individual #715 and Individual #339.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to six components; most commonly, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, appropriate data, and basic information (timely height, weight, and vital signs).

35. Psychiatry clinic was observed for two individuals. For Individual #935, data used by psychiatry staff did not meet acceptable standards, affecting the psychiatrists' ability to make data based decisions and instead having to rely on bad data or anecdotal

information. Data were not being collected on the specific psychiatric indicators for each psychiatric disorder for both individuals. Once there are psychiatry goals (indicator 4), data on psychiatric indicators should be presented.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Summary: This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
36. Both the assessments and prescriber review of the assessments were not routinely occurring in a timely manner.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary: Interim clinics were held when requested and documentation contained the relevant information. This has been the case for some time now and, therefore, indicators 38 and 39 will be moved to the category of requiring less oversight. Indicator 37 will remain in active monitoring, but with sustained high performance might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
37	Emergency/urgent and follow-up/interim clinics were available if needed.	83% 5/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	0/1	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 5/5	1/1	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 5/5	1/1	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A

Comments:
37-38. Emergency/interim clinics were available and there was documentation of emergency/interim clinics occurring for five individuals. There were no additional clinics documented or requested for Individual #816. Because there were reported increased incidences of physical restraints for this individual, there should have been additional clinical encounters and, as a result, he was scored as not meeting criteria for indicator 37.

39. When clinics occurred, documentation was appropriate.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators met criteria during this review and the previous two reviews, too. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments:											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Polypharmacy meeting met criteria and there was documentation of the meeting discussion (though it could be done in more detail to reflect the kind of robust discussion observed by the Monitoring Team). Documentation, however, did not also end up in the records of the individuals, where it would be available for team members, future reviews, etc. Correcting this would result in increased scores for indicators 44 and 45. All three indicators will remain in active monitoring. With sustained high performance, indicator 46 might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	20% 1/5	N/A	0/1	0/1	0/1	0/1	N/A	1/1	N/A	N/A
45	There is a tapering plan, or rationale for why not.	40% 2/5	N/A	0/1	0/1	0/1	1/1	N/A	1/1	N/A	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication	100% 5/5	N/A	1/1	1/1	1/1	1/1	N/A	1/1	N/A	N/A

	changes, or (b) at least annually if stable and polypharmacy has been justified.										

Comments:
44. These indicators applied to five individuals. Polypharmacy was justified in the psychiatric documentation for Individual #715. The other individuals meeting criteria for polypharmacy did not have justification included in the psychiatric clinical documentations. Justification was located for all individuals in the polypharmacy meeting minutes.

45. There was documentation regarding tapering plans for all individuals included in the polypharmacy documents. Psychiatric documentation did not regularly include information regarding tapering plans.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for the five individuals selected by the Monitoring Team meeting criteria for polypharmacy. The polypharmacy committee meeting was observed during the visit and was a facility level review of regimens.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: One individual who had reliable data was making progress. The others were not making progress and/or there were not any reliable data to make that determination. Goals were not updated based upon progress or lack of progress. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3	N/A	N/A	N/A	N/A	N/A	0/1	0/1	0/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/5	0/1	N/A	N/A	0/1	0/1	N/A	N/A	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
6. Individual #715 was making progress and his data were reliable. Individual #611, Individual #436, Individual #816, Individual #935, and Individual #339 were not making progress toward their target behavior objectives. Individual #613, Individual #609, and Individual #994 were making progress according to the facility's notes, however, their data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing.

7. Individual #994's most recent progress note indicated that he achieved two objectives (SIB and property destruction) in October

2016, however, no new goals/objectives were established. Individual #715's November 2016 progress note indicated that SIB and possession of contraband objectives were achieved in August 2016, however, no new goals/objectives were established. Finally, Individual #816's property destruction objective was achieved in September 2016, however, no new goals/objectives were established.

8. Individual #611, Individual #436, Individual #816, Individual #935, and Individual #339 were not making progress, however, there was no evidence in their progress notes of actions to address the absence of progress.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: Mexia SSLC had, and has had, PBSP summaries for all individuals for this review and the last two reviews, too. Therefore, indicator 17 will be moved to the category of requiring less oversight. Staff training and staff credentials improved since the last review, but were not yet at criteria for all individuals (indicator 16 and 18), though three individuals met criteria for all three indicators. Indicators 16 and 18 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	44% 4/9	1/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1

Comments:

16. Individual #609, Individual #994, Individual #715, and Individual #611 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on the its implementation.

17. Mexia SSLC utilized a brief PBSP for all individuals.

18. Individual #609, Individual #436, and Individual #935's functional assessments and/or PBSPs were not written by a behavioral specialist who was enrolled in, or had completed, BCBA coursework. While onsite, the Monitoring Team spoke with the director of behavioral services and with the facility director about the potential benefits of partnering with a local college or university, especially one that already has an approved behavior analyst certification program (e.g., Baylor).

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Progress notes, graphs, and data presentations met criteria and with sustained high performance, these three indicators (19, 20, 21) might move to the category of requiring less oversight after the next review. The Monitoring Team's criteria for content and occurrence of internal and external peer reviews were met at 100% for this review and for the two previous reviews. These two indicators (22, 23) will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
19	The individual's progress note comments on the progress of the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

21. In order to score this indicator, the Monitoring Team observed Individual #816 and Individual #935's psychiatric clinic meetings. In Individual #935 and Individual #816's meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. There was evidence of follow-up/implementation of recommendations from Individual #816's peer review.

23. The Monitoring Team observed Individual #101 external peer review. Individual #101 was reviewed in peer review because he had not been progressing as expected. His peer review included the review of his functional assessment and PBSP. There was participation and discussion by the behavioral health services team to improve his PBSP. Additionally, Mexia SSLC had documentation that internal peer review meetings were consistently occurring weekly, and that external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Mexia SSLC's data collection systems adequately measured target and replacement behaviors and the facility set treatment and data integrity measures and goals. The goals were met for two individuals. Given the recent changes in the electronic health record as well as the scores for indicator 30, this outcome and its indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

26- 27. The target behavior data collection system for the majority of individuals included the identification of high frequency target behaviors that were recorded hourly or every two hours, and low frequency behaviors that were recorded at least once a shift. Replacement behaviors were generally collected hourly. These data collection systems adequately measured the target behaviors.

29. Mexia SSLC established that IOA, DCT, and treatment integrity assessments would be assessed at least quarterly, and the minimum goal level was determined to be 80%.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were achieved for Individual #816 and Individual #715.

Ensuring that PBSP data are reliable, and that PBSPs are implemented as written is crucial to evaluating the effects of interventions, and should be established as a priority for the behavioral health services department.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #609 – diabetes, and cardiac disease; Individual #935 – osteoporosis, and seizures; Individual #281 – other: hypertension, and other: hypothyroidism; Individual #1 – GI problems, and osteoporosis; Individual #175 – respiratory compromise, and other: hypothyroidism/adrenal insufficiency; Individual #595 – other: renal disease, and diabetes; Individual #407 – constipation/bowel obstruction, and diabetes; Individual #444 – aspiration, and GI problems; and Individual #519 – GI problems, and cardiac disease).

None of the goals/objectives reviewed were clinically relevant, achievable, and measurable.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
Summary: Six of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
	ii. Colorectal cancer screening	100% 4/4	N/A	N/A	1/1	1/1	1/1	N/A	N/A	1/1	N/A
	iii. Breast cancer screening	50% 1/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1	N/A
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	67% 4/6	N/A	0/1	0/1	1/1	1/1	N/A	1/1	1/1	N/A
	vii. Cervical cancer screening	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. Overall, the individuals reviewed received timely preventive care, which was good to see. The following problems were noted:

- No documentation was found of Individual #407's varicella status.
- Individual #935 had not had a DEXA scan, despite long-term use of anti-epileptic drugs, including Dilantin.
- For Individual #281, the immunization record did not include the Zoster vaccine, even though the annual medical assessment did. In addition, a DEXA was completed in 2015, but a FRAX score was not calculated. Justification was not provided for not

treating his high fracture risk.
- Individual #444's last mammogram was on 2/19/15.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Of concern, five of the nine individuals reviewed had diabetes (i.e., Individual #609, Individual #935, Individual #1, and Individual #175) or pre-diabetes (i.e., Individual #407). The Center should look at the overall prevalence, and conduct an analysis to determine whether or not there might be a correlation between prescribed medications and diabetes and/or pre-diabetes diagnoses.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. On 3/10/15, the Ethics Committee met. Per the minutes, the individual "has had some recurrent medical issues, including a recurrent urinary tract infection, very large prostate, neurogenic bladder and because of that he had a chronic Foley catheter. The biggest concern health-wise over the past year is gradual weight loss that has been extensively evaluated." The community physician participating by phone went on to state that the individual's "declining health would justify a DNR." This justification is not consistent with State Office Guidelines, and the Center did not submit documentation of a more recent review of the individual's DNR status.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 90% for Indicator 4.f, and Round 11 - 88% for Indicator 6.f), Indicator f will move to the category requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.

			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519

a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	40% 4/10	1/2	0/1	0/1	2/2	1/1	0/1	N/A	0/1	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	20% 2/10	1/2	0/1	0/1	0/2	1/1	0/1		0/1	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	44% 4/9	1/1	N/A	2/2	N/A	0/2	N/A	1/2	0/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 2/3	N/A		1/1		N/A		1/1	0/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 8/8	1/1		2/2		1/1		2/2	2/2	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	88% 7/8	1/1		1/2		1/1		2/2	2/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	13% 1/8	0/1		0/2		0/2		0/1	1/2	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	25% 2/8	0/1		1/2		1/2		0/1	0/2	

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 10 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #609 (mandible fracture on 8/30/16, and otitis media on 11/4/16), Individual #935 (dizziness on 8/25/16), Individual #281 (cerumen impaction on 11/4/16), Individual #1 (pneumonitis on 10/12/16, and contusion on 11/20/16), Individual #175 (intertrigo/ ceruminosis on 8/18/16), Individual #595 (abrasion on 8/11/16), Individual #444 (somnolence on 10/19/16), and Individual #519 (facial laceration/contusion on 10/24/16).

a. The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to

accepted clinical practice were for Individual #609 (mandible fracture on 8/30/16), Individual #1 (pneumonitis on 10/12/16, and contusion on 11/20/16), and Individual #175 (intertrigo/ceruminosis on 8/18/16).

b. The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #609 (mandible fracture on 8/30/16), and Individual #175 (intertrigo/ceruminosis on 8/18/16).

The following describe some of the concerns noted:

- On 11/4/16, the PCP documented that Individual #609 had bilateral bulging ear drums with a shallow meniscus and moist canals. The diagnosis was acute serous otitis media. Isopropyl alcohol drops were prescribed. Alcohol drops might be helpful in drying fluid in the external ear canal, but this management does not address the diagnosis of serous otitis media. The PCP did not prescribe antibiotics for this adult with diabetes who was diagnosed with serous otitis media. No follow-up was documented.
- On 8/22/16 at 3:35 p.m., nursing staff documented that Individual #935 complained of dizziness and nausea. His blood glucose was 102. At 10:39 p.m., it was noted that the individual was sweaty and complained of nausea and dizziness. The on-call MD ordered oral Zofran. On 8/25/16 at approximately 11:20 a.m., the individual was on the ground, and direct support professional staff reported that he complained of dizziness and fell. The incident was reported to sick call. On 8/25/16, the PCP documented: "reports earlier in the week of transient dizziness and reported episode of brief unresponsiveness. Vital signs were adequate per report and blood glucose was 86 randomly. He has been assessed by the CMRN [Case Manager RN] and LVN." Diabetic medications were to be discontinued due to fear of hypoglycemia. His previous workup immediately after an unresponsive episode at the ED yielded no clues as to cause. He was resistant to allow exam. The PCP provided no follow-up on this issue. On 8/30/16, nursing staff continued to document that the individual had an unsteady gait. There was an attempt to contact the Medical Director, but he was attending a death review. The PCP was contacted and recommended obtaining labs. On 8/31/16, the PCP documented lab levels including an elevated Dilantin and vitamin D, but there was no assessment of the individual. The next note from the PCP was related to an upward trend of the Dilantin level.
- On 10/12/16 at approximately 2:30 a.m., Individual #1 had a temperature of 102.7 degrees. The on-call provider was notified and orders were given to perform a rapid flu test and place the individual on sick-call. The individual was also given Tylenol. The PCP documented an assessment completed at 10:00 a.m. At the time of the exam, the individual appeared ill and was afebrile. A chest x-ray showed slight opacity of the right lung. The individual was treated for pneumonitis due to the chest x-ray findings and the history of drinking thin liquids on 10/9/16. No documentation was found of follow-up to this issue.
- On 11/20/16, Individual #1's PCP documented that the individual had a 15 centimeter (cm) by 5 cm bluish discolored bruise on the right forearm. The etiology of the bruise was unknown. The motor and neurovascular systems were all intact. The plan was to obtain an x-ray, and follow up with PCP in seven days. The individual refused the x-ray, and there was no documentation that the PCP followed up.
- On 10/19/16, the PCP wrote that the RN Case Manager informed her that the Physical Therapist would like to have labs ordered to see why Individual #444 was always so sleepy. "They requested the following labs: Vitamin B12 and ammonia." The individual was referred for a sleep study. The PCP did not document any assessment of the individual prior to ordering these diagnostics. On 10/22/16, the PCP documented that the individual was being evaluated due to coughing. The physical

exam revealed that she was "somewhat somnolent" with abnormal breath sounds. She was referred to the ED for evaluation and was diagnosed with an upper respiratory infection.

- On 10/24/16, nursing documented that another individual struck Individual #519 in the head with a fist. The injury was described as a small laceration to the middle of the forehead with active bleeding and a noticeable knot, a blackish hue spreading in each inner corner from bridge of nose to periorbital area, and eyes with bloodshot sclera. On 10/25/16, the PCP documented that x-rays of facial bones were negative for acute fracture. There was no documentation of a medical assessment, just a report that x-rays were negative for fracture.

For five of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #609 (chest pain on 8/20/16), Individual #281 [lethargy/urinary tract infection (UTI) on 9/2/16, and apnea/UTI on 10/24/16], Individual #175 (acute-on-chronic respiratory failure on 9/13/16, and G-tube dysfunction on 8/7/16), Individual #407 (aspiration pneumonia/respiratory failure on 10/1/16, and intractable nausea and vomiting on 8/25/16), and Individual #444 (severe sepsis and aspiration pneumonia on 8/10/16, and sepsis/pneumonia on 9/4/16).

c. IPNs documenting an evaluation or providing a summary were found for Individual #609 (chest pain on 8/20/16), Individual #281 (lethargy/UTI on 9/2/16, and apnea/UTI on 10/24/16), and Individual #407 (intractable nausea and vomiting on 8/25/16).

d. For Individual #444 (severe sepsis and aspiration pneumonia on 8/10/16), the transfer occurred during business hours, but no documentation was found of a medical assessment.

e. For the acute illnesses reviewed, it was positive the individuals reviewed received timely treatment at the SSLC.

f. The individual that was transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff was Individual #281 (apnea/UTI on 10/24/16).

g. At times, IDTs did not hold ISPA meetings, and in other instances PCPs did not attend ISPA meetings.

h. Upon their return to the Facility, the individuals for whom there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness were: Individual #281 (lethargy/UTI on 9/2/16), and Individual #175 (G-tube dysfunction on 8/7/16).

The following describe some of the concerns noted:

- On 8/19/16, the PCP documented that on 8/8/16, Individual #609 saw the cardiologist due to chest pain and electrocardiogram (EKG) abnormalities. A stress test was ordered for 8/23/16. On 8/20/16, the individual was transferred to the ED for evaluation of chest pain. Per the PCP note on 8/21/16, the individual was discharged from the ED with non-cardiac chest pain, with stress test pending. On 8/24/16, a note stated only the echo ejection fraction was normal. On 8/31/16, the next PCP note was related to jaw pain. On 9/19/16, documentation indicated that the stress test was non-diagnostic due to poor exercise capacity. No ischemic changes were noted. There was no discussion related to the need to proceed to a diagnostic that did not require exercise.

- On 10/21/16, the PCP saw Individual #281, and noted that blood pressures were running borderline high in the clinic. Follow-up was in two weeks. On 10/24/16, nursing staff documented that the individual was coughing with thick mucus, had little oral intake, and was tachypneic with a rapid thready pulse. He was intermittently alert. The individual was transferred to the ED for evaluation. The individual was diagnosed with a UTI and returned to the Center. On 10/25/16, the PCP documented in the post-ED note that one episode of apnea was noted the previous day. The individual would continue on Levaquin for treatment of UTI. On 10/30/16, the individual was seen again for evaluation of elevated blood pressures. Per the PCP, no clonidine was given because the individual's blood pressure did not get higher than 160/90, and the hypertension specialist had recommended that clonidine not be used. Follow-up did not appear adequate given the increasing frequency of ED evaluations, and a reported episode of apnea.
- On 8/7/16 at 8:45 a.m., Individual #175 was transferred to the ED because the G-tube reportedly broke in half and the bulb could not be deflated. Per the Discharge Summary of the admitting physician, she was "momentarily noted to be hypoxic and wheezing for which she was placed on supplemental oxygen and breathing treatments." On 8/10/16, the PCP conducted follow-up, but there was no follow-up after that. On 8/17/16, the next PCP entry was made regarding the need to replace the G-tube. On 8/10/16, no medical provider attended the ISPA meeting. Moreover, the IDT determined that supports were appropriate, but the IDT did not document discussion that the individual was found to be hypoxic and wheezing when she arrived at the hospital for a G-tube change.
- Similarly, per the admitting history and physical, on 9/13/16, Individual #175 was being evaluated at her routine pulmonary clinic appointment. She was found to be unresponsive and was transferred to the ED for evaluation as she was noted to have marked hypercapnia. She was admitted with the diagnosis of acute-on-chronic respiratory failure. The PCP did not complete an IPN within one business day of her admission. On 9/16/16, she was discharged, and on 9/17/16, the PCP saw her. There was no further follow-up. The next provider entry was on 9/20/16, but the provider signed it on 12/5/16. It was a urine culture report.
- On 8/25/16 at 8:00 a.m., the PCP documented that Individual #407 returned from the hospital on 8/24/16, and had no emesis since returning. At 1:00 p.m., the PCP documented that the individual had recurrent emesis and was being sent back to the hospital. Per the hospital discharge, from 8/25/16 to 8/31/16, the individual was admitted for intractable nausea and vomiting. On 9/1/16, the individual returned to the hospital after vomiting and foaming at the mouth. On 9/3/16, the discharge diagnosis was resolved nausea and vomiting. On 9/5/16, the PCP documented a post-hospital note stating that this was a note for 9/4/16. From the note, it was unclear if the PCP actually saw the individual on 9/4/16. This note did not provide any information regarding the hospitalization. It simply stated the diagnosis was aspiration pneumonia, and indicated the individual's present condition appeared improved from yesterday (there was no note for a previous exam). The note indicated further follow-up with the PCP was indicated.

  On 10/1/16, nursing staff documented that Individual #407 had copious amount of frothy milk substance coming from his mouth. The individual was hypoxic and tachypneic, and, therefore, was sent to the ED. On 10/1/16, the only comment from the provider was that the provider spoke with the ED doctor in addition to speaking with the guardian about transfer. On 10/12/16, Individual #407 died with causes of death listed as aspiration pneumonia, and encephalopathy.
- For Individual #444, on the morning of 8/10/16, the medical provider conducted follow-up for an idiopathic and intermittent rash. Benadryl was prescribed. Around 3:00 p.m., the individual was noted to be jerking, shivering and had coarse breath sounds. She was transferred to the ED. Per the hospital Discharge Summary, the individual presented to the ED on 8/10/16,

and met four out of four systemic inflammatory response syndrome (SIRS) criteria for severe sepsis secondary to aspiration pneumonia. On 8/22/16, Individual #444 returned to the Center. There was no documentation of a post-hospital assessment. The first medical provider contact was dated 8/30/16. It was for follow-up of pneumonia and rash.

On 9/4/16 at around 3:00 a.m., nursing staff documented that the individual had a fever. The on-call medical provider gave orders for labs and Tylenol was given. At around 9:54 a.m., the provider was contacted again because the individual was having respiratory distress and was being sent to the ED. Per hospital notes, Emergency Medical Services (EMS) staff found the individual in respiratory distress, with tachycardia, hypotension, and oxygen saturations in the low 80s. The individual was admitted into the Intensive Care Unit with sepsis and pneumonia. On 9/9/16, she was discharged to swing bed, and on 9/18/16, returned to the Center. On 9/18/16, the PCP wrote a note documenting that the individual would be returning from an alternative care facility, but documented no post-hospital assessment.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.

Summary: The Center's scores for these indicators have varied. However, since the last review, these scores generally showed regression. They will all remain under active oversight.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	63% 10/16	1/1	0/2	2/2	2/2	2/2	1/1	0/2	1/2	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	44% 7/16	1/1	0/2	1/2	1/2	2/2	1/1	0/2	0/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	56% 9/16	0/1	0/2	2/2	2/2	2/2	1/1	0/2	1/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	83% 10/12	1/1	0/2	2/2	2/2	2/2	1/1	N/A	1/1	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	33% 2/6	N/A	0/2	N/A	N/A	0/1	N/A	N/A	1/2	1/1

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #609 for cardiology on 8/15/16; Individual #281 for urology on 8/29/16, and eye on 9/21/16; Individual #1 for cardiology on 7/2/16, and podiatry on 7/27/16; Individual #175 for neurology on 9/27/16, and pulmonary on 11/22/16; Individual #595 for podiatry on 10/24/16; Individual #407 for pulmonary/sleep on 9/30/16, and audiology of 6/6/16; Individual #444 for ear, nose, and throat on 6/17/16, and gastroenterology (GI) on 12/2/16; and Individual #519 for GI on 8/10/16, and podiatry on 9/14/16. The Center provided only two consultations for Individual #935, but they were outside of the dates for the

document request, so IPNs were not available. Because it was clear that this individual had consultations that fell within the review period, zeros were assigned to the related indicators.

a. The consultations for which documentation showed PCPs reviewed reports, and indicated agreement or disagreement with the recommendations were for: Individual #609 for cardiology on 8/15/16; Individual #281 for urology on 8/29/16, and eye on 9/21/16; Individual #1 for cardiology on 7/2/16, and podiatry on 7/27/16; Individual #175 for neurology on 9/27/16, and pulmonary on 11/22/16; Individual #595 for podiatry on 10/24/16; Individual #444 for ear, nose, and throat on 6/17/16; and Individual #519 for GI on 8/10/16.

b. Those for which this was done timely included: Individual #609 for cardiology on 8/15/16; Individual #281 for urology on 8/29/16; Individual #1 for podiatry on 7/27/16; Individual #175 for neurology on 9/27/16, and pulmonary on 11/22/16; Individual #595 for podiatry on 10/24/16; and Individual #519 for GI on 8/10/16.

c. The consultations for which the PCPs wrote IPNs that included all of the components State Office policy requires, including discussion regarding whether or not a referral to the IDT is needed were those for: Individual #281 for urology on 8/29/16, and eye on 9/21/16; Individual #1 for cardiology on 7/2/16, and podiatry on 7/27/16; Individual #175 for neurology on 9/27/16, and pulmonary on 11/22/16; Individual #595 for podiatry on 10/24/16; Individual #444 for ear, nose, and throat on 6/17/16; and Individual #519 for GI on 8/10/16.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, which was good to see.

e. Individual #175 was diagnosed with severe sleep apnea and required a CPAP. Although this issue was referred to the IDT, no relevant ISPA documentation was found.

On 12/8/16, Individual #444's IDT held an ISPA meeting to discuss issues including the GI consult. Her mother and sister attended, and expressed a desire to not have an enteral tube placed even though the individual was not eating and continued to lose weight. The medical provider was not in attendance. The IDT noted that the GI consult included the diagnosis of failure to thrive, which the RN Case Manager questioned. It would have been essential for the PCP or a provider to attend to answer such questions.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519

a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	28% 5/18	1/2	0/2	1/2	0/2	0/2	1/2	1/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #609 – diabetes, and cardiac disease; Individual #935 – osteoporosis, and seizures; Individual #281 – other: hypertension, and other: hypothyroidism; Individual #1 – GI problems, and osteoporosis; Individual #175 – respiratory compromise, and other: hypothyroidism/adrenal insufficiency; Individual #595 – other: renal disease, and diabetes; Individual #407 – constipation/bowel obstruction, and diabetes; Individual #444 – aspiration, and GI problems; and Individual #519 – GI problems, and cardiac disease).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #609 – diabetes, Individual #281 – other: hypothyroidism, Individual #595 – diabetes, Individual #407 – constipation/bowel obstruction, and Individual #519 – cardiac disease. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #609's cardiac disease, the most recent interim medical summary indicated that lipids would be checked due to "somewhat high risk," but it provided no insight regarding the approach to management of hyperlipidemia. Cardiovascular risk should be calculated using appropriate risk models. This information should be used to guide the decision regarding the use of statins. While a statin was prescribed, there should be a determination made about the intensity of the statin based on calculated risk scores.
- Individual #935 was rated at medium risk for osteoporosis. No DEXA scan had been completed, despite the long-term use of Dilantin.
- Individual #935 was treated for a seizure disorder, but the medical documentation presented showed no discussion of the need to continue anti-epileptic drugs (AEDs) with the last seizure being documented in 2008. The individual should be referred to neurology for evaluation and justification of the need to continue the AEDs (i.e., they might very well be justified, but there is little discussion about the seizure classification, history, etc. in the various assessments). Documentation in his records indicated that neurology services were not available at the Center.
- On 7/8/16, Individual #281 saw the nephrologist who noted the following regarding hypertension management: "Stop atenolol, B-blockers are not first line anti-HTN [hypertensives]. Restart Lisinopril at 10mg po [by mouth] daily… He has stage 2 HTN and will require 2 meds. Start diuretic… Do not give clonidine but titrate his BP medications as clonidine withdrawal can cause rebound HTN." However, in October 2016, IPNs documented that clonidine was being given for control of hypertension. On 6/16/16, a cardiology evaluation noted: "Blood pressure appeared well controlled on a low dose of Lisinopril and HCTZ. Recommend restarting those medications. Not clear why he was switched to atenolol." It was not clear why clonidine was utilized every four hours, or why Lisinopril was discontinued and atenolol started (there was no ADR reported for the use of an ACE inhibitor). This was complicated by the fact the multiple physicians were making medication changes for the management of hypertension.
- For Individual #175, hypothyroidism was not included in IRRF or IHCP. The annual medical assessment indicated that she was biochemically euthyroid. However, the hypothermia section listed hypothyroidism as a cause for hypothermia. It should also be noted that the annual medical assessment stated that the hypothermia might be due to a cortisol deficiency: "It is possible that she has adrenal insufficiency which causes her to have hypothermia." The IRRF noted that in 2015, the work-up

for adrenal insufficiency was negative. Adrenal insufficiency is a serious medical condition that can result in significant morbidity and mortality if untreated. The PCP should document a definitive outcome of any work-up that has been done.

- Individual #595 had been treated with lithium on a long-term basis. His lab studies showed creatinine levels that were at the upper limit of normal or elevated. Chronic lithium ingestion is associated with several forms of renal injury, including diabetes insipidus and chronic tubulointerstitial nephropathy. It was not clear why a young individual with an abnormal creatinine (who remained at risk for development or renal disease) had not been referred for a nephrology evaluation. It should also be noted that this individual was treated with desmopressin for enuresis. This drug is also used to treat diabetes insipidus. Per the annual medical assessment, Individual #595 "developed a very mild elevation in creatinine which is now chronic. The desmopressin was discontinued because it was debatable whether it was working and per the CP [Clinical Pharmacist] the combination with lithium could cause renal concerns." An ADR for lithium and the increase in creatinine was reported, but this was not discussed in the PCP documentation.
- The active problem list of Individual #407's annual medical assessment did not document prediabetes (diagnosed in 2015) as a diagnosis. Therefore, there was no plan to address this problem. The American Diabetes Association recommends the implementation of a diabetes prevention program with consideration given to the use of pharmacologic agents for younger individuals in an effort to delay the onset of diabetes mellitus.
- Individual #444's annual medical assessment did not have a plan related to pneumonia risk. The Active Problem List provided a limited plan related to dysphagia stating: "currently on a modified texture diet, calorie controlled, pureed diet. She is tolerating her diet well; therefore, we will continue the current diet plan." There was no further discussion related to aspiration prevention. The interim medical reviews noted the two hospitalizations for pneumonia. There was little discussion about the supports and the need for changes in supports in order to minimize aspiration events.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	56% 10/18	2/2	1/2	1/2	1/2	1/2	1/2	1/2	0/2	2/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were not consistently implemented.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given the timely completion of QDRRs at Mexia SSLC (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), and timely practitioner review (Round 9 – 100%, Round 10 – 92%, and Round 11 - 100%), indicators a and c will be placed in the category requiring less oversight. The Pharmacy Department should focus on improving the quality of the QDRRs. The Monitoring Team will also continue to review the Center's implementation of agreed-upon recommendations.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	61% 11/18	2/2	2/2	2/2	2/2	0/2	0/2	0/2	2/2	1/2
	ii. Benzodiazepine use;	100% 14/14	N/A	N/A	2/2	2/2	2/2	2/2	2/2	2/2	2/2

	iii. Medication polypharmacy;	100% 12/12	2/2	N/A	N/A	2/2	2/2	2/2	2/2	N/A	2/2
	iv. New generation antipsychotic use; and	60% 6/10	2/2	2/2	N/A	2/2	N/A	0/2	N/A	N/A	0/2
	v. Anticholinergic burden.	100% 14/14	2/2	2/2	N/A	2/2	2/2	2/2	N/A	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 12/12	2/2	2/2	2/2	2/2	N/A	2/2	N/A	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 6/6	1/1	2/2	1/1	2/2	N/A	1/1	1/1	N/A	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. At times, the Pharmacy Department did not further review abnormal or outdated lab results to determine significance followed by recommendations, if clinically appropriate. For example:

- For Individual #175, the QDRRs did not document the proper monitoring for diabetes mellitus. For example, other records showed increased urinary albumin over a period of months, but the QDRR did not address this abnormal lab value and/or make any recommendations.
- Individual #595 had a slightly elevated creatinine level. This was clinically significant in a very young individual, particularly one who has chronic lithium treatment, which is associated with several forms of renal injury. There was no recommendation for further evaluation.
- The Clinical Pharmacist indicated that Individual #407 was not at risk for metabolic syndrome. The diagnosis of metabolic syndrome requires three criteria. This individual met all three: abdominal girth greater than 40, treatment of hyperlipidemia, and fasting blood glucose greater than 110.
- For Individual #519, the Clinical Pharmacist did not comment on a Vitamin D level that was higher than optimal (i.e., 68). He also had hyperlipidemia, but an atherosclerotic cardiovascular disease (ASCVD) score was not noted for the individual.

The QDRR for Individual #595 noted he had “no risk" for metabolic syndrome. However, the individual had risks for the development of metabolic syndrome. He was overweight based on body mass index (BMI), and was prescribed psychotropic medication inclusive of a next generation antipsychotic. Although he did not meet any of the criteria for metabolic syndrome, he did have risk factors, which the IDT should address. The Pharmacy’s assessment of risk in this manner results in a low risk rating that is often used in the

individual's IRRF and IHCP.

Similarly, for Individual #519, the Clinical Pharmacist noted the individual had two risk factors for metabolic syndrome. However, elevated triglycerides and increased abdominal girth are criteria for metabolic syndrome. In fact, Individual #519 met three criteria, and the annual medical assessment included a diagnosis of metabolic syndrome.

c. and d. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they implemented them.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/6		0/1	0/1	0/1	0/1	0/1			0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6		0/1	0/1	0/1	0/1	0/1			0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6		0/1	0/1	0/1	0/1	0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6		0/1	0/1	0/1	0/1	0/1			0/1

Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. Individual #609, Individual #407, and Individual #444 were at low risk for dental, so goals/objectives were not necessary. These individuals were part of the core group, though, so the Monitoring Team conducted full reviews of their dental services and supports. For the remaining six individuals, in addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these six individuals, the Monitoring Team conducted full reviews of the

processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individuals have no diagnosed or untreated dental caries.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	80% 4/5	1/1	1/1	N/A	N/A	N/A	1/1	1/1	N/A	0/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	N/R	N/A	N/A	N/R	N/R	N/R	N/A	N/A	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: b. When individuals' exams identified them as having periodontal disease, but no periodontal charting and/or x-rays were available, the Monitoring Team could not rate this indicator (e.g., Individual #281, Individual #1, and Individual #175). The Monitoring Team is applying the "N/R" score to this round of reviews to allow State Office to work with the Centers to improve practice. However, beginning in the next round of reviews, if an individual should have had periodontal charting, and it is not completed, or a justification is not provided for a lack of periodontal charting, then these scores will be scored 0.

c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Given that over the last two review periods and during this review, individuals and/or their staff received tooth-brushing instruction from Dental Department staff at preventative visits (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicator b will move to the category requiring less oversight. The remaining indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519

a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	38% 3/8	1/1	0/1	0/1	0/1	1/1	1/1	0/1	N/A	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	75% 6/8	1/1	1/1	0/1	1/1	1/1	1/1	0/1	N/A	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	71% 5/7	1/1	1/1	1/1	0/1	0/1	1/1	N/A	N/A	1/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	75% 6/8	1/1	1/1	0/1	0/1	1/1	1/1	1/1	N/A	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. Individual #444 was edentulous. b. It was positive that Dental Department staff provided the individuals reviewed with tooth-brushing or oral care instructions at preventative visits.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on documentation the Center submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had dental emergencies.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: For this review and the last one, the Center included measurable strategies for suction tooth brushing in ISPs for individuals who needed it, and documentation was present to show staff implemented the strategies. If the Center maintains this performance, likely during the next review, one or more of these indicators might move to the category requiring less oversight. The Center does need to focus on periodically monitoring the procedures, and ensuring QIDP monthly reviews include specific data and analysis of data related to suction tooth brushing, as appropriate.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	80% 4/5	N/A	N/A	1/1	1/1	1/1	N/A	1/1	0/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	80% 4/5			1/1	1/1	1/1		1/1	0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/5			0/1	0/1	0/1		0/1	0/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/5			0/1	0/1	0/1		0/1	0/1	
Comments: a. and b. It was positive that for the individuals reviewed, ISPs included measurable plans/strategies for suction tooth brushing, and evidence was available to show they were implemented. c. Individual monitoring data was not available to show periodic monitoring occurred to ensure that staff were safely completing the technique.											

Outcome 9 – Individuals who need them have dentures.											
Summary: It was good to see some improvement since the last review with regard to the Dentist's assessment of the appropriateness of dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	86% 6/7	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1

b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. Since the last review, improvement was noted with regard to the Center's performance on this indicator.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Over the past two reviews and this one, the Center's scores for these indicators have varied. In comparison with the last review, some improvement was noted with regard to nursing assessments at the onset of signs and symptoms of illness, as well as pre- and post-hospitalization nursing assessments. However, nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	80% 8/10	2/2	N/A	2/2	1/1	0/1	N/A	2/2	1/2	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	60% 6/10	0/2		2/2	1/1	0/1		2/2	1/2	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	50% 2/4	1/1		1/1	0/1	N/A		N/A	0/1	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	83% 5/6	1/1		1/1	N/A	0/1		2/2	1/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/10	0/2		0/2	0/1	0/1		0/2	0/2	
f.	The individual's acute care plan is implemented.	0% 0/10	0/2		0/2	0/1	0/1		0/2	0/2	
Comments: At the time of the Monitoring Team's onsite review, the Nursing Department was implementing a Corrective Action Plan (CAP) for staffing. As of the week of 3/20/17, there were 38 nursing vacancies, six of which were RN Case Managers, and the remainder											

of which were direct care nursing. Based on the Monitoring Team's review, the problems with staffing, which the CAP was designed to address, had negatively impacted documentation of follow-up care, including development of acute care plans.

The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for six individuals, including Individual #609 – chest pain on 8/20/16, and mild head injury on 9/8/16; Individual #281 – distal urethral wound on 8/12/16, and resolved apneic episode on 10/24/16; Individual #1 – pneumonitis on 10/13/16; Individual #175 – acute-on-chronic respiratory failure with hypercapnia, asthma exacerbation, and UTI on 9/13/16; Individual #407 – aspiration pneumonitis on 7/7/16, and pneumonia on 8/21/16; and Individual #444 – rash on 8/10/16, and tongue swelling obstruction oral airway on 10/29/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP" were: Individual #281 – distal urethral wound on 8/12/16, and resolved apneic episode on 10/24/16; Individual #1 – pneumonitis on 10/13/16; Individual #407 – aspiration pneumonitis on 7/7/16, and pneumonia on 8/21/16; and Individual #444 - tongue swelling obstruction oral airway on 10/29/16.

e. For the following acute illnesses/occurrences, nursing staff had not developed acute care plans: Individual #609 – chest pain on 8/20/16, and mild head injury on 9/8/16; Individual #281 – distal urethral wound on 8/12/16, and resolved apneic episode on 10/24/16; Individual #175 – acute-on-chronic respiratory failure with hypercapnia, asthma exacerbation, and UTI on 9/13/16; Individual #407 – aspiration pneumonitis on 7/7/16 (i.e., although a 7/11/16 IPN indicated an acute care plan was initiated, none was found in the documentation provided); and Individual #444 – rash on 8/10/16, and tongue swelling obstruction oral airway on 10/29/16.

Common problems with the two acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	33% 6/18	0/2	2/2	0/2	0/2	1/2	0/2	2/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	measurable goal/objective.	0/18									
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #609 – dental, and diabetes; Individual #935 – cardiac disease, and weight; Individual #281 – respiratory compromise, and infections; Individual #1 – GI problems, and skin integrity; Individual #175 – aspiration, and seizures; Individual #595 – circulatory, and falls; Individual #407 – respiratory compromise, and infections; Individual #444 – constipation/bowel obstruction, and hypothermia; and Individual #519 – fractures, and other: metabolic syndrome).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #935 – cardiac disease, and weight; Individual #175 – seizures; Individual #407 – respiratory compromise, and infections; and Individual #444 – hypothermia.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following infection control practices during medication administration (f, and previously e). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 6/6	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/R									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia	N/R									

	since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 5/5	N/A	N/A	N/A	1/1	1/1	1/1	N/A	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	83% 5/6	1/1	N/A	N/A	1/1	0/1	1/1	N/A	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of medication administration for seven individuals, including Individual #609, Individual #935 (refused medications), Individual #1, Individual #175, Individual #595, Individual #444, and Individual #519.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. This indicator was not assessed during this review, but will be during upcoming reviews. According to the State Office Nursing

Discipline Coordinator and RN Case Manager, the Center had just recently completed training using the curriculum State Office provided to assist the Centers in complying with these requirements. In April 2017, full implementation was scheduled to begin.

f. For the individuals observed, nursing staff followed their PNMPs, which was good to see.

g. For the individuals observed, nursing staff generally followed infection control practices. The nurse who administered Individual #175's medication did not follow infection control procedures for glove use/exchange.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Continued work was needed to ensure that, as appropriate, individuals' IDTs refer them to the PNMT, or the PNMT makes self-referrals. Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/2	N/A	0/1	0/1	0/2	0/2	0/1	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/2		0/1	0/1	0/2	0/2	0/1	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2		0/1	0/1	0/2	0/2	0/1	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2		0/1	0/1	0/2	0/2	0/1	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2		0/1	0/1	0/2	0/2	0/1	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to	60%	N/A	0/1	1/1	0/1	N/A	N/A	1/1	1/1	N/A

	or reviewed by the PNMT, as appropriate;	3/5									
ii.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5		0/1	0/1	0/1			0/1	0/1	
iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/5		0/1	0/1	0/1			0/1	0/1	
iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5		0/1	0/1	0/1			0/1	0/1	
v.	Individual has made progress on his/her goal/objective; and	0% 0/5		0/1	0/1	0/1			0/1	0/1	
vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5		0/1	0/1	0/1			0/1	0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: weight, and constipation/bowel obstruction for Individual #609; fractures for Individual #281; choking for Individual #1; aspiration, and fractures for Individual #175; choking, and falls for Individual #595; fractures for Individual #407; fractures for Individual #444; and weight, and GI problems for Individual #519.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed five areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #935; aspiration for Individual #281; falls for Individual #1, aspiration for Individual #407, and aspiration for Individual #444.

These individuals should have been referred or referred sooner to the PNMT:

- In May 2015 and August 2015, Individual #935 met criteria for referral to the PNMT with no evidence of referral at those times. On 3/31/16, he was finally referred after a 41-pound weight loss in the previous year (i.e., monthly weights of 166, 160, 158, 158, 152, 143, 144, 149, 136, 136, 136, 130, and 125). Moreover, no IDT discussion was found of continued lower weight through 11/15/16, and then a big jump in weight as of 11/27/16 (i.e., from 127.2 on 11/15/16 to 144 on 11/27/16, according to the three-month weight record submitted).
- The PNMT should have at least reviewed Individual #1. He experienced an increasing number of falls, including one in each August and September 2016, two in October 2016, one in November 2016, two in December 2016, four in January 2017, and four in February 2017. In other words, in the last six months, he had 15 falls with 10 of those in the last three months.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and

analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	17% 1/6	0/1	0/1	0/1	0/1	N/A	N/A	0/1	1/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, except for the IHCP for fractures for Individual #444, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, documentation generally was not found to confirm the implementation of the PNM action steps that were included.

c. Individual #281's IHCP was not updated. The PNMT did not work with the IDT to develop clinical indicators. The PNMT also did not work to individualize re-referral criteria to proactively identify significant changes of status for him. As a result, he would need to have another aspiration pneumonia event to be referred back to the PNMT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: The Center's rate of PNMP implementation during this review was similar to the last two (i.e., 61% in Round 10, and 70% in Round 9). Although this rate was higher than many other Centers, focused efforts are needed to improve this rate. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.	

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	65% 24/37
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 4/8
	Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during six out of eight observations (75%). Staff followed individuals' dining plans during 17 out of 28 mealtime observations (61%). Oral care was completed correctly one out of one times (100%).	

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A					N/A		N/A		
	Comments: a. As noted above, Individual #175's IDT had not documented a justified determination regarding whether or not she should progress along the continuum to oral intake.										

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, for individuals reviewed, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/8	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A

	measurable goal.	0/8									
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/2	0/1	0/1	0/1	N/A	0/1	0/1	0/1	N/A

Comments: a. and b. Individual #175 did not appear to have a need for a goal/objective, but as noted elsewhere had not had a quality assessment completed. Individual #519 had functional motor skills, so did not require a goal/objective.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

Summary: The Monitoring Team will continue to review these indicators.

			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/4	0/2	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Over a period of time, Individual #609 refused to participate in the programs, or was a did not attend his appointments. Although the IDT discussed discontinuation of the programs at an ISPA meeting, they did not problem-solve to identify potential solutions to his refusals.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

Summary: Given that over the last two review periods and during this review, individuals observed generally had adaptive equipment that was in working order (Round 9 – 100%, Round 10 – 88%, and Round 11 - 93%), Indicator b will move to the category requiring less oversight. Since the last review, the Center's score related to the cleanliness of individuals' adaptive equipment had improved. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, the Center should focus on making improvements (Round 9 – 69%,

Round 10 – 63%, and Round 11 – 73%). During future reviews, it will also be important for the Center to show that it has quality assurance mechanisms in place for these indicators that meet the requirements of the Settlement Agreement. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	452	296	524	528	25	185	469	427	533
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 15/15	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	93% 14/15	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	73% 11/15	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
		Individuals:									
#	Indicator		175	321	61	99	395	293			
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1			
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1			
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1			

Comments: a. The Monitoring Team conducted observations of 15 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed generally was in working order. The exception to this was Individual #296's wheelchair, because the right brake was stiff and difficult to operate.

c. Based on observation of Individual #452, Individual #469, Individual #524, and Individual #533 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. Two indicators, in engagement and in communication, had sustained high performance scores to be moved the category of requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

The ISP personal goals that were developed did not have data to allow progress to be assessed. Action steps were not consistently implemented for all goals and/or action plans for any of the individuals.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

During this review and the last two, individuals with AAC devices whom the Monitoring Team observed generally had their devices with them and readily available. Therefore, the related indicator will move to the category requiring less oversight. However, more work is needed to ensure individuals use their AAC/EC devices functionally. In addition, IDTs did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills.

Three of 21 SAPs were rated as progressing. Almost half of the SAPs contained all of the required components, which was a dramatic improvement from previous reviews. Less than half of the SAPs were implemented correctly, however, improvement was seen in the frequency and manner in which Mexia SSLC was monitoring the actual implementation in SAPs.

Mexia SSLC set engagement level goals for each residence and day program site. Various new activities and opportunities had been, and were being, created on and off campus.

Community outings and community SAP training occurred for some individuals, but did not meet the various indicator criteria. It was good to see that outings were occurring.

Mexia SSLC had a long history of working closely with the public school district. One unit was for school-aged individuals (under 18 years old) and many individuals in other units on campus also received educational services (ages 18-21). The facility had a liaison whose full time job was to support the collaboration and integration of educational services with their lives at the facility and with their eventual obtaining of their high school diplomas. Some additional attention was needed by IDTs to incorporate IEP objectives into the ISP.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Although some goals were individualized, they did not meet criterion with ISP indicators 1-3 and, thus, the indicators of this outcome also did not meet criteria. Specifically, the goals that were developed did not have data to allow progress to be assessed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	609	436	935	175	1			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/5			
Comments: 4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Indicator 39 showed good improvement from the time of the last review; indicator 40 did not. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	609	436	935	175	1			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	50% 3/6	0/1	1/1	1/1	1/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments:											

39. Staff knowledge regarding individuals' ISPs was sufficient for three individuals (Individual #935, Individual #609, Individual #436), but for the others, insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.

40. Action steps were not consistently implemented for all goals and/or action plans for any of the individuals, as noted throughout this report.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: All four indicators showed improvement from the last review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
6	The individual is progressing on his/her SAPS	14% 3/21	0/1	0/3	1/3	0/1	0/2	0/2	2/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	38% 3/8	1/1	0/2	N/A	N/A	0/2	N/A	N/A	N/A	2/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	62% 8/13	1/1	0/2	2/2	N/A	0/2	N/A	3/3	N/A	2/3

Comments:

6. Three SAPs were rated as progressing (e.g., Individual #715's reading SAP). Five SAPs had insufficient data to determine progress (i.e., less than three months of data), and were scored as N/A (e.g., Individual #436's make change SAP). Nine other SAPs had insufficient data to determine progress, but were scored as 0 because their data were not demonstrated to be reliable (e.g., Individual #613's write his address SAP). Eight SAPs (e.g., Individual #613's reading SAP) were scored 0 because they were not making progress, and two SAPs were progressing, however, were scored as 0 because they did not have reliable data (e.g., Individual #609's math SAP).

7-9. Individual #609's medication side-effects SAP objective was achieved and the next step initiated. Additionally, three of the eight SAPs judged as not progressing (e.g., Individual #339's operate your radio), had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for eight SAPs (e.g., Individual #715's subtraction SAP).

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Almost half of the SAPs contained all of the required components, which was a dramatic improvement from previous reviews. A closer look at the results showed that most if not all of the SAPs for some individuals were complete (four individuals) whereas for the other five individuals, none (or one) of the SAPs were complete. It may be that the SAP development skills vary across SAP developers. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
13	The individual's SAPs are complete.	42% 11/26	0/3	2/3	0/3	3/3	0/2	1/3	0/3	2/3	3/3
Comments: 13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Eleven SAPs were scored as complete which represents a dramatic improvement from the last review. The most common missing components were problems with operational definitions (e.g., Individual #611's reading SAP), and unclear instructions concerning the training step or steps (e.g., Individual #715's reading SAP).											

Outcome 5- SAPs are implemented with integrity.											
Summary: Although less than half of the SAPs were implemented correctly (based on Monitoring Team observation), improvement was seen in the frequency and manner in which Mexia SSLC was monitoring the actual implementation in SAPs. This was reflected in improved scores for indicator 15, which may result ultimately in improved scores for indicator 14, too. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
14	SAPs are implemented as written.	40% 2/5	N/A	1/1	N/A	1/1	0/1	N/A	N/A	0/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	42% 11/26	2/3	2/3	1/3	2/3	1/2	1/3	2/3	0/3	0/3
Comments: 14. The Monitoring Team observed the implementation of five SAPs. Individual #613's count change SAP and Individual #436's make change SAP were judged to be implemented and recorded as written. The DSPs implementing Individual #935's read the driver's license manual SAP, Individual #816's combine bills SAP, and Individual #339's operate a vibrator SAP were not implemented and recorded as written.											

15. Since the last monitoring review, Mexia SSLC established that each SAP would have an integrity assessment at least once every six months, and at a level of at least 80%. Fourteen of the SAPs reviewed did have integrity checks, with 11 of those being above 80%.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.

Summary: Both indicators showed decreased performance since the last review and both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
16	There is evidence that SAPs are reviewed monthly.	31% 8/26	2/3	0/3	0/3	0/3	0/2	2/3	3/3	1/3	0/3
17	SAP outcomes are graphed.	70% 16/23	1/3	2/3	1/3	1/3	2/2	3/3	3/3	N/A	3/3

Comments:

16. Eight SAPs were reviewed in QIDP monthly reports and included a data based review (e.g., Individual #715's SAPs). Some SAPs, however, were not reviewed (e.g., Individual #935's SAPs), others were reviewed, but only one month of SAP data was presented (e.g., Individual #339's SAPS), or the reviews were not monthly (e.g., Individual #436's make change SAPs last review was June 2016).

17. Seventy percent of the available SAP data were graphed. The exceptions were Individual #611's math and reading SAPs, Individual #609's checking account and identify medication side effects SAPs, and SAPs for Individual #613 and Individual #436 for which data were not reviewed. Three SAPs for Individual #816 were not included in this indicator because they were new.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.

Summary: Mexia SSLC set engagement level goals for each residence and day program site. This was the case for the last two reviews, too. Therefore, indicator 20 will be moved to the category of requiring less oversight. Mexia SSLC usually regularly measured engagement, thus, with sustained high performance indicator 19 might move to the category of less oversight after the next review. Various new activities and opportunities had been, and were being, created on and off campus. This may result in improvements in scores for indicators 18 and 21 in the future. These three indicators (18, 19, 21) will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 611	613	609	436	935	994	715	816	339
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's	89%	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

	treatment sites.	8/9									
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	56% 5/9	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus and in school during the onsite week. The Monitoring Team found three (Individual #715, Individual #436, Individual #611) of the nine individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

There was little functional training or meaningful activity going on in the day program for two of the individuals who's ISPs we reviewed in detail in domains 2 and 4 (Individual #1, Individual #175). On three different days, staff were not sure where one of the individuals was during the day. The Monitoring Team found him hanging out in another resident's room with no programming and no staff support or presence. The other individual spent a majority of her day with little interaction from staff, little stimulation, and minimal training opportunities.

19-21. Mexia SSLC conducted monthly engagement measures in the majority of residential and day programming sites. Individual #715's residence, however, did not have an engagement measure since July 2016. Mexia SSLC's established an individualized engagement goal for each residence and day program site. The facility's engagement data indicated that Individual #816, Individual #715, Individual #994, and Individual #935's residential and/or day treatment sites did not achieve their goal level of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

Summary: Community outings occurred, but did not meet criteria for this indicator. Community SAP training occurred for some individuals, but also did not meet criteria. It was good to see that outings were occurring. With additional work, in large part around setting targets/goals for outings and SAP training, it is likely that the facility can make progress on these indicators. All three will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	611	613	609	436	935	994	715	816	339
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Individual #436 and Individual #611 had individualized community outing goals. Individual #436 achieved his community outing goals, however, Individual #611 did not. There was evidence that the remaining individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal is achieved.

23. The majority of individuals had documentation of some training of SAPs in the community, however, there were no established goals for this activity. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

Summary: Mexia SSLC had a long history of working closely with the public school district. One unit was for school-aged individuals (under 18 years old) and many individuals in other units on campus also received educational services (ages 18-21). The facility had a liaison whose full time job was to support the collaboration and integration of educational services with their lives at the facility and with their eventual obtaining of their high school diplomas. With attention to the sub-indicators that did not meet criteria, performance should improve.

#	Indicator		Individuals:								
		Overall Score	611	715							
25	The student receives educational services that are integrated with the ISP.	0% 0/2	0/1	0/1							

Comments:
25. Individual #715 and Individual #611 were under 22 years of age and attended public school. Both students received educational services. Of the six sub-indicators, four met criteria. The two that did not were that public school information was in the ISP and that ISP action plans supported the IEP. The facility had a full time liaison to the public schools. He was knowledgeable about every student, the public school program, graduation requirements, and transition from school to work. Moreover, his relationship with the public school district and the facility's IDTs was positive and problem-solving oriented.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.

#	Indicator		Individuals:								
		Overall	609	935	281	1	175	595	407	444	519

		Score									
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2	0/1			0/1					
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2	0/1			0/1					
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2	0/1			0/1					
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2	0/1			0/1					
Comments: None.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	609	935	281	1	175	595	407	444	519
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 1/6	N/A	N/A	0/1	0/1	1/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	17% 1/6			1/1	0/1	0/1	0/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6			0/1	0/1	0/1	0/1	0/1	0/1	
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/6			0/1	0/1	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/6			0/1	0/1	0/1	0/1	0/1	0/1	
Comments: a. and b. The goal/objective that was clinically relevant, as well as measurable was Individual #175's goal/objective related to the use of the Big Step. The one that was measurable, but not clinically relevant was for Individual #281 (i.e., environmental control).											

c. through e. Although it did not appear that Individual #609, Individual #935, or Individual #519 required communication goals/objectives, they were part of the core group, so full reviews were conducted. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: ISP integrated reviews were missing, overdue, and/or did not include data to substantiate that staff implemented strategies and action plans related to communication. The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 609	935	281	1	175	595	407	444	519
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	N/A	N/A	0/1	0/1	0/1	N/A	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented. For each of the three individuals, integrated reviews were missing and/or overdue by months.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Summary: Given that over the last two review periods and during this review, individuals observed generally had their AAC devices present and readily available (Round 9 – 100%, Round 10 – 100%, and Round 11 - 89%), Indicator a will move to the category requiring less oversight. The Center is encouraged to continue to focus on ensuring individuals use them functionally.

#	Indicator	Overall Score	Individuals: 617	451	567	533	175	321	494	577	549
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 4/8	0/1	N/A	1/1	1/1	1/1	1/1	0/1	0/1	0/1
c.	Staff working with the individual are able to describe and	67%									

	demonstrate the use of the device in relevant contexts and settings, and at relevant times.	2/3
Comments: a. and b. It was positive that individuals' AAC devices often were present and readily accessible. However, when opportunities for using the devices presented themselves, staff did not consistently prompt individuals to use them.		

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) to meet their appropriately identified needs, consistent with their informed choice.

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier in 2016, the Center began additional post-move monitoring responsibilities, and had begun to follow individuals in the community for a year as opposed to 90 days.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Overall, the transition department staff made continued progress in planning for, and supporting, individuals' transitions since the time of the previous review. The transition department staff was experienced and committed to successful transitions. They were very receptive to feedback from the Monitoring Team and asked a number of good questions regarding some of the outcomes and indicators. However, as noted in the comments under each outcome of this domain below, more work is needed in order to meet criteria with the various indicators of this domain.

Fourteen individuals transitioned from the facility to the community since the last monitoring review and 18 were on the active referral list. Many of these individuals, including the two reviewed in detail by the Monitoring Team, had serious behavioral, psychiatric, forensic, and medical needs.

Many CLDP supports in the CLDPs for these two individuals were measurable. This was very good to see. It was not yet the case for all supports, so more work is needed here. In particular, there needs to be focus on the development of pre-move training supports that include some specific components: the identification of staff to be trained, specific competencies to be achieved, the methodologies required to teach these competencies, and how staff competencies would be measured and/or demonstrated.

Across the seven sub-indicators of indicator 2, there were many supports that the IDT and the transition staff had correctly identified, as well as some that were identified by the Monitoring Team, but not included in the list of supports. For example, both individuals had considerable employment capabilities and wanted to be gainfully employed. The IDTs did not update the vocational assessment for either one and included minimal vocational information in the CLDPs. Supports also did not focus on the achievement of actual employment outcomes. The only support for one individual was a referral to DARS. The other individual wanted to be a welder. His supports called for him to tour a local college that offered welding class, but did not provide for any additional actions toward enrolling or gaining actual employment in the field.

Transition staff had already identified the need for IDT members to improve recommendations in their transition assessments and to identify supports that might need to be modified or provided differently in the new community settings. A plan was underway to provide IDT members with additional training. Timely transitions took place for both individuals. Transition logs and pre-move ISPA reflected good participation by the IDT in the transition process. The supports, however, sometimes deferred to the provider to make their own evaluations about key supports, such as regarding skill acquisition and nursing.

Post move monitoring was completed as required, done timely, and occurred in all locations, wherever in the state that might be. Comments were provided regarding every support that, for the most part, gave the reader a good understanding of the status of the support. Some comments, however, did not reflect the three prongs of post move monitoring: direct observation, interview of relevant staff, and documentation.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: Mexia SSLC showed continued progress in writing supports in a way that was measurable; this was the case for many of the supports. The one aspect that needed attention was regarding the pre-move supports for training of community provider staff. Mexia SSLC also showed continued progress in making the list of pre- and post-move supports more comprehensive. Some supports that were not included in the list, however, were identified by the Monitoring Team. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	227	701							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments:
Fourteen individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #227, Individual #701). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Mexia SSLC Admissions and Placement staff while onsite. Across the two individuals, there were serious behavioral, psychiatric, forensic, and medical needs.

Overall, the transition department and staff made good progress in planning for, and supporting their transitions compared with the previous review. However, as noted below, more work is needed in order to meet criteria with the various indicators of this domain.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and

community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make adjustments as needed. Many CLDP supports defined by the IDTs for Individual #227 and Individual #701 were measurable, but there was need for improvement in the area of pre-move training requirements.

- The IDT developed 22 pre-moves supports and 36 post-move supports for Individual #227.
    - There was a lack of detail in the various training supports. For example, supports included training residential and day habilitation staff on his smoking schedule, behavior support plan, supervision requirements, and current skill acquisition plans (SAPs). This was good to see, however, none of these CLDP pre-move training supports defined specific competencies or how those would be demonstrated. They required a signed inservice sheet showing competency, but a signature would not necessarily have been sufficient for that purpose.
        - In one case, this additional detail (regarding a pre-move training support and the evidence to be reviewed) was done thoroughly. This was positive. The pre-move support was to inservice the provider on Individual #227's medications. In this instance, the PMM Checklist listed the medications, the indications, and the side effects. It also required inservice sheets showing competency as well as interview with specific staff. The IDT should provide similar detail for all training supports.
    - At times, post-move supports did provide specific expectations for some of the pre-move training items. For example, one included the details of the smoking schedule. This was positive, but it still did not require the PMM to verify staff competence or knowledge of this support.
    - A post-move support called for Individual #227 to continue to participate in the Positive Behavior Support Plan (PBSP) to reduce/eliminate future challenging behaviors, but again did not specify any required staff knowledge or competency.
    - The IDT developed several supports related to Individual #227's need for supervision, requiring one to one at all times, except when he was alone in his bedroom or the bathroom. A related support called for Individual #227 to live in an environment with peers who were not known to be sexually promiscuous, further stating that he would be likely to take advantage of any opportunity that would put both him and any partner at risk. Another support required a door monitoring device for his bedroom to alert staff if he were to leave the room or a peer enter. Only one of these required the PMM to interview staff to ensure they were knowledgeable of the requirements and why they were necessary, but a clear and comprehensive understanding of Individual #227's need for supervision was essential to his success and everyone's safety.
- For Individual #701, the IDT developed nine pre-move supports and 24 post-move supports. Many supports were measurable, which was positive, but this was not true for all supports. Similar to Individual #227's supports, the need for improvement was in the area of pre-move training. On a positive note, pre-move training supports for targeted behaviors provided specific expectations. On the other hand, pre-move training for medications and side effects did not provide specific expectations. All measurable training supports should include detail about who needs to be trained, the training methodology required, the competency criteria and how those competencies will be demonstrated

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of these CLDPs met criterion overall, as described below:

- Past history, and recent and current behavioral and psychiatric problems:
  - Examples of past history and recent and current behavioral and psychiatric problems that were not addressed for Individual #227 included the following:
    - The ISP stated clearly there were restrictions on Individual #227's freedom of movement, but this was not clearly translated to the CLDP. The ISP noted significant factors related to his need for supervision. These included a history of engaging in inappropriate sexual activity, a diagnosis of human immunodeficiency virus (HIV) combined with a lack of understanding of the risks associated with having sex, continually verbalizing sexual acts he wanted to have, and expressing that he would engage in these if he had the opportunity. In making the recommendation for transition, the IDT agreed significant supports would be needed for community placement due to his lack of insight and accountability related to his sexual behaviors and more specifically due to the HIV diagnosis. The related supports did not specify that staff should be aware of the specific risk related to HIV. While the support did indicate he should not live in an environment with peers who were known to be sexually promiscuous, the support did not make it clear that staff needed to be aware of the nature of the potential risk to any sexual partner.
    - It was positive to see that Center staff had identified having immediate access to various clinicians after transition as a concern and were developing strategies to address it. For example, when such a need was identified early in the transition process, the Center was planning to ask potential providers to include how they would accommodate it. But, Individual #227 had a significant history of frequent psychiatric hospitalizations when living in community settings. The CLDP included a support to receive counseling services as soon as possible, but absolutely within 45 days. The IDT specified this timeframe due to a known tendency to experience an increased level of anxiety during transitions. Given that fact, 45 days appeared to be a lengthy delay. The narrative indicated he could see the Center's BCBA in the first 30 days, if counseling was needed, but this was not included in the supports.
    - The IDT met on several occasions after transition to address behavioral concerns and agreed on additional supports, but did not revise the CLDP or PMM Checklist to include monitoring these to ensure their implementation.
    - Individual #227 had a history of selling and using drugs, with some related criminal charges still active. The Center's psychiatrist indicated Individual #227 would need treatment in a substance abuse reduction psychological treatment program oriented towards individuals with intellectual disabilities. A support did indicate he should continue counseling at least twice monthly to address anxiety, mood disturbances, bizarre thoughts, sexual behavior, and HIV disease support. The support did not specify the need for this counseling to address substance abuse, nor did any other support.
  - On positive note, the IDT defined a training support for Individual #701 related to behavioral issues that was specific and detailed. CLDP supports did not address the importance of staff knowledge his need for monitoring and supervision, however. For example:
    - He had a history of poly-substance abuse (alcohol, marijuana, heroin, K2, methamphetamine, hydrocodone) and a known tendency to refuse prescribed psychoactive medications and substitute them with illegal substances. The psychiatry assessment noted Individual #701 would need strong supports about alcohol and drug use and equal support to stay on his medications. One support called for him to participate in individual

counseling to address his historical substance abuse as well as a possible referral to Narcotics Anonymous within 30 days of transition. This was positive, but no support addressed staff knowledge in this area. Given his history and potentially increased access to drugs and alcohol in a community setting, it would have been critical for his direct support staff to have awareness of these issues.
        - Individual #701 also had a recent history of theft, burglary, and criminal trespass. No support required any staff awareness, but again would have been important in this new setting.
        - Although the CLDP narrative indicated he would be receiving line-of-sight supervision of group home and/or day habilitation staff while away from home, the IDT did not include a specific support indicating this level of supervision or what staff should be alert to.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the respective IDTs identified many supports for various follow-up appointments and consultations, which was positive to see. There were, however, other needs identified by the Monitoring Team in the areas of safety, medical, healthcare, therapeutic, risk, and supervision needs, including the following:
    - For Individual #227:
        - The IDT for Individual #227 did not call for pre-move training about many of his health care needs. Per the transition staff, the IDT deferred this responsibility to the provider nurse, calling for her to complete an assessment within seven days and then provide the necessary training to the remaining provider staff. Individual #227's significant health risks and the need for staff awareness of possible signs and symptoms should have been clearly spelled out, and staff knowledge verified, prior to transition. Per the Integrated Risk Rating Form (IRRF,) he had diagnoses of cardiac disease, asymptomatic, chronic anemia related to his HIV status, and hypothyroidism. He was at high risk for weight loss, infections, and skin integrity due to his HIV status. He was followed by neurology to rule out parkinsonism and medication-induced parkinsonism. Pre-move training supports addressed training on current medications and a wedge to elevate his head of bed (which were good to see), but did not include any of the other health risks and health conditions. Supports did not include neurology follow-up or specify nursing staff to monitor any of above.
        - Per the medical assessment, if Individual #227 developed abdominal pain, provider staff needed to be aware he had an umbilical hernia and that this would need to be checked. The CLDP did not address this staff knowledge.
        - The medical assessment also stated staff needed to be aware of two very important things, including to be cautious with any illness, such as a simple cold (that could develop into something more serious rather quickly) and that staff should report any fever of more than 99 degrees. The support required staff knowledge to report the fever, but did not included the initial part of caution. Early identification of even mild symptoms was also needed, hopefully, even before a fever developed.
        - Individual #227 was at risk for weight loss and intake was encouraged for weight maintenance. Several assessments noted he could have seconds at any meal, but should not have thirds because this would typically cause him to vomit. The CLDP support stated he could have seconds, but did not address the concern about third portions.
    - For Individual #701:

- The CLDP included a broad support for the provider to be trained on medications and side effects. It did not provide any expectation for specific staff knowledge, other than to indicate a competency quiz would be administered. The inservice training described many potential side effects of his psycho-active medications, including a description of indications of tardive dyskinesia. Documentation indicated that only a verbal competency test was administered. The verbal test did not address the indications of tardive dyskinesia. It also did not indicate whether staff passed or failed.
- As noted above, the CLDP for Individual #701 did not specify a requirement for staff knowledge regarding his history of refusal of prescription medications and substituting illegal drugs. It also did not document consideration of medication administration when he was with his family, particularly because of this history of refusing prescription medications.
- Individual #701 required a vision assessment every six months due to the possible side effects of one of his medications, but the CLDP support only called for him to have a vision exam within six months of transition. It should have explicitly documented the need for the exams to occur every six months. It should have also called for staff knowledge of signs of visual changes to be observed for and reported.
- The CLDP did not specify a support related to his long-standing fear of needles and refusals of dental care, either for staff knowledge of this fear or for strategies for assisting him to successfully receive dental care in the community.

- What was important to the individual was captured in the list of pre-/post-move supports.
  - Individual #227's ISP vision statement briefly stated what he wanted to achieve over the next few years, reflecting preferences found in his Preferences and Strengths Inventory (PSI). These included joining a church in the community, calling his brother once a week, becoming employed as a janitor, learning to speak Spanish, and living near Bryan, TX. The CLDP only addressed the move to Bryan. ISP action plans called for him to make weekly phone calls to his brother and to make calls to his father and mother; the IDT included none of these in the CLDP. The CLDP identified that he hoped to reconnect with his family by moving to the Bryan area, but the only support related to family contact indicated he should be restricted from off-site visits with the family due to a lack of IDT knowledge about their ability to provide adequate supervision. The CLDP did not include any support to assist him to re-connect with his family in a safe manner or to have regular calls with his brother.
  - Overall, the CLDP for Individual #701 identified those things that were most important to him. These included living closer to his mother and daughter so he could visit them more often. The CLDP also documented that he wanted to work and earn money so that he could make regular support payments to his daughter. The CLDP included supports for working and having the opportunity to set up child support payments once he started working. It also included a support for him to be able to have monthly visits with his family, but this did not represent an opportunity to visit more often than he typically had. Transition staff acknowledged this support could have been more strongly stated to describe the expectation that visits would be more frequent.

- Need/desire for employment, and/or other meaningful day activities: For both individuals, the CLDPs included some employment supports, but these needed to be more assertive and outcome oriented. Examples included:
  - Individual #227's ISP indicated he was able to work six to eight hours a day and earn wages, had held jobs, and worked

well with supervision. His ISP goal was to obtain work as a janitor. Both the nursing and social work assessments noted work and the opportunity to earn a steady income were very important to him. The CLDP included only a support for a referral to the Department of Assistive and Rehabilitative Services (DARS) within 60 days, but included no clear rationale for that delay or what other supports could assist him to obtain employment.
    - CLDP supports did call for day habilitation staff to be trained in Individual #227's various needs and preferences, but the CLDP did not include a support for actual participation in day habilitation. No support described what meaningful activity he could be engaged in at day habilitation, particularly as that activity might advance his goal for employment.
    - A vocational assessment for Individual #227 was not provided. A Functional Skills Assessment (FSA) Summary was referenced in the CLDP narrative, but that document provided very little vocational detail that would support obtaining work in the community.
    - For Individual #701, work and earning money were referenced throughout his ISP, pre-move ISPAs, and his assessments, including his desire to be a welder. Supports included to begin working within four weeks, two weeks after obtaining his state identification card (ID). This would have provided him with an opportunity to work and earn money fairly soon after transition, but he could have begun sooner if the IDT had arranged for him to obtain the ID before he transitioned.
    - The CLDP also included a support for Individual #701 to tour a local college that offered welding classes within 60 days, but it did not provide for any additional action towards enrolling. It also did not define any outcome of gaining employment as a welder.
    - One of the important advantages of transitioning should be enhancing access to opportunities for meaningful community integration. The CLDP listed several activities Individual #701 wanted to participate in that could have led to such integration, but the CLDP did not specifically address these with supports. For example, the CLDP indicated he wanted to try bowling and to join a basketball team, to learn to read, and to go shopping for his own clothes. A single support indicated he should be able to participate in leisure activities of his choice, such as playing basketball, going shopping, or watching television on a monthly basis. This support did not assertively address opportunities to become engaged in activities in his community that could provide for meaningful integration. It also did not appear to expand upon the opportunities available while residing at the Center.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: The CLDP for Individual #701 met criterion for this sub-indicator. It included specific detail about how to prompt his use of coping skills and staff use of verbal praise. For Individual #227, the CLDP did not include specific supports describing positive reinforcement, incentives, and/or other motivating components to his success. Instead, it included only some broadly worded supports, such as opportunities to participate in preferred activities and to continue to participate in his Positive Behavior Support Plan (PBSP).

- Teaching, maintenance, participation, and acquisition of specific skills: Neither of these CLDPs addressed specific needs in this area. Examples included:
    - Individual #227's ISP and assessments identified opportunities for teaching, maintenance, participation, and acquisition of specific skills. The ISP included SAPs for math skills, telling time, and counting change after making a purchase. The FSA identified that community awareness and community participation were areas of need, although it provided no further detail as to any aspects of those broad categories. The PSI stated he would like to cook his own

hamburger. CLDP supports did not address any specific teaching, maintenance, participation, and acquisition of specific skills such as these. Instead, a support called for pre-move inservice to cover current SAPs and a post-move support to be re-assessed by the provider within 30 days for training objectives. The latter support did not require any outcome for implementation of any training objectives.

- Individual #701 was participating in a Health Information Program and the documentation indicated it would help him make decisions concerning his health and safety upon his return to the community. While this information was included in the CLDP, the IDT decided not to make any further recommendations in this area. Just as for Individual #227, the only support for Individual #701 for the teaching, maintenance, participation, and acquisition of specific skills was for him to be re-assessed for areas of skill acquisition training, including for self-administration of medication, within 30 days of transition. This did not give the provider the benefit of any experience and assessment already completed at the Center, nor was it worded in a manner that called for any skill training implementation to take place.

- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, the Center implemented a good process for reviewing CLDP assessments and for making and documenting team decisions about recommendations. Still, there were recommendations that were either not addressed or did not have an adequate rationale provided for not being included.
  - For Individual #227, some examples of recommendations that were not included without clear justifications included:
    - The medical assessment made recommendations for staff knowledge regarding his umbilical hernia and caution about not letting him consume third portions at meals. These were not addressed, as described above.
    - The nursing assessment indicated Individual #227 was due for prophylaxis in August 2016, which would have been within the recommended six-month recall period. The IDT decided he could wait until his annual February 2017 exam to get a referral for prophylaxis because his risk was rated low. This is not the standard of care for community oral care, and was of particular concern for someone with an immune deficiency.
    - The medical assessment documented that he needed to continue neurology consultation monitor tremor/drug induced Parkinsonism. The last consult was on 3/22/16, with a recommendation to return in one year.
  - For Individual #701, some examples included:
    - A support called for him to have a vision exam within six months. The support did not describe his need for a vision exam to occur <u>every</u> six months because he took Seroquel.
    - Similarly, the dental assessment recommended prophylaxis every six months, but the support only required he be seen within six months. It did not include any recommendation about needed frequency.
    - The behavioral health assessment recommended that the IDT should consider referral for additional cognitive and adaptive testing. The CLDP discussion stated the IDT discussed the recommendation and agreed it could be removed, but gave no justification for that determination.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Mexia SSLC continued to provide post move monitoring all across the state for all individuals within required timelines, at all locations, and in a standard report format. Good detail was provided for many of the supports (though not yet for all). Assertive action was taken by the PMM and IDTs in many cases. For some supports, however, follow-up did not occur or was not followed through to resolution. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	227	701								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	50% 1/2	1/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	Not rated	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated	N/A	N/A								

Comments:

3. Post-move monitoring had been completed for four PMM periods for Individual #227 and for two periods for Individual #701. These were timely and included observations at all locations. PMM reports were done in the proper format. The Checklists generally included comments regarding the provision of every support. For Individual #227, comments by the PMM also often provided important details that were not specified in the supports. This was positive. For Individual #701, the PMM provided comments for each support as well, although these were not as thorough and helpful as those for Individual #227. For both individuals, some comments were still not as thorough in addressing the respective supports as needed. For example:

- Individual #227's PMM Checklists did not include detail about interim actions taken by the IDT to address emerging and

worsening behaviors.

- For Individual #701, the comments did not consistently include detail about all the evidence specified in the supports. For example, the provider was to complete a nursing assessment that addressed SAMs within seven days. The PMM reported the nursing assessment was completed and that all staff were inserviced on Individual #701's medications and delegated to administer, but this did not indicate whether SAMs, or any other of his health care needs, had been addressed.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports: In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports. For Individual #227, for example, the PMM provided additional detail about supports above and beyond what the supports dictated. It was then often possible to determine whether those supports were being received as required, when it might not have been otherwise. This was not yet a consistent practice, however. For both individuals, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described in indicator #1.

5. Based on information the PMM collected, these two individuals were not regularly receiving all of the supports listed in the CLDP without sufficient justification. As described in indicator #4 above, reliable and valid data were not consistently available to ascertain whether supports were in place as needed.

- Individual #227 had not received some important supports as required. Examples included:
  - He had not been seen by a psychiatrist within 30 days.
  - He had not been seen by a counselor within 45 days, despite having demonstrated significant need during that timeframe. The IDT had discussion about possibly having Skype counseling sessions with the Center BCBA, but this had not been possible.
  - A DARS referral had not been initiated within 60 days. This support was still incomplete at 180 days, in part because Individual #227 was refusing to participate by that point.
  - No family contact had been initiated through the180 day period.
  - Documentation from a 10/7/16 ISPA indicated the IDT had met on 9/16/16, at which time Individual #227 stated he wanted to go to group counseling so he could talk to people. The documentation further indicated the BCBA was aware of a NAMI group he might attend and the IDT was to follow-up. No additional documentation was found and transition staff indicated this had not occurred.
- In many cases, the evidence collected by the PMM reflected that Individual #701 was receiving the supports as listed. In other instances, the IDT failed to translate some needs described in the CLDP narrative into formal supports, resulting in no evidence being available to determine if these were being met. For example:
  - The requirements for supervision were not included in any support and no evidence was collected to confirm he was receiving line of sight supervision at the day habilitation and on outings.
  - His needle phobia was discussed in the narrative review of the dental assessment, but was not included in the dental supports. The provider scheduled a dental visit for Individual #701, but he refused the procedure upon discovering that intravenous sedation was planned. He was charged $250 for not completing the appointment. The IDT was aware that he consistently refused to receive dental care when needles were involved and should have developed a support that at least ensured the dental provider had this knowledge before planning his treatment.

6. Overall, for Individual #227, the PMM accurately assessed whether a support was present or not, based on the evidence. The PMM's scoring for Individual #701 was also frequently correct based on the evidence available, but this was not as consistent. For example, the additional questions section asked if personal belongings were in the home and available, to include whether the individual's room was decorated with personal items. The PMM documented that personal possessions were available, but the room was not yet decorated; the item was scored as present. A support calling for a nursing assessment to address SAMs was marked as present, but no evidence substantiated this. No evidence of competency demonstration by new staff but marked as present.

7-8. The Center's protocol for review of the PMM Checklists called for transition staff to identify any area of concern that would require IDT attention and to call for a meeting as indicated. The Center still needed improvement in consistent implementation of corrective actions in a timely manner. Examples included:

- For Individual #227:
    - It was positive his IDT met in ISPA many times to address behavioral issues that arose within the short period after transition. It was not always possible to track IDT actions and recommendations through this process because these were not incorporated into the PMM Checklists for ongoing monitoring. Some recommendations were not implemented, but documentation did not indicate the IDT followed-up to consider other options for meeting those needs. For example, at an ISPA meeting on 9/16/16, Individual #227 said he wanted to attend group counseling so he could talk to others. The IDT discussed that the BCBA had found a NAMI group session he could attend. This would have been an important action, given that Individual #227 had not yet been able to access counseling services. He said he would like to attend, but no follow-up action was taken. The IDT also discussed the possibility for Skype counseling with the BCBA at the Center, but no further follow-up documentation was found. In interview, transition staff indicated this had not been feasible. The Center should consider a process for ensuring recommendations from post-move IDT deliberations are monitored and receive timely follow-up through resolution. This would help prevent things falling through the cracks.
- For Individual #701, the only follow-up noted to the failed dental appointment, as described under indicator 5 above, was the PMM explaining to him the importance of completing the appointment and not wasting his money. Given his known history and the likelihood the same result would recur at his next dental visit, the IDT should have taken a more assertive approach.
- The Monitoring Team did see several positive examples in which the PMM took assertive follow-up action for Individual #701. These included:
    - For a support calling for Individual #701 to participate in leisure activities of choice, the PMM requested the provider to re-inservice staff on keeping more specific and detailed observation notes about the outings.
    - For a support for Individual #701 to perform monthly testicular self-checks, the PMM worked with the provider to ensure a calendar was developed to help him keep track as well as have completion documented.
    - Individual #701 had gained 10 pounds in one month at the time of the 45-day PMM visit and the PMM requested he be seen by a dietitian as indicated in the supports. No evidence indicated the provider was aware of the issue and had plans to take the required action. The support was marked as NA, but the PMM did appropriately mark it for follow-up prior to the 90-day visit to ensure action was timely.

9-10. The Monitoring Team was unable to observe the conduct of post move monitoring during the onsite review week due to scheduling conflicts and the distance to the individuals who were to receive post move monitoring during the week.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: One individual had no negative events occur. The other had a series of negative events that eventually led to him wanting to move to another city. Some actions should have been taken by the IDT during transition planning to have reduced the likelihood of the behaviors and incidents occurring. In general, supports in key areas were not assertive enough and, as a result, left him bored, lonely, frustrated and with no mental health support to help him work through it. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	227	701								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1								

11. Individual #701 had not experienced any PDCT events, which was good to see given his many needs. On 2/10/17, Individual #227 moved to another home in another city, following some difficulties in adjusting to his initial transition. The IDT had not developed CLDP supports that were sufficiently assertive to meet his needs in several areas. These included:

- The CLDP did not include assertive supports to address his significant history of frequent psychiatric hospitalizations when living in community settings and his known tendency to experience an increased level of anxiety during transitions. The CLDP included a support to receive counseling services as soon as possible, but absolutely within 45 days. Given his identified needs, 45 days was a lengthy delay. The CLDP narrative indicated he could see the Center's BCBA in the first 30 days, if counseling was needed, but this was not included in the supports. No counseling services had been provided and the IDT did not identify or discuss the lack as one possible source of disruption at the time of the PDCT ISPA. This could have continued to be an important needed support as another transition occurred. The IDT did not provide any documentation that counseling services had been obtained or identified prior to this second move.
- As described in more detail above in indicator 2, the IDT also did not develop assertive supports for other important preferences and needs. For one, employment and the opportunity to earn a steady income were very important to him. The CLDP included only a support for a referral to the Department of Assistive and Rehabilitative Services (DARS) within 60 days, but included no clear rationale for that delay or what other supports could assist him to obtain employment. For another, he also hoped to reconnect with his family by moving to the Bryan area, but the only support related to family contact indicated he should be restricted from off-site visits with the family due to a lack of IDT knowledge about their ability to provide adequate supervision. The CLDP did not include any support to assist him to re-connect with his family in a safe manner and no family contact had been established. In the PDCT process, the IDT should have considered whether the lack of these supports may have had a negative impact on his adjustment and satisfaction with his new home.

It was positive, however, for the Monitoring Team to see that the transition department staff recognized the need for IDTs to consider how they might develop more assertive supports in these areas for future transitions. For example, they discussed a plan for taking additional steps in the early planning stages to ensure timely access to resources, such as counseling. This would include having providers describe at their initial presentation how they would be able address immediate access to specific supports when needed.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary: This outcome focuses upon a variety of transition activities. Mexia SSLC attended to all of these activities as reflected in the comments below. Diverse participation in the transitions led to good scores for indicators 13 and 18. Attention to the documentation requirements of indicators 15-17 may result in improved performance for those indicators, and attention to staff training for community providers may result in improved performance for indicators 14 and 19. Transition assessments continued to need improvement. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	227	701								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1								
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1								
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as	0%	0/1	0/1								

	dictated by the individual's needs.	0/2									
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. All assessments did not meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Updated with 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. The Center did not provide updated vocational or pharmacy/QDRR assessments.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals. For Individual #227, most available assessments provided a summary of relevant facts, but the FSA did not. For Individual #701, the dental, FSA, and psychiatry assessments did not include detailed summary. For example, his dental assessment did not discuss his fear of needles or strategies tried for providing oral care without sedation. The FSA included a list that repeated: Area of Strength: Independent, without specifying what the areas were.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Transition staff had pro-actively identified the need for IDT members to improve recommendations in their discharge assessments to support a successful transition and to identify supports that might need to be modified or provided differently in the new community settings. A plan was underway to provide IDT members with additional training. For this review, assessments that were not available or updated continued to have a negative impact on the scoring of this indicator for both individuals. Some available assessments provided a set of recommendations setting forth the services and supports the individual needs to successfully transition to the community, but this was not consistent. For Individual #227, for example, the social work, nursing, and behavioral health assessments included helpful recommendations, while the FSA and medical assessments did not.
- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: Assessments did not consistently meet criterion for this indicator. Again, the many missing and late assessments factored into this determination.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator. Criterion was met for both CLDPs.

- IDT members actively participated in the transition planning process. There was documentation to show IDT members actively participated in the transition planning process. Both CLDPs met criterion in this regard.
- The CLDP specified the SSLC staff responsible for transition activities, and the timeframes in which such actions are to be completed: Both CLDPs met criterion for this sub-indicator.
- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Criterion was met for this sub-indicator for both individuals.

14. Documentation did not indicate Center staff provided training of community provider staff that met the needs of these two individuals. Training did not consistently define the training methodology or competency criteria for key supports or include any competency testing or demonstration, as described further in indicators 1 and 2. Mexia SSLC's IDTs should focus on the development of pre-move training supports that include the identification of staff to be trained, specific competencies to be achieved, the methodologies required to achieve those competencies, and how staff competencies would be measured and/or demonstrated.

- Individual #701's pre-move support for training on targeted behaviors was the best example of a training support that provided clear expectations of the specific knowledge provider staff should acquire.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting its consideration of the need for any such collaboration. Neither of these CLDPs did so.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. The CLDPs did not document a statement regarding the need for any setting assessment and did not meet criterion.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. Neither of these CLDPs met criterion.

18. Both CLDP's met criterion for collaboration between SSLC staff and LIDDA staff.

19. Neither of these CLDPs met criterion for pre-move supports being in place in the community settings on the day of the move. For both individuals, pre-move supports did not require evidence of staff knowledge and competence. It is incumbent upon the Center to ensure staff competence to provide supports essential to health and safety prior to the move, rather than waiting seven days until the first PMM visit. The initial seven days after transition is a critical period, during which a lack of staff knowledge can lead to negative outcomes. Other observations included:

- For Individual #227, it was positive that the PMSR included many detailed comments. For example, a pre-move support called for the provider to be inserviced on Individual #227's supervision requirements. The PMM reported very thoroughly on most of these, even including details that were not in the support. It was good to see the PMM was well-versed in the actual requirements of his supervision needs, although the support itself did not provide those specifics.

- For Individual #701, the PMM indicated that inservice supports for medication and side effects for both residential and day habilitation staff were in place. Both required that staff competency be demonstrated by a written quiz, but the PMM documented a verbal quiz was given and that staff correctly answered the questions. A verbal quiz did not provide documentation that each staff independently answered each of the questions correctly. The PMM should require the specific competency methodology determined to be appropriate by the IDT before indicating the support was present.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Mexia SSLC attended to referrals and there were no extended periods where activities were not occurring related to both transitions. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	227	701							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1							

Comments:

20. Transition was timely for both individuals. Individual #227 was referred on 11/2/15 and transitioned on 8/1/16. While this exceeded 180 days, the Transition Specialist logs were very thorough and detailed, documenting ongoing and timely efforts to address the many needs of this individual. Individual #701 was referred on 8/30/16 and transitioned on 12/21/16, within 180 days. Again, the very detailed Transition Specialist logs indicated a well-organized transition process.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - In the past six months, individuals who have experienced a fracture;
    - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
  a. PNMT
  b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical and/or dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus