United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

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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. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

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.

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. At the last review, 11 of these indicators were in or were moved to the category of requiring less oversight. During this review, 11 other indicators had sustained high performance scores and will be moved to the category of requiring less oversight; these were in restraint and ANE/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.

<u>Restraint</u>
Management and review of crisis intervention restraint improved since the last review, due, in large part, to the leadership of the new director of behavioral health services. Overall, documentation was done properly, with a small number of exceptions. Seven of the nine indicators in outcome 2 were now in the category of requiring less oversight. The proper administration of crisis intervention chemical restraint documentation, however, was not done correctly by psychiatry. For three restraints, there were no recommendations for revision of services and supports, and/or there were not current CIPs in place at the time of the restraint.

The census-adjusted rate of crisis intervention restraint remained about the same as at the last review (but no longer showed an ascending trend). The average duration of a crisis intervention restraint remained low. After discussion with the director of behavioral services, it appeared that some of the restraint occurrences might be due to new admissions. Some secondary data graphs/analyses, such as pulling out the first three or six months of any new admission, might be helpful to the Center's analyses of these data and for supporting the observation of the effect of new admissions.

There were a low number of crisis intervention chemical restraints, no occurrences of crisis intervention mechanical restraint, and no individuals had protective mechanical restraints for self-injurious behavior (PMR-SIB).

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing essential follow-up for abnormalities in vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained.

Restraint reduction committee remained active, meeting every week. At the restraint reduction committee meeting held during the onsite review week, there was video review, a series of questions about the restraint, and attendance from IDT members, DSPs who were involved in the restraint, assistant unit directors, security/camera staff, and a PMAB trainer. There was active participation from attendees.

At the time of the onsite review, Mexia SSLC did not, and since implementation of the Settlement Agreement, never utilized pre-treatment sedation (PTS) or total intravenous anesthesia (TIVA) for the completion of dental treatment. As found during multiple previous reviews, individuals who required more than basic dental services were referred off campus for treatment. This resulted in lengthy treatment delays for some of the individuals reviewed. In some instances, needed treatment had not been provided. The Dental Director reported that the Center plans to implement the use of PTS and TIVA in the future. As Center staff were aware, this will require the development and implementation of policies to address criteria for the use of TIVA, as well as medical clearance for TIVA. Given the risks involved with TIVA, it is essential that the Center develop and implement such policies.

Abuse, Neglect, and Incident Management

Mexia SSLC continued to have a high volume of allegations and investigations, the second most of any Center. There were more than 600 allegations in the Tier 1 document request, about of a quarter of which were in the unfounded category, and there were about 125 investigations of serious injuries and other serious incidents.

Overall, various aspects of incident management and investigations met criteria, such as staff training, inclusion of specific elements of an investigation, and implementation of recommendations. Center investigators sometimes attended IDT meetings, such as ISPA meetings, to follow-up and to contribute to team discussions. This was a good practice to see occurring. Unit directors led daily morning unit meetings during which any incidents were reviewed that occurred over the past day (or weekend/holiday). The meetings covered a set of standard topics that were discussed in great depth at some of the meetings. Unit directors appeared to be knowledgeable about the individuals and staff in their units and most of the unit's important issues.

Supports were in place for those incidents for which there were previous occurrences, trends, or histories. The Center was addressing peer to peer aggression in attempts to understand, manage, and reduce occurrences. The Monitoring Team

recommends continual usage of the data to drive decision-making. That is, implementation of actions without resultant effect requires revision and/or different actions to be developed and taken.

About half of the investigations had problems with proper/timely reporting. There were a variety of reasons for this. To address this, investigations and investigation reviews should thoroughly look at the circumstances surrounding reporting if there is any indication of late or incorrect reporting.

One investigation was problematic in several areas: reporting timeframes, alleged perpetrator reassignment timeframes, contract staff cooperation, and appropriateness of the administrative action taken (Individual #588, death).

Supervisory review did not identify the same issues that were identified by the Monitoring Team. Additional improvement is needed in the analysis of data and trends regarding incidents, injuries, and abuse, neglect, and exploitation. This is outcome 10, indicators 19-23.

Other

It was good to see that the Center completed clinically significant Drug Utilization Evaluations (DUEs), as well as necessary follow-up on DUE recommendations.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Management and review of crisis intervention restraint improved since the last review, due, in large part, to the leadership of the new director of behavioral health services. The census-adjusted rate of crisis intervention restraint remained about the same as at the last review, but no longer showed an ascending trend. The average duration of a crisis intervention restraint remained low. Data on usage of restraints, PTS, and TIVA for medical and dental procedures was presented and there was low usage in restraints and PTS. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	44% 4/9	1/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1
Comments:											

1. Twelve sets of monthly data provided by the facility for the past nine months (October 2017 through June 2018) were reviewed. The overall usage of crisis intervention restraint at Mexia SSLC had maintained since the time of the last review and showed a high stable frequency. The Center, however, remained about in the middle when compared with the census-adjusted rates of crisis intervention restraints at the other 12 Centers.

The director of behavioral health services attributed this, at least in part, to new admissions. To that end, the director might consider creating a secondary graphic summary (for their own reviews) that separates new admissions (e.g., for first six months perhaps) from the center-wide data. The frequency of crisis intervention physical restraints was also high, paralleling the overall usage of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention restraint, however, continued to decrease to just under three minutes.

In addition, there was very infrequent usage of crisis intervention chemical (on the average about once per month), there were zero occurrences of crisis intervention mechanical restraint, and no use of protective mechanical restraint for self-injurious behavior. There were no reported injuries due to restraint application, however, see the section below on nursing assessments of potential restraint related injuries. There continued to be a large number of individuals who had one or more crisis intervention restraints each month, that is, around 20 individuals per month, about the same as at the last review.

The four sets of data regarding use of non-chemical restraints for medical or dental procedures, the use of pretreatment sedation for medical and dental procedures, and the use of TIVA were presented. There was little, or no, usage of non-chemical restraints or of pretreatment sedation. Usage of TIVA remained about the same as at the last review. The Monitoring Team suggests that the Center review these four data sets together in looking at usage of restrictive procedures for the completion of medical and dental assessments or procedures. For instance, an increase in usage of pretreatment sedation may be due to the Center helping individuals no longer need the more intrusive TIVA protocol. Along those lines, the Center director was making arrangements for TIVA to occur on campus, and for pretreatment sedation to be an option more available to IDTs, especially as an alternative to TIVA.

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

The restraint reduction committee was meeting each week. The Monitoring Team reviewed recent meeting minutes and attended a meeting during the onsite week. The meeting had improved greatly compared with two visits ago. The meeting was led by the director of behavioral health services and included a review of each restraint that occurred over the previous week. This included video review, a series of questions about the restraint, and attendance/participation from IDT members, DSPs who were involved in the restraint, assistant unit directors, security/camera staff, and a PMAB trainer. There was active participation from attendees. The director also reported that the group reviews center-wide data from time to time.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. All five received crisis intervention physical restraints (Individual #740, Individual #763, Individual #620, Individual #15, Individual #685) and one received crisis intervention chemical restraint (Individual #620). Data from the facility showed a decreasing trend in frequency or very low occurrences over the

past nine months for none of these individuals. The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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: Due to sustained high performance over this and the previous three reviews, four indicators, 5, 7, 8, and 10 will be moved to the category of requiring less oversight. The same might occur for indicator 11 if high performance is sustained. Indicator 9 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 740	763	15	620	685				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 9/9	1/1	1/1	2/2	3/3	2/2				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
7	There was no injury to the individual as a result of implementation of the restraint.	89% 8/9	1/1	1/1	1/2	3/3	2/2				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	1/1	1/1	2/2	3/3	2/2				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	25% 1/4	0/1	1/1	0/1	Not rated	0/1				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 9/9	1/1	1/1	2/2	3/3	2/2				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 9/9	1/1	1/1	2/2	3/3	2/2				

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for five different individuals (Individual #740, Individual #763, Individual #620, Individual #15, Individual #685). Of these, eight were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. 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.

7. During one restraint, a minor scratch occurred.

9. Because criterion for indicator #2 was not met for any of the individuals, this indicator was scored for them. All supports were in place to have reduced the likelihood of the behaviors occurring that led to restraint for one of the individuals. For the others, there were problems with late assessments (Individual #740), diagnoses (Individual #15), and engagement (Individual #685).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Due to sustained high performance over this and the previous three reviews, this indicator will be moved to the category of requiring less oversight			Individuals:								
#	Indicator	Overall Score	740	763	15	620	685				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	1/1	1/1	1/1	Not rated	1/1				
Comments:											

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: Indicator 14 will remain in active monitoring for possible review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score	740	763	15	620	685				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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				
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: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing essential follow-up for abnormalities in vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is	Individuals:

accurate and consistent in the various places that restraint documentation is maintained. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	740	763	620	15	685				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/8	0/1	0/1	0/2	0/2	0/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 2/8	0/1	0/1	1/2	1/2	0/2				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	13% 1/8	0/1	0/1	1/2	0/2	0/2				

Comments: The crisis intervention restraints reviewed included those for: Individual #740 on 4/11/18 at 7:34 p.m.; Individual #763 on 4/22/18 at 3:45 p.m.; Individual #620 on 4/19/18 at 9:16 a.m., and 5/3/18 at 12:28 a.m. (chemical); Individual #15 on 3/2/18 at 3:40 a.m., and 4/28/18 at 7:43 a.m.; Individual #685 on 3/10/18 at 1:08 a.m., and 5/18/18 at 3:28 p.m.

a. through c. For none of the crisis intervention restraints reviewed, did nurses conduct all of the necessary physical assessments.

For the following restraints, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint: Individual #740 on 4/11/18 at 7:34 p.m.; Individual #620 on 4/19/18 at 9:16 a.m., and 5/3/18 at 12:28 a.m. (chemical); Individual #15 on 4/28/18 at 7:43 a.m.; and Individual #685 on 5/18/18 at 3:28 p.m.

For the following restraints, the nurses documented whether or not the individual sustained restraint-related injuries of other negative health effects: Individual #620 on 4/19/18 at 9:16 a.m., and Individual #15 on 4/28/18 at 7:43 a.m.

The following provide examples of problems noted:

- Often, nurses described individuals' mental status as "no change from baseline," or "oriented x4" without providing any details.
- For Individual #740, on 4/11/18, the nurse did not conduct follow-up assessments for elevated pulse rates. The nurse did not document a head-to-toe assessment to check for restraint-related injuries. It also appeared that the nurse was not made aware of another restraint. In an IPN addendum, dated 4/11/18 at 8:49 p.m., the nurse noted: "I was unaware of the bear hug restraint until notified of the horizontal restraint and arrived on scene in front of the wood shop. Bear hug for 1919-1928 and horizontal from 1934-1938 for AGO [aggression] and breaking out windows."
- For Individual #763, the times on the restraint checklist and the IView entries appeared to conflict. In addition, the nurse noted a "superficial scratch" on the back of his neck, but did not provide measurements or documentation of follow-up.
- For Individual #620's physical restraint on 4/19/18, times in various documents also were in conflict. For example, the Restraint Checklist indicated staff notified the nurse of the restraint at 9:20 a.m., but the nurse arrived at 9:16 a.m. Moreover, the flowsheet stated that staff notified the nurse at 9:10 a.m., and the nurse arrived at 9:12 a.m. It was good to see that the nurse conducted follow-up with regard to the individual's refusals of vital signs (i.e., attempted to obtain them three times), as well as to address the individual's head banging (i.e., follow-up for mild head injury).
- For Individual #620's chemical restraint on 5/3/18, it was concerning that the IView information provided in response to

document request #II.14 was different than that provided with the Flowsheets in response to document request #I.50.j. In the former, the nurse's arrival time was not documented. The individual refused the first set of vital signs. Appropriately, the nurse provided the individual's respiration rate, which did not require the individual's cooperation. However, although it appeared that the nurse attempted a second time to obtain vital signs (i.e., information was provided for pulse, respirations, and temperature), data was not available for blood pressure or oxygen saturations, and the nurse did not document whether or not the individual refused. In addition, the nurse did not document the site of the intramuscular (IM) injection. Nurses did not document ongoing assessments for potential side effects of the chemical restraint, which include allergic reaction, chest tightness, and trouble breathing.

- For Individual #15's restraint on 3/2/18 at 3:40 a.m., the nurse documented being "on scene after restraint was over." According to the Face-to-Face report, the restraint ended at 3:47 a.m. However, the only IView vital sign documentation the Monitoring Team found was for 3:40 a.m. (i.e., in response to document request #II.14, because I.50.j was blank), which was when the restraint reportedly started. Documentation regarding the scratch the individual sustained during the restraint did not include follow-up.

  Of significant concern, Individual #15 reportedly bit a staff member during the restraint, but the Center provided no additional information regarding the human bite, for example, as to whether or not there was contact of body fluids, or other follow-up occurred according to the protocols for a human bite. The individual that did the biting can be as at risk as the staff member who was bitten.
- For Individual #685's restraint on 3/10/18 at 1:08 a.m., nursing documentation was much later than the actual time of the restraint, and the first vital signs were documented at 9:36 p.m. on 3/10/18.
- For Individual #685's restraint on 5/18/18, the nurse's initial assessment, at 3:30 p.m., revealed a high pulse rate and respirations. However, follow-up did not occur until over five hours later at 8:45 p.m. This was concerning given that vital signs serve as an early warning of changes in an individual's condition, and nurses play an important role in reassessing the individual accordingly. In addition, no skin or pain assessment was found in the documentation submitted.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary:			Individuals:									
#	Indicator	Overall Score										
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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	740	763	15	620	685				
16	For crisis intervention restraints, a thorough review of the crisis	100%	1/1	1/1	2/2	3/3	2/2				

	intervention restraint was conducted in compliance with state policy.	9/9									
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	57% 4/7	0/1	1/1	1/1	0/2	2/2				

Comments:
17. For three restraints, there were no recommendations for revision of services and supports, and/or there were not current CIPs in place at the time of the restraint (Individual #740, Individual #620). For Individual #620 5/3/18, there was no documentation to show that recommendations were implemented.

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: The proper review form was not completed (indicator 47). Crisis intervention chemical restraint was infrequently used at Mexia SSLC. Moreover, multiple medications were not used and follow-up did occur. This was the case for this review and the two previous reviews, too. Therefore, indicators 48 and 49 will be moved to the category of requiring less oversight. Indicator 47 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	620								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/1	0/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1								

Comments:
47-48. These indicators applied to one individual, Individual #620. There was no documentation of the post restraint review by psychiatry. In this restraint episode, one medication was utilized.

49. Review of the psychiatric documentation revealed psychiatric follow-up the day after the chemical restraint.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Supports were in place for those incidents for which there were previous occurrences, trends, or histories. The Center was addressing peer to peer aggression in attempts to understand, manage, and reduce occurrences. This

Individuals:

indicator will remain in active monitoring.													
#	Indicator	Overall Score	891	740	966	15	620	685	466	588	748	845	978
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 13/13	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
The Monitoring Team reviewed 13 investigations that occurred for 11 individuals. Of these 13 investigations, nine were HHSC PI investigations of abuse-neglect allegations (two confirmed, five unconfirmed, one unfounded/streamlined, one clinical referral). The other four were for facility investigations of a serious injury fracture, theft, and unauthorized departures. The clinical referral was following investigation of the death of an individual. About one-quarter of the allegations during the review period were deemed for streamlined investigations due to the frequent unfounded allegations made by specific individuals.

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 #891, UIR 18-1208, HHSC PI 45927368, unconfirmed allegation of emotional abuse, 12/2/17
- Individual #891, UIR 18-1373, theft, 2/12/18
- Individual #740, UIR 18-1253, HHSC PI 46047508, unconfirmed allegations of physical/emotional abuse and neglect, 12/19/17
- Individual #966, UIR 1-6-18(JC), HHSC PI 46127448, unconfirmed allegation of neglect, 1/5/18
- Individual #966, UIR 2-21-18(FG), HHSC PI 46444788, confirmed allegation of neglect, 2/21/18
- Individual #15, UIR 5-23-18(DS), HHSC PI 47000548, unconfirmed allegation of physical abuse, 5/23/18
- Individual #620, UIR 1-17-18(FG), HHSC PI 46200269, unconfirmed allegation of physical abuse, 1/14/18
- Individual #685, UIR 2-11-18(FG), HHSC PI 46377670, confirmed allegation of physical abuse, 2/11/18
- Individual #466, UIR 4-18-18(NB), HHSC PI 46706067, unfounded allegation of emotional abuse, streamlined investigation, individual identified by HHSC PI for streamlined investigations, 4/8/18
- Individual #588, UIR 4-5-18(NB), HHSC PI 46692067, clinical referral of a neglect allegation re death, 3/18/18
- Individual #748, UIR 18-573, discovered fracture of right jaw, cheek, and nose 5/9/18 (he was victim of peer to peer aggression, this was also investigated by HHSC PI, unconfirmed allegation of neglect)
- Individual #845, UIR 18-523, unauthorized departure and law enforcement contact, 4/14/18
- Individual #978, UIR 18-1456, unauthorized departure, 3/16/18

1. For all 13 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.

Criteria were met for all 13 investigations.

Regarding peer to peer aggression: Mexia SSLC continued to regularly review and take actions regarding peer to peer aggression. Occurrences of peer to peer aggression were discussed each day during each unit's morning meeting, and then later in the morning at IMRT meeting. At the end of each week (on Fridays), management discussed trends (e.g., top aggressor, top victim, timeframe in which the incidents of aggression occurred, home/unit, type of injuries sustained, types of protection that the team implemented, location). IDTs presented recommendations to the IMRT and to management. IMRT sometimes made additional recommendations for the IDT to implement. They also looked at whether the same individual was the top aggressor and/or victim over a period of six or so months. IMRT followed-up to ensure recommendations were implemented via utilizing a section of their daily minutes. Other actions were nurse assessments of the aggressor and the victim, review of video if available, and holding a critical incident review meeting, and having a behavioral health services staff onsite from 4:00 pm to midnight every day. In addition, the Center prepared a monthly report specifically regarding peer to peer aggression. It included data for the month, data trends over the previous six or so months, and specific actions being taken for individuals and also center-wide. The Center was showing a good effort in attempting to manage and reduce occurrences of peer to peer aggression. Even so, frequency of peer to peer aggression was not yet decreasing markedly (about 60 occurrences per month each of the most recent three months).

IMRT met each day and followed a standard set of topics. New employees attended an IMRT meeting to see what types of topics were discussed and to be introduced to the IMRT. This seemed to be a good idea, that is, to connect new employees to the IMRT process.

Another positive was that Center investigators sometimes attended IDT meetings, such as ISPA meetings, to follow-up and to contribute to team discussions.

Five individuals at Mexia SSLC were designated for streamlined investigations by APS. Two were chosen for a review of documentation to see if APS protocols and SSLC protocols were being followed (Individual #466, Individual #519). There was documentation that APS had reviewed their cases and continued with the determination of appropriateness for streamlined investigations. The Center addressed both individuals' frequent false accusations via their PBSPs.

The Monitoring Team also had some specific comments regarding the following individuals:

- Individual #620: There was a need to obtain additional records and previous assessments and for his neurological needs to be addressed, especially regarding his diagnosis of intracranial pressure, including how it was determined. The Monitoring Team also suggested that a trauma-informed care perspective be incorporated into his programming, as well as a reassessment of his autism diagnosis.
- Individual #15: He had a wide range of diagnoses, thus, a new psychiatric evaluation should be considered. Relevant psychiatric indicators and goals should be developed and measured. His medication regimen had incorrect indications and a polypharmacy review was warranted. Similar to Individual #620, incorporation of a trauma-informed care perspective into his programming should be explored.
- Individual #891: The individual and his family may benefit from a professional advocate, especially regarding his long-term goals.
- Individual #35: Consultation with an orientation and mobility specialist might help the IDT develop functional training targets.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

Summary: Discrepancies in information in the UIR regarding reporting times, some late reporting, and missing facility director/designee notifications resulted in about half of the investigations not meeting criteria with the reporting requirements monitored by this indicator. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	966	15	620	685	466	588	748	845	978
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	54% 7/13	1/2	1/1	1/2	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1

Comments:

2. The Monitoring Team rated seven of the investigations as being reported correctly. The other six were rated as being reported late or incorrectly reported. 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 criteria 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 #891 UIR 18-1208: This incident was reported by the individual to the campus administrator and then it was immediately reported to DFPS intake (on 12/2/17). HHSC PI at first considered it for referral, but two days later determined it was an allegation for investigation. Thus, the Center correctly and timely reported the allegation and reassigned the alleged perpetrator. The facility director/designee, however, was not notified until two days later (on 12/4/17).
- Individual #966 UIR 2-21-18: This was reported by the video security observer, though not within one hour and, further, the incident should have been reported by staff who was part of the 2:1 staffing.
- Individual #620 UIR 1-17-18: The HHSC PI report showed that the allegation was reported to DFPS intake on 1/17/18 at 4:02 pm. The UIR (page 2) showed facility behavioral health services reported it as suspected ANE after a routine video review of the restraint. This video review occurred (per UIR) on 1/18/18. The UIR also showed (page 6) facility director/designee notification on 1/17/18. The dates were not reconciled in the UIR.
- Individual #588 UIR 4-5-18: In the UIR (page 2), the Center acknowledged it reported the alleged neglect, but not when it was first discovered in the facility review process.
- Individual #748 UIR 18-573: Per the UIR (page 17), the incident occurred at 8:42 pm and was reported to the facility director/designee at 9:50, just more than one hour later.
- Individual #845 UIR 18-523: Per the UIR (page 6), the incident occurred at 2:10 pm and was reported to the facility director/designee at 4:27 pm. The incident occurred off campus, but it still should have been reported within one hour.

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:			Individuals:										
#	Indicator	Overall Score											
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.											
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.												
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.												
Comments:													

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.													
Summary: In one case, the individual was not protected. This indicator will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	891	740	966	15	620	685	466	588	748	845	978
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 12/13	2/2	1/1	2/2	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
Comments: For Individual #588 UIR 4-5-18, reassignment of alleged perpetrators occurred on 4/5/18, though absence of proper assessment of the individual were evident as of 3/18/18 and were not realized by nursing supervisory staff.													

Outcome 5– Staff cooperate with investigations.													
Summary:			Individuals:										
#	Indicator	Overall Score											
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.											
Comments:													

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.													
Summary: Both indicators showed improved performance, however, an important aspect of evidence collection regarding PBSP implementation was missing from one case. These indicators will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	891	740	966	15	620	685	466	588	748	845	978
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.											
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	92% 12/13	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	0/1	1/1	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% 12/12	1/1	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 9. For Individual #748 UIR 18-573, not all relevant evidence was collected because in an incident where implementation of a PBSP can be important evidence this should be addressed in the UIR. For instance, staff interviews, review of data sheets, and interview with behavioral services staff would be relevant, especially regarding if the PBSP was implemented in the time period just preceding the incident.													

Outcome 7– Investigations are conducted and reviewed as required.													
Summary: Most investigations (92%, i.e., all but one) were completed within the required timelines. Thus, indicator 12 will be returned to the category of requiring less oversight. Supervisory review did not detect problems in half of the investigations. This was about the same level of performance as in the last review. This indicator (13) will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	891	740	966	15	620	685	466	588	748	845	978
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.											
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).	92% 12/13	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the	54% 7/13	1/2	1/1	1/2	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1

	investigation was thorough and complete and (2) the report was accurate, complete, and coherent.												

Comments:
12. Twelve investigations were completed within the 10-day requirement or had approved reasonable extensions. For Individual #748 UIR 18-573, the incident occurred on 5/9/18 and the investigation was completed on 5/29/18, but there were no extension requests.

13. The supervisory review did not detect the various problems in the investigations as noted above (e.g., late reporting, missing evidence). 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: Both types of audits/investigations were occurring, but not as often as necessary and documentation was not as complete as necessary. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	966	15	620	685	466	588	748	845	978
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	73% 8/11	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	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.	64% 7/11	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1

Comments:
14. For three individuals, the significant injuries audits did not have an entry under whether any action was taken (Individual #15), or had a mark of N/A for actions taken and whether an injury report was generated (Individual #466, Individual #978).

15. For four individuals, non-serious injuries occurred that should have been subjected to a non-serious injury investigation, but weren't (e.g., non-serious discovered injuries to scalp, eyes).

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

Summary: Performance returned to 100% for all investigations. Therefore, indicators 16, 17, and 18 will be returned to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 891	740	966	15	620	685	466	588	748	845	978

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	2/2	1/1	2/2	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 6/6	1/1	N/A	2/2	N/A	N/A	1/1	N/A	1/1	1/1	N/A	N/A
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 9/9	2/2	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A

Comments:
17. There were eight cases during the review period in which there were one or more confirmations of physical abuse category 2. In seven of these cases, the staff persons' employment was terminated. In one case, staff discipline occurred without following of SSLC State Office protocol being followed. The Center Director was aware of this and implemented actions to ensure it would not happen again.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.

Summary: This outcome consists of facility indicators. A variety of data were collected, but no analysis was occurring. These indicators 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.	No									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
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. Of the seven required data sets, two were not being tracked and trended: staff alleged to have caused the incident, and date/time/shift of incident.

20-23. Mexia SSLC collected a lot of data, however, it was not displayed in a way that lent itself to analysis, that is, to analysis regarding

identifying where the preponderance of problems are (e.g., location, shift, day of week), to determining trends, or to identifying systemic. There was very little narrative summation. One corrective action plan (CAP) was found. It was for developing a thorough UIR. This is a relevant topic, but there were no CAPs addressing any care, service/support, or protection issues. Similarly, QAQI Council meeting presenters showed a lot of data on their slides, but merely read the narratives from the slides aloud. The narratives, moreover, described the data, but did not provide any analysis or deeper explanation/understanding.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. At the time of the onsite review, Mexia SSLC did not, and since implementation of the Settlement Agreement, never utilized PTS or TIVA for the completion of dental treatment. As found during multiple previous reviews, individuals who required more than basic dental services were referred off campus for treatment. This resulted in lengthy treatment delays for some of the individuals reviewed. In some instances, needed treatment had not been provided. The Dental Director reported that the Center plans to implement the use of PTS and TIVA in the future. As Center staff were aware, this will require the development and implementation of policies to address criteria for the use of TIVA, as well as medical clearance for TIVA. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For Individual #272, who had dental work completed at the local hospital, the Center did not have a policy to determine whether she met the criteria for the use of TIVA. However, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, post-operative vital sign flow sheets were submitted, and an operative note defined procedures and assessment completed.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	If the individual is administered oral pre-treatment sedation for	0%	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	medical treatment, proper procedures are followed.	0/1										

Comments: On 2/1/18, Individual #620 was administered Ativan 2 milligrams (mg) and Seroquel 300 mg by mouth (PO). The nurse also gave him his evening medications: Depakote 750 mg and propranolol 40 mg. No evidence was found to show that the PCP sought IDT or other interdisciplinary input. Informed consent was not present, and the Center indicated that this was due to it being an emergency administration. Nurses documented limited vital sign information "due to refusals."

In its comments on the draft report, the State questioned the Monitoring Team's finding that no evidence was found that the PCP sought IDT or other interdisciplinary input. The State cited a QIDP note, dated 2/1/18, documenting a call to the individual's mother. It read in part: "…The IDT had felt that these symptoms could be related to medical issues and were pursuing having [Individual #620] be [sic] seen however it would be through the ER so that CT scan, labs and other medical procedures could be completed however [Individual #620] would need to be sedated in order to get him transported…" The medical audit tool includes a sub-indicator for Indicator a that reads: "With the input of the interdisciplinary committee/group, the PCP determines medication and dosage range" (emphasis added). The note the State provided includes no reference to discussion about the medication or the dosage range. In addition, the medical audit tool identifies the specific documentation on which the Monitoring Team relies to assess the Center's compliance with this indicator, specifically, the "ISP or documentation from Committee dealing with Pre-Treatment Sedation." As the State indicated in its comments, "There was not an ISPA in the chart to submit for evidence; however, there is documentation from the QIDP that the IDT had been consulted about the situation in an IPN." Without an ISPA, the Monitoring Team is unable to review signatures to determine which members of the IDT were present when the "IDT was consulted," or what discussion occurred.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.

Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										

4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	365	512	306	588	376				
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.	20% 1/5	1/1	0/1	0/1	0/1	0/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1				

Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed the five deaths. Causes of death were listed as:

- On 10/8/17, Individual #365 died at the age of 46 of aspiration pneumonia.
- On 12/13/17, Individual #512 died at the age of 84 of aspiration pneumonia. On 1/3/18, the clinical death review was completed. On 4/4/18, the administrative death review was completed.
- On 2/18/18, Individual #306 died at the age of 51 of stage V chronic kidney disease, sepsis, pneumonia, and volume overload. On 3/1/18, the clinical death review was signed/completed. On 4/2/18, the administrative death review was completed.
- On 3/28/18, Individual #588 died at the age of 43 of aspiration pneumonia, possibly related to ingestion of baby oil. On

4/6/18, the clinical death review was completed. On 4/30/18, the administrative death review was completed.

- On 4/3/18, Individual #376 died at the age of 85 of cardiopulmonary arrest, and respiratory failure. On 4/24/18, the clinical death review was completed. On 5/24/18, the administrative death review was completed.

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of nursing or medical care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. For example:

- For Individual #588, the clinical death review included reviews from all disciplines. Often, the discipline lead completed the review. However, for medical, the PCP who last provided care completed the review. There are a number of problems associated with this method for completing the medical death review:
  - The physician who participated in care of the individual cannot provide an objective review of the medical care.
  - The individual had significant dysphagia and ingested a hydrocarbon. Nursing staff requested that a provider evaluate the individual in sick call. Two providers stated this was not necessary. However, the death review included no recommendations related to medical care.
- Of significant concern, on 3/28/18, Individual #588 died, but on 4/10/18, his PCP finalized/signed his annual medical assessment. Integrated progress notes also were dated after his death. For example, after the 4/6/18 clinical death review cited concerns about the lack of contact with poison control in response to the individual ingesting baby oil, on 4/10/18, the PCP wrote an IPN indicating that the poison control website was used for guidance. Standard procedures for addressing mortalities, including standard investigation procedures, require that the Center have procedures in place to freeze/close the record at the time of death. None of the investigations or death reviews that the Center submitted addressed this issue. This issue requires immediate attention.
- The majority of the QA Nursing review findings did not result in recommendations in the administrative or clinical death review. This was despite findings in the QA nursing reviews that raised serious concerns, such as: nursing staff not completing follow-up according to guidelines, injury report(s) not completed in IRIS, lung assessments not completed, etc.

e. In the summaries of recommendations the Center provided, often, the section for "monitoring" stated: "none decided." Moreover, the recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation was developed to address the concern: "Nursing follow-ups not being documented." The recommendation read: "The Nursing Administration to re-evaluate nursing follow-ups including: nursing follow-up oversight and compliance; nursing follow-up process and guidelines; Nursing to ensure all nurses involved and campus wide receive competency based training in Nursing Guidelines dated December 2017; and recommend nursing guidelines from December 2017 be placed on all the homes campus wide." The expected evidence was an in-service training. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were completing necessary follow-up.

In addition, based on the documentation submitted, the Monitoring Team often could not discern the status of the completion of the recommendations as written.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1				1/1					
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1				1/1					
d.	Reportable ADRs are sent to MedWatch.	N/A				N/A					
Comments: a. through d. On Friday, 4/27/18, an ammonia level was drawn for Individual #410. As the State explained in it comments to the draft report, it was not until three days later, on Monday, 4/30/18, that the PCP received the results, and reported the ADR. It was positive that the PCP completed necessary clinical action, and the P&T Committee thoroughly discussed it.											

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: During the last review and this review, the Center completed clinically significant DUEs and needed follow-up. If the Center sustains this level of performance, after the next review, Indicators a and b might move to the category of less oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1
Comments: a. and b. In the six months prior to the review, Mexia SSLC completed two DUEs, including: • A DUE on Clindamycin that was presented to the Pharmacy and Therapeutics (P&T) Committee on 12/28/17. The group developed an action plan to address the two recommendations. The P&T Committee minutes documented that the needed process changes were made to address these ongoing actions; and • A DUE on proton pump inhibitors (PPIs) that was presented to the P&T Committee on 3/12/18. The group developed an action plan, but information about its impact was not yet available. Based on the clinical guidelines for gastroesophageal reflux disease (GERD) that State Office is currently finalizing, the Center should be able to conduct ongoing audits to ensure PCPs follow the guidelines.		

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. At the last review, 19 of these indicators were in or were moved to the category of requiring less oversight. For this review, three other indicators were moved to this category, in psychiatry and behavioral health services. One indicator in behavioral health services, however, was returned to active monitoring.

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 Monitoring Team observed many positives interactions between staff and individuals.

The new director of behavioral health services was actively making improvements in behavioral health services. She was an active participant in many center-wide meetings.

Assessments

About half of the IDTs considered what the individual needed and would be relevant to the development of the ISP. IDTs, however, did not arrange for and obtain all of these needed, relevant assessments prior to the IDT meeting for about half of the individuals.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for the great majority of the risk ratings reviewed, 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.

Significant work is needed with regard to the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, pre-natal histories, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate. Improvements also are needed with regard to the timeliness of annual medical assessments.

Although some improvement was noted with regard to the quality of annual dental exams, the Dental Department should continue to focus on improving the quality of both annual dental exams as well as dental summaries.

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.

Psychiatry annual reviews occurred for all individuals. None of the annual evaluations contained all 16 of the required elements.

Most annual behavioral health updates were current. Most functional assessments were current and all (but two) were complete.

Most individuals had FSA and vocational assessments that were current. Most (all but two) vocational assessments included recommendations for SAPs.

Improvements are needed with regard to IDTs referring individuals to the PNMT, when needed, and/or the PNMT making self-referrals. The Center also should focus on the completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.

Since the last review, the Center has continued to regress with regard to the timeliness and/or completion of the correct type of OT/PT assessments. In addition, many problems existed with regard to the quality of OT/PT assessments.

A number of individuals for whom Speech Language Pathologists (SLPs) potentially should have completed comprehensive assessments only had updates or screenings. In addition, the quality of communication comprehensive assessments needed significant improvement.

Individualized Support Plans

Regarding ISP goals, Mexia SSLC maintained performance, which means that more work needs to be done to develop individualized goals in all six goal areas (especially regarding health and wellness), ensure they are written in measurable terms, and collect data on the individual's status on each.

The underlying action plans were not created to likely lead to accomplishment of goals. On the positive, Mexia SSLC IDTs were addressing referral and transition related topics at annual IDT meetings. Most of ISP action plans were not fully implemented. There was little evidence that individuals were making progress.

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.

QIDP monthly reviews included little meaningful information regarding progress towards goals and efficacy of supports.

In psychiatry, Mexia SSLC made progress in that, for most individuals, some psychiatric indicators were identified in one or more documents. For some individuals, some sub-indicators met criterion. The next steps, of defining these indicators in observable terminology, ensuring they related to the diagnosis, and collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed.

In behavioral health, individuals who needed a PBSP had one. There was improvement in the quality and content of PBSPs, though, same as at the last review, one-third of the individuals had objectives that were not measurable due to references to baseline data that were never collected.

More individuals had more SAPs than at the last review. There was improvement in the percentage of SAPs that were based on assessment results.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Mexia SSLC maintained performance, which means that more work needs to be done to develop individualized goals in all six goal areas (especially regarding health and wellness), ensure they are written in measurable terms, and collect data on the individual's status on each. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	891	15	620	685	35	272				
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	4/6	3/6	3/6	1/6	3/6				
2	The personal goals are measurable.	0% 0/6	4/6	4/6	2/6	3/6	1/6	2/6				
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	1/6	0/6	1/6				
Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #620, Individual #15,												

Individual #891, Individual #685, Individual #272, and Individual #35. 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. The ISP relies on the development of personal goals as a foundation. 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 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 goal areas. Therefore, none had a comprehensive set of goals that met criterion. For this set of individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 18 of 36 personal goals met criterion for this indicator. This was similar to the last review when 19 goals met criterion. Goals that met criterion were:

- Individual #620's goals for recreation, relationships, greater independence, and living options.
- Individual #15's goals for recreation, day/work, greater independence, and living options.
- Individual #891's goals for recreation, day/work, greater independence, and living options.
- Individual #685's goals for recreation/leisure, greater independence, and living options.
- Individual #272's goal for recreation/leisure, greater independence, and living options.
- Individual #35's living option goal.

Although IDTs had created the above goals (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.

2. Of the 18 personal goals that met criterion for indicator 1, 16 also met criterion for measurability (also similar to the last review). The two that did not were Individual #620 and Individual #272's recreation/leisure goals.

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 their achievement. The presence of a personal goal that meets criterion is a prerequisite to this process.

3. One of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals (also similar to the last review). This was Individual #272's greater independence goal.

As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the Center. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals.

The Monitoring Team suggests that the QIDP department involve the unit directors in the goal to get all ISP action plans implemented.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: This set of indicators speaks directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring each of these indicators. Performance remained about the same as at the time of the last review, indicating that some focus or specialized approach to improvement is warranted. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	15	620	685	35	272			
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	2/6	1/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	1/1	1/1	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.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

Comments:

8. Eighteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could 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.

Two of the goals had action plans that were likely to lead to the accomplishment of the goal. Individual #891's action plans to support his recreation/leisure and greater independence goal had reasonable action plans to support these goals.

For the most part though, IDTs were not developing action steps that would lead to measurable progress towards goals. Although the Center acknowledged that IDTs needed additional training on developing action plans to support goals at the last review, there had been no identifiable progress in developing action plans to support goals.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress.

9. One of the ISPs had action plans that integrated preferences and opportunities for choice. While all of the ISPs integrated some preferences, only Individual #15 appeared to have opportunities to make significant choices throughout his day. He had some control over his work schedule and leisure time.

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way.

Since the last onsite review, self-advocacy committee had been more active than in many years, due to the facilitation and leadership of the Center's new human rights officer. The Monitoring Team attended their meeting during the onsite week. More than two dozen individuals attended, there was an agenda, a guest speaker, and snacks at the end. Self-advocacy meeting (and self-advocacy activities) can provide an opportunity to learn to, and engage in, decision-making. Self-advocacy related activities can be incorporated into individuals' ISPs as goals or as action plans supporting other goals.

11. Three of six ISPs met criterion for this indicator to support the individual's overall independence. These were:

- Individual #620's goal to wash his own clothes. Goals in his PBSP also focused on decision making and greater independence.
- Individual #891's work and budgeting goals were focused on greater independence.
- Individual #685's communication goals supported greater independence.

For the other three individuals,

- Individual #15's greater independence goal to make pizza would minimally support his independence, however, the IDT needs to identify other skills that he will need to function more independently in the community.
- Individual #272's IDT also needs to identify skills that would give her additional opportunities to have some control over her day.
- Individual #35's goals did not support opportunities for her to exert more independence during her day. Her ISP preparation meeting was observed. Her IDT had a good discussion regarding ways that her communication goals could be revised to support greater independence.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating 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 most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Some examples of this lack of integrated supports included:

- Individual #620's SLP and teacher reportedly had developed a good rapport with him and had some discovered some successful strategies for working with him. It was not evident that these strategies had been shared with the IDT and integrated into teaching strategies for other goals.
- It as not evident that Individual #15's IDT has taken an integrated approach to addressing his risk for falls. His behavior health staff and physical therapist had addressed his risk for falls separately, however, it did not appear that his psychiatrist had been consulted regarding the impact that medication changes might have had on his increase in falls.
- It was not apparent that Individual #685's communication strategies were integrated into all action plans and used consistently throughout his day.
- Individual #35's IDT needs to consider an integrated assessment and supports that would expand her functional communication.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration. Individual #15 had goals to attend church and work in the community and Individual #891 had a goal to work in the community. Action plans, however, had not been implemented and IDTs had not addressed barriers to implementation.

Individuals were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. Two ISPs included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

- Individual #15 and Individual #891 had goals to seek employment in the community.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things. Individual #685, Individual #272, and Individual #35 did not spend a majority of their day outside of their homes.

16. ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers.

18. Action plans did not describe detail about data collection and review, in almost all cases. Overall, ISPs did not usually include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated, not individualized, and, in most cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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

Summary: Ten of these 11 indicators showed improved or maintained performance compared to the last review (i.e., all except indicator 27). Some of the indicators remain at a low level of performance. Overall, however, Mexia SSLC IDTs were addressing referral and transition related topics at annual IDT meetings. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	891	15	620	685	35	272			
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).	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			

21	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	0/1	1/1	1/1	0/1	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).	100% 6/6	1/1	1/1	1/1	1/1	1/1	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.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
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.	0% 0/1	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.	33% 1/3	0/1	N/A	N/A	0/1	N/A	1/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	50% 1/2	N/A	N/A	N/A	N/A	0/1	1/1			

Comments:

19. Four ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.

- Individual #685's ISP noted that he was unable to communicate his preferences. His IDT did not describe his known environmental preferences other than to note that he needed a structured environment.
- Individual #272's ISP noted that she has not expressed her preferences. It was documented that she last went on a community home visit in 2009, however, her reaction to the visit was not documented.

20. An annual ISP meeting was not being held for any of the individuals in the review group during the onsite week. The Monitoring Team, however, attended an annual ISP meeting for another individual, Individual #811. The individual expressed his preference for where he wanted to live. He was able to do so very clearly.

21. All ISPs included the opinions and recommendation of the IDT's staff members.

22. Five ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Individual #685 did not have

an LAR and the team did not document his preferences.

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. For the most part, ISPs did not document discussion regarding placement options that might support current support needs, preferences, and strengths. It was not clearly documented in Individual #891, Individual #685, or Individual #272's ISPs that the IDT considered other living options that might support their needs.

24. 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 #35 had been referred to the community; no obstacles were defined.

25. At Individual #811's annual ISP meeting, the Monitoring Team observed discussion of the obstacles to referral, which appeared to be primarily his refusing to participate in programming.

26. Five of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. Individual #35 had been referred to the community, however, the IDT did not develop action plans to facilitate her referral.

27. At Individual #811's annual ISP meeting, specific plans to address the barrier(s) to referral were not discussed, nor was a criterion for future discussion by the IDT, such as number of occurrences, and time frame.

28. Individual #891 and Individual #685 did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. Individual #620, Individual #15, and Individual #35's ISPs indicated that their LAR was familiar with living options. Individual #272's ISP included action plans to educate her LAR on living options.

29. Individual #35's IDT agreed to refer her to the community, however, no action plans were developed to facilitate referral.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: Individuals attended their ISP meetings. With sustained high performance, this indicator (33) might be moved to the category of requiring less oversight after the next review. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all (indicator 32). Moreover, one or more important team members were missing from each individual's IDT. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	15	620	685	35	272			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual										

	was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
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	0/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

33. Five individuals attended their ISP meetings. Individual #620 did not attend his ISP meeting.

34. None of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #620's ISP was developed within 30 days of admission, however, none of his goals were now relevant. The IDT had not met to revise his ISP.
- The psychiatrist did not attend Individual #15, Individual #891, or Individual #685's ISP meetings, although for all three, ongoing psychiatric supports were recommended by the IDT.
- Individual #35's PCP and physical therapist were not present at her meeting.
- Individual #272's home manager was unable to state relevant information regarding her current status and supports.

Overall, QIDPs and other team members had little expectation for growth or greater independence. For the most part, QIDPs expressed the IDT's vision for individuals in terms of better behavior and better health. The IDT members were not tracking progress towards goals or addressing barriers when individuals were not making progress.

IDTs need a better understanding of the ISP process and how to develop a good vision statement, then how to support individuals to achieve that vision.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Various assessments were not obtained or were submitted late. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	15	620	685	35	272			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			

	to the annual meeting.										
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:

35. Four IDTs did not consider what 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.
    - Individual #620's IDT did not document his need for a neurological assessment to determine status and supports needed to address his diagnosis of intracranial pressure.
    - Individual #15's IDT did not consider his need for a comprehensive physical therapy assessment related to numerous falls over the past year.
    - Individual #891's IDT needed to request further assessment to determine what skills he needed to learn to achieve his work goal.
    - Individual #685's ISP contained conflicting information regarding what signs he knew and used to communicate. His communication dictionary indicated that he already used some of the signs that SAPs were developed to teach. The SLP needs to complete a functional communication assessment.

36. IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting for five of the individuals.
    - Individual #620's psychiatry, OT, SLP, nursing, and FSA assessment were not submitted timely prior to his ISP meeting. Hearing and vision exams were not current.
    - Individual #15's behavioral health assessment was not submitted 10 days prior to his annual ISP meeting.
    - Individual #891's FSA, behavioral health assessment, and vocational assessment were not submitted 10 days prior to his annual meeting.
    - Individual #685's psychiatry and nursing assessments were not submitted 10 days prior to his annual IDT meeting.
    - Individual #35's preference assessment was late and was not adequate for planning.

Without relevant assessments for the IDT to review, it is unlikely that comprehensive supports and services were developed, and all risks were addressed.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: It was good to see that IDTs regularly met. Follow-up to resultant recommendations could not be determined. Implementation of ISP action plans continued to be a problem at Mexia SSLC. QIDP monthly reviews were occurring. This foundation was now in place. The content/quality of those reviews needs improvement, such that more of an assessment/analysis of progress occurs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	15	620	685	35	272			

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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met routinely to review supports, services, and serious incidents. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. Furthermore, reliable and valid data were rarely available to guide decision-making.

IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals.

QIDP monthly reviews included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

Some QIDP monthly reviews included data for some action plans, but did not include an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently implemented or effective.

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility's response to incidents. In most cases, the facility reviewed incidents and assigned follow-up action for staff to complete to ensure any contributing factors identified were addressed. The Monitoring Team, however, could not determine whether actions for staff to complete were ever implemented and reviewed.

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, particularly when goals are not consistently implemented.

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	Individuals:

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	15	620	35	410	272	157	588	142	577
a.	The individual's risk rating is accurate.	17% 3/18	1/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2
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.	50% 9/18	1/2	2/2	2/2	1/2	1/2	2/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #15 – dental, and infections; Individual #620 – constipation/bowel obstruction, and seizures; Individual #35 – diabetes, and gastrointestinal (GI) problems; Individual #410 – falls, and weight; Individual #272 – circulatory, and fractures; Individual #157 – skin integrity, and cardiac disease; Individual #588 – aspiration, and GI problems; Individual #142 – choking, and osteoporosis; and Individual #577 – respiratory compromise, and infections].

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 #15 – dental, Individual #410 – weight, and Individual #157 – skin integrity.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and generally updated the IRRFs at least annually. However, 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. The following individuals did not have changes of status in the specified risk areas: Individual #15 – dental; Individual #620 – constipation/bowel obstruction, and seizures; Individual #35 – diabetes, and GI problems; Individual #410 – weight; Individual #272 – circulatory; and Individual #157 – skin integrity, and cardiac disease.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.	
Summary: Mexia SSLC made progress in that, for most individuals, some psychiatric indicators were identified in one or more documents. For some individuals, some sub-indicators met criteria. The next steps, of defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed. Additional specific comments are provided below.	Individuals:

Moreover, the Monitoring Team has revised the wording and sub-indicators for indicators 4, 5, and 6 in order to provide more guidance and specific feedback to the Centers. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
The scoring in the above boxes have a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

4. Psychiatric indicators:
A number of years ago, the State proposed terminology to help avoid confusion between psychiatric treatment and behavioral health services treatment, although the two disciplines must work together in order for individuals to receive comprehensive and integrated clinical services, and to increase the likelihood of improvement in psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder.

Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder.

The Monitoring Team looks for:

a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms and at least one psychiatric indicator related to the increase of positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving. The indicators cannot be solely a repeat of the PBSP target behaviors.
b. The indicators need to be related to the diagnosis.
c. Each indicator needs to be defined/described in observable terminology.

Mexia SSLC showed progress in this area in that most individuals had one or more indicators related to the reduction of psychiatric symptoms. The psychiatric indicators for reduction for five individuals (Individual #685, Individual #15, Individual #763, Individual #143, Individual #891) met criteria for sub-indicators a and b above in that the indicators were present and were related to the diagnosis. Two of these five individuals, (Individual #685, Individual #763), also met criteria with sub-indicator c, in that the indicators were fully defined/described using observable terminology.

Some individuals had different lists of psychiatric indicators in different documents and sometimes within the same document. In some cases the chosen psychiatric indicators were not directly related to the diagnosis. Many indicators were not defined or described in observable terminology (e.g., disturbed sleep, mood symptoms).

None of the individuals had psychiatric indicators for increase in positive/desirable actions.

5. Psychiatric goals:
The Monitoring Team looks for:
d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

At Mexia SSLC, there were no goals written regarding psychiatric indicators for reduction or for increase. Goals need to include the psychiatric indicator and a criterion.

There were notations regarding what type of data were to be collected, specifically that incidents would be documented in care tracker or that rating scales, specifically the BPRS or ADHD rating scales, would be utilized. For events to be captured in care tracker, detailed operational definitions of the symptoms must be provided to staff. This may improve the accuracy of the captured data.

Regarding rating scales, there was no documentation of the frequency with which the scales should be performed or who was responsible for performing the assessment. When rating scales are utilized, data should be trended over time so it is possible to determine improvement/exacerbation of symptoms over time.

Moreover, ratings scales may not be sensitive enough to capture the level of detail that the psychiatrist and IDT would want to have in order to make treatment decisions.

6. Documentation:
The Monitoring Team looks for:

f. The goal to appear in the ISP in the IHCP section.
g. Over the course of the ISP year, goals are sometimes updated/modified, discontinued, or initiated. If so, there should be some commentary in the documentation explaining changes to goals.

At Mexia SSLC, psychiatric indicators/goals were not incorporated into the Center's overall documentation system. That is, they were not in the IHCP and, therefore, were not part of the ISP and QIDP monthly reviews.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At Mexia SSLC, reliable data were not reported for psychiatric indicators. Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Summary: Mexia SSLC made progress in that for most individuals, some psychiatric indicators were identified in one or more documents. The next steps, ensuring consistency of the indicators between documents, defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance improved for indicators 13 and 15, but decreased for indicators 14 and 16. With sustained high performance, indicator 13 might be moved to the category of requiring less oversight after the next review. These four indicators will remain in active monitoring. Note that criteria for all four indicators were met for one individual.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
15	If admitted within two years prior to the onsite review, and was	75%	1/1	N/A	N/A	N/A	0/1	N/A	1/1	N/A	1/1

	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.	3/4									
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.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments:

13. Individual #143 did not have a CPE provided for review. Reportedly the evaluation had been performed, but staff were unable to locate the document.

14. The Monitoring Team looks for 14 components in the CPE. One of the evaluations, regarding Individual #620, met all of the requirements. Six of the remaining examples did not include a sufficient bio-psycho-social formulation. This was the most common deficiency. Four evaluations were lacking sufficient information in one element, two evaluations were lacking sufficient information in two elements, and one evaluation was lacking sufficient information in three elements.

15. For the four individuals admitted in the two years prior to the onsite review, all had a CPE performed within 30 days of admission. Individual #966 was admitted to the facility on 5/31/17 and had a CPE completed within 30 days on 6/6/17. There was an IPN documented by nursing on the day of admission, but no progress notes from primary care.

16. There were seven individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #891, Individual #740, Individual #763, Individual #966, Individual #15, Individual #442, and Individual #685.

Outcome 5 – Individuals' status and treatment are reviewed annually.

Summary: Annual reviews occurred for all individuals. Given this sustained high performance, indicator 17 will be moved to the category of requiring less oversight. Content in the documentation for the annual review and for the final ISP document did not meet criteria. Also, psychiatrists infrequently attended annual ISP meetings (or provided acceptable rationale for why their attendance was not necessary). These other three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
17	Status and treatment document was updated within past 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	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	0/1	0/1	0/1	0/1	N/A	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	22% 2/9	0/1	0/1	0/1	0/1	1/1	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. All were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the annual evaluations contained all of the required elements. The evaluations were missing from one to 11 elements. Two evaluation were missing one element, one evaluation was missing three elements, one evaluation was missing five elements, one evaluation was missing six elements, one evaluation was missing seven elements, one evaluation was missing nine elements, and one evaluation was missing 11 elements.

20. The psychiatrist attended the ISP meeting for two of the individuals in the review group.

If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

21. There was a need for improvement with regard to the 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: Given sustained high performance in creation of complete PSPs, this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. Because none of the individuals in the review group had a PSP, two PSP documents were requested and reviewed. The PSP regarding Individual #216 and Individual #385 included the required information.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: There were improvements in the consenting process and documentation as evident below in the scores for indicators 29 and 31. The Center reported that they had been (and were continuing to) work on this. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
28. Current medication consent forms were provided for all medications prescribed for seven individuals included in the review group. Two individuals, Individual #966 and Individual #891, did not have consent forms for Cogentin, a medication that has significant anticholinergic side effects.

29. The consent forms included adequate medication side effect information in eight examples. Individual #620 was prescribed Tegretol, a medication that has significant interactions with other medications. This was not reviewed in the consent forms.

30. The risk versus benefit discussion was not included in the consent forms in six examples. The consent forms for Individual #763, Individual #620, and Individual #685 included a risk versus benefit discussion. This was good to see. The psychiatrists indicated that they had begun to include this documentation in the consent forms.

31. The consent forms in eight examples included alternate and non-pharmacological interventions. Consent forms regarding medications prescribed to Individual #966 indicated there were no alternatives.

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 PBSPs had one. Same as at the last review, one-third of the individuals had objectives that were not measurable due to references to baseline data that were never collected. As a result, indicator 3 will be returned to active monitoring. On the other hand, goals/objectives were based on assessments for this review and the last review (with one exception this time and last time). Given this overall sustained high performance, indicator 4 will be moved to the category of requiring less oversight. Additional attention to data collection may help indicator 5 show better performance. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, due to decreased performance on indicator 3 for two consecutive reviews, indicator 3 will be returned to active monitoring.									
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.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
5	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:

3. Individual #143's spitting objective, Individual #685's food stealing objective, and Individual #442's unequal trading objective were defined as a 20% decrease from baseline, however, baseline levels were not available, therefore, these objectives were not measurable.

Thus, one-third of the individuals had objectives that were not measurable. This was the case at the last review, too. Therefore, indicator 3 will be returned to active monitoring.

4. Individual #763's functional assessment suggested adding sleeping in school as a target, however, it was not included in his PBSP.

5. All individuals had interobserver agreement (IOA) in the last six months that were at or above 80%. None of the individuals,

however, had data collection timeliness assessments in the last six months. It should be a priority for Mexia SSLC to ensure that all PBSP data are consistently reliable.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

Summary: Performance on all three indicators improved somewhat markedly from the last review. All three indicators were at criteria for seven of the individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	0/1	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).	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

10. Individual #740's (10/16) annual behavioral health update was not current.

11. Individual #740's (10/16) functional assessment was not current.

12. Individual #891's functional assessment was rated as incomplete because the direct assessment was implemented on 7/26/17 and 8/1/17 within weeks of his admission and it indicated that there were insufficient data because no target behaviors were observed. Similarly, the indirect assessment indicated that staff had not seen targets, and neither the direct nor the indirect assessments were after target behaviors occurred. Individual #740's functional assessment was rated as incomplete because it did not include a direct assessment.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: Similar to outcome 3 above (indicators 10-12), these three indicators also improved since the last review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
15	The PBSP was complete, meeting all requirements for content and	89%	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	quality.	8/9										

Comments:
13. Individual #143, Individual #966, Individual #15, and Individual #620 had documentation that their PBSPs were implemented within 14 days of attaining the necessary consents. It is important that Mexia SSLC document that every PBSP is implemented after consent has been obtained.

14. The PBSP was written in the last year for all individuals, except for Individual #740 (PBSP dated 10/26/16) and Individual #442 (PBSP dated 4/27/17). Both, however, were reported to have been updated right before the onsite review week (i.e., earlier in July 2018).

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Individual #740, Individual #143, Individual #763, Individual #966, Individual #15, Individual #620, Individual #442, and Individual #685's PBSPs were rated as having all 13 components.

The one PBSP rated as incomplete was Individual #891's because it did not include operational definitions. This represents a substantial improvement in the quality of PBSPs from the last review when 62% of the PBSPs were scored as complete.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary:			Individuals:									
#	Indicator	Overall Score										
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.											
	Comments:											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577

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	N/A	1/1	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.	63% 5/8	0/1	N/A	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. Of significant concern, on 3/28/18, Individual #588 died, but on 4/10/18, his PCP finalized/signed his annual medical assessment. Standard procedures for addressing mortalities, including standard investigation procedures, require that the Center have procedures in place for freezing/closing the record at the time of death. This issue requires immediate attention.

In its comments on the draft report, the State disputed the finding for Individual #157, and referenced the documents the Monitoring Team previously reviewed. The Lead Monitor reviewed the documents. On 3/16/18, the PCP signed the current AMA. Although a note indicated this was a "correction of the AMA performed on 1/22/18," the Center submitted no evidence, even after discussion on site, to verify that the AMA was completed timely.

c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Significant improvements are needed with regard to the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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, complete interval histories, allergies or severe side effects of medications, and complete physical exams with vital signs. Most, but not all included past medical histories, lists

of medications with dosages at the time of the AMA, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, pre-natal histories, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #15 – other: Vitamin D deficiency, and polypharmacy/side effects; Individual #620 – other: intracranial hypertension, and seizures; Individual #35 – respiratory compromise, and other: hyperthyroidism; Individual #410 –constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures, and diabetes/metabolic syndrome; Individual #157 – cardiac disease, and skin integrity; Individual #588 – GI problems, and cardiac disease; Individual #142 – diabetes/metabolic syndrome, and respiratory compromise; and Individual #577 – other: adrenal insufficiency, and respiratory compromise).

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	39% 7/18	1/2	0/2	0/2	2/2	1/2	1/2	2/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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 #15 – other: Vitamin D deficiency, and polypharmacy/side effects; Individual #620 – other: intracranial hypertension, and seizures; Individual #35 – respiratory compromise, and other: hyperthyroidism; Individual #410 –constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures, and diabetes/metabolic syndrome; Individual #157 – cardiac disease, and skin integrity; Individual #588 – GI problems, and cardiac disease; Individual #142 – diabetes/metabolic syndrome, and respiratory compromise; and Individual #577 – other: adrenal insufficiency, and respiratory compromise).

The following IHCPs set forth medical actions steps that addressed the at-risk or chronic condition in accordance with current standards of practice consistent with risk-benefit considerations: Individual #15 – polypharmacy/side effects; Individual #410 – constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures; Individual #157 – skin integrity; and Individual #588 – GI problems, and cardiac disease.

b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Dental

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

Summary: The Center should continue its focus on improving the quality of dental exams and summaries. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 15	620	35	410	272	157	588	142	577
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	56% 5/9	1/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/8	0/1	0/1	Not rated (NR)	0/1	0/1	0/1	0/1	0/1	0/1

Comments: Individual #35 had good oral hygiene and was edentulous. She was part of the outcome group, so a limited review was conducted.

b. It was positive that for five of the nine individuals reviewed, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- A summary of the number of teeth present/missing;

- Treatment provided/completed;
- An odontogram; and
- A treatment plan.

Most, but not all included:

- Information regarding last x-ray(s) and type of x-ray, including the date; and
- Sedation use.

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

- Periodontal charting.

c. The annual dental summary is a document that the IDTs use. The dentist used dental codes in these documents, which is meaningless to most IDT members. The dentist should write what was done using proper dental nomenclature and not dental codes. The documents were not signed. In addition, the documents stated: "the dental services department recommends…" A provider has to be accountable for the treatment recommendations, not a department.

On a positive note, it was good to see that all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- The number of teeth present/missing;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- Recommendations for the risk level for the IRRF.

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

- Recommendation of need for desensitization or another plan;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- A description of the treatment provided (i.e., treatment completed and date); and
- Provision of written oral hygiene instructions.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Based on the Monitoring Team's review of annual and quarterly nursing assessments and physicals, problems were noted with either the timeliness or with regard to the completion of thorough physical assessments. Assessments reviewed did not include sufficient clinical data or analysis of such data. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	13% 1/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	38% 3/8	1/1	N/A	N/A	0/1	1/1	N/A	0/2	0/1	1/2

Comments: a. Based on the Monitoring Team's review of annual and quarterly nursing assessments and physicals, problems were noted with either the timeliness (i.e., Individual #35's annual and quarterly assessments) or with regard to the completion of thorough physical assessments (i.e., with the exception of Individual #577's annual), including, for example, Braden scores, fall assessments, and/or assessments of reproductive systems. Mental status descriptions often were incomplete. In addition, abnormal findings (e.g., vital signs, mental status changes) often did not result in further analysis, narrative, or follow-up.

Some of these issues appeared to be related to IRIS, and the State Office Discipline Lead was working to make changes to the system. However, other issues were unrelated to IRIS, and require corrections on the part of Center staff.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #15 – dental, and infections; Individual #620 – constipation/bowel obstruction, and seizures; Individual #35 – diabetes, and GI problems; Individual #410 – falls, and weight; Individual #272 – circulatory, and fractures; Individual #157 – skin integrity, and cardiac disease; Individual #588 – aspiration, and GI problems; Individual #142 – choking, and osteoporosis; and Individual #577 – respiratory compromise, and infections).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses did not include complete status updates, including relevant clinical data, and/or analyze this information, including comparisons with the previous quarter or year, and/or make 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 examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- For Individual #588, a nursing IPN, dated 3/18/18 at 9:40 p.m., reported: "per home charge…, pt [patient] suspected of ingesting unknown amount of baby oil." The record stated: "See I-view for v/s [vital signs]." However, no vital signs were found for the corresponding IPN time. Nurses did not follow Nursing Guidelines for PICA/Aspiration. Standards of Care were not followed for notification of Poison Control and the on-call PCP. The next nursing entry was dated 3/19/18 at 11:38 a.m., noting "a call was make [sic] to sick call to RN… for MD notification of ingestion of this substance."

  As discussed above with regard to acute medical issues, on 3/22/18, at 6:45 a.m., nursing staff reported Individual #588 was in respiratory distress with a respiration rate of 45 and oxygen saturations of 84 to 86%. The PCP was contacted and the individual was transferred to the ED for evaluation.

  A chest x-ray done in the ED showed right upper lobe and right perihilar pneumonia. The individual experienced respiratory distress and was air-flighted to a higher level of care. He was admitted to the ICU. The chest x-ray showed bilateral pneumonia. He experienced respiratory distress and was intubated. He required Pressors for blood pressure support. He failed attempts at extubation, and, therefore, bronchoscopy was performed. Cultures were negative and the secretions were reported as thick. He developed acute respiratory distress syndrome and multi-organ failure. The parents elected to withdraw ventilator support. On 3/28/18, he died.
- On 4/12/18 at 10:09 a.m., a nursing IPN reported that Individual #410 "went to stand up from couch and while sitting on the edge of the couch, slid off of couch onto his bottom." No nursing assessment was found in IView.
- On 12/29/17, at 11:59 a.m., a nursing IPN noted a "stat" call related to Individual #142 experiencing a choking event. The IPN referred the reader to IView. An IView entry was found for vital signs at 12:15 p.m., which documented a temperature of 36.4 Celsius (97.5 Fahrenheit), which was low, a pulse rate of 113, which was high, and blood pressure of 147/78, which was high for systolic. No other assessments were included, such as a respiratory assessment.
- On 4/19/18 at 10:22 p.m. a nursing IPN included the following for Individual #577: "Assessment increased cough continues after cough syrup and neb [nebulizer] treatments. Placed on Sick Call." A corresponding medical IPN, dated 4/20/18, indicated the PCP prescribed Tessalon Perles and Z-PKK. The PCP's assessment was: "Upper Respiratory/Persistent hacking cough Pterygium." Nursing notes were found for 4/20/18 at 12:12 a.m., and 4/20/18 at 4:34 a.m., noting no further coughing, "rested well the rest of the night." However, corresponding IView documentation was not found for the 4/19/18 and 4/20/18 nursing IPNs, for vital signs and respiratory assessments.

On a positive note:

- On 5/19/18, Individual #15 was diagnosed at the Center with cellulitis, and prescribed intramuscular (IM) antibiotics. A nursing IPN, dated 5/19/18, at 1:20 p.m., documented an initial assessment for the individual's complaint of right leg swelling and heat. The nurse documented the measurements and noted the area was tender to the touch. The record indicated notification to the Campus RN. On 5/19/18 at 1:30 p.m., the nurse recorded vital signs in IView.
- On 12/7/17, Individual #272 experienced a serious injury, which was diagnosed as a comminuted fracture of the left humerus and second rib fracture. Based on IView documentation, dated 12/7/17 at 7:00 a.m., the nurse documented vital signs and

notification to the physician, including the reason. The documentation showed an assessment of the affected areas, and the individual's response to pain. An IView entry, dated 12/7/17 at 7:20 a.m., included a pain scale and documented administration of acetaminophen. Based on the initial signs and symptoms, the nursing assessment was completed in accordance with applicable standards of care.

- On 1/21/18, Individual #577 was diagnosed with Influenza A. The initial nursing IPN, dated 1/20/18 at 4:46 a.m., and corresponding IView assessment were based on the individual's signs and symptoms, as well as the presenting abnormal vital signs (i.e., elevated heart rate of 120, and high respiration rate of 24). At 4:50 a.m., the individual's vital signs were not outside the perimeters for vital signs. On 1/20/18 at 5:30 a.m., the follow-up nursing IPN and corresponding IView included assessments that followed standards of care and were based on the individual's signs and symptoms.

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 multiple 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.

#	Indicator	Overall Score	Individuals: 15	620	35	410	272	157	588	142	577
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. None of the IHCPs reviewed contained nursing interventions that met the individuals' needs.

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: Improvements are needed with regard to timely referral of individuals to the PNMT. The Center also should focus on the completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	29% 2/7	0/1	N/A	1/2	0/1	0/1	N/A	N/A	N/A	1/2
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	29% 2/7	0/1		1/2	0/1	0/1				1/2
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	60% 3/5	N/A		1/2	N/A	1/1				1/2
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	43% 3/7	0/1		1/2	0/1	1/1				1/2
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3	N/A		0/1	N/A	N/A				2/2
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7	0/1		0/2	0/1	0/1				0/2
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	0/1		N/A	0/1	N/A				N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth	0%	N/A		0/2	N/A	0/1				0/2

	and complexity necessary.	0/5									

Comments: a. through g. For the five individuals that should have been referred to and/or reviewed by the PNMT:

- Although Individual #15 did not meet the specific criteria for referral to the PNMT for falls, the frequency of his falls over a number of months should have triggered at least a PNMT review of his status. Based on document review, he experienced a varying number of falls depending on the sources. However, at a minimum, it appeared he fell the following number of times per month: September 2017 – 2, October – 1, November – 1, December – 3, January 2018 – 1, February – 6, May – 3, and June – 3.
- According to Individual #35's IRRF, on 10/13/17, she was treated at the Center for aspiration pneumonia. No evidence was found to show that her IDT referred her to the PNMT, or that the PNMT made a self-referral. From 1/11/18 to 1/15/18, she was hospitalized, and again, diagnosed with aspiration pneumonia. On 1/16/18, the IDT made a timely referral to the PNMT for the second aspiration pneumonia. It was not until 1/22/18, that the PNMT RN conducted the post-hospitalization review, and evidence was not found to show the PNMT discussed it. Based on documentation provided, the Monitoring Team could not confirm the PT, Registered Dietician (RD), or an MD/PCP's participation in the assessment.
- Although Individual #410 did not meet the specific criteria for referral to the PNMT for falls, the frequency of his falls over a number of months should have triggered at least a PNMT review of his status. At a minimum, it appeared he fell the following number of times per month: August 2017 – 3, September – 3, October – 3, December – 2, January 2018 – 2, and April – 9. The PNMT minutes stated that he had not had any falls since 4/27/18, after an Ativan reduction on 4/27/18. However, the PNMT conducted no actual assessment to determine if the medication potentially impacted his falls since August, or merely was the potential cause for the increase in April.
- On 12/7/17, Individual #272 experienced a serious injury, which was diagnosed as a comminuted fracture of the left humerus and second rib fracture. This required referral to the PNMT. On 12/7/17, the IDT held a Critical Incident Team ISPA meeting. Documentation from that meeting indicated that the IDT decided a PNMT assessment was not needed, because the IDT had initiated the appropriate additional supports and the cause of the fractures were being investigated. The PNMT made a self-referral, but not until 12/20/17. The assessment did not include evidence of the RD's participation (except for listing the name at the bottom of the assessment).
- From 9/15/17 to 9/20/17, Individual #577 was hospitalized for aspiration pneumonia. His IDT chose not to make a referral to the PNMT. Reportedly, the PNMT conducted a review. It was unclear why the PNMT did not make a self-referral. On 3/27/18, the individual was admitted to the hospital with pneumonia, and on 4/1/18, returned to the Center. The PCP wrote a brief assessment noting the individual had bilateral pneumonia due to aspiration. On 4/6/18, the PNMT conducted a review and stated that they "found" he had a previous pneumonia and would complete an evaluation that was due 4/30/18. On 6/2/18, Individual #577 was transferred to the ED for respiratory distress and returned to the Center. On 6/6/18, he was hospitalized with aspiration pneumonitis. On 4/6/18, and 6/13/18, the PNMT RN completed post-hospitalization reviews, and the PNMT reviewed this information. Based on documentation provided, the Monitoring Team could not confirm the PT, RD, or an MD/PCP's participation in the assessment.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

h. As noted above, Individual #35 and Individual #577 should have had comprehensive PNMT assessments in October 2017, and

September 2017, respectively, but did not. The following summarizes some of the concerns noted with the three assessments that the PNMT completed:

- For Individual #35, the PNMT identified the root cause of her aspiration pneumonia as constipation. However, the PNMT presented no data presented to support this conclusion. In addition, the PNMT offered limited intervention recommendations to address this concern. The PNMT did not propose any goals/objectives.
- For Individual #272, the PNMT did not provide evidence/rationale for determining that the cause(s) for her fractures were her rolling over or from the sling during transfer. The PNMT identified the underlying cause as osteoporosis, but again, did not provide sufficient rationale for this conclusion.
- For Individual #577, the PNMT did not discuss the individual's relevant medical history and its impact on supports and services, but merely listed events related to pneumonia. The PNMT determined that the aspiration event occurred post emesis during bathing. [Although not relevant to the quality of the most recent assessment, it was not clear why they had not previously identified the issue with the Arjo gurney used during bathing, and specifically, the difficulty maintaining the correct head-of-bed elevation (HOBE) as the gurney was set at 45 degrees. No evidence was found that the PNMT thoroughly evaluated the use of the gurney in July as part of the previous assessment.] In July 2017, the PNMT determined the root cause of the aspiration pneumonia was micro-aspirations. However, in the most recent assessment, they did not address the micro-aspiration, other than to list it as a predisposing factor. In the most recent assessment, the PNMT did not provide details about the aspiration pneumonia that was diagnosed on 9/15/17.

On a positive note, all of the assessments reviewed included:

- The presenting problem;
- Discussion of the individual's behaviors related to the provision of PNM supports and services;
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
- Evidence of observation of the individual's supports at his/her program areas;
- Assessment of the individual's current physical status; and
- Discussion as to whether existing supports were effective or appropriate.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The PNMPs reviewed still had missing information. With minimal effort and attention to detail, though, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	The individual has an ISP/IHCP that sufficiently addresses the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0/18									
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable 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 the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 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 falls for Individual #15; falls, and GI problems for Individual #620; falls, and aspiration for Individual #35; falls, and choking for Individual #410; aspiration, and fractures for Individual #272; weight, and falls for Individual #157; falls, and aspiration for Individual #588; choking, and falls for Individual #142; and falls, and aspiration for Individual #577.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. Individual #577's IHCP for aspiration included preventative interventions.

c. All individuals reviewed had PNMPs and/or Dining Plans. Problems varied across the PNMPs and/or Dining Plans reviewed.

- All of the PNMPs, as applicable to the individuals' needs included:
  - Descriptions of assistive/adaptive equipment
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions; and
  - Oral hygiene instructions.

- Most, but not all of the PNMPs reviewed, as applicable to the individuals:
  - Were reviewed and/or updated within the last 12 months (i.e., Individual #272's PNMP was not updated timely after her fracture).
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Most PNMPs/Dining Plans did not include triggers;
  - As applicable, all PNMPs/Dining Plans were missing some or all pictures, particularly of adaptive equipment; and
  - Complete communication strategies.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

e. The IHCPs reviewed did not identify the necessary clinical indicators.

f. The IHCP that identified triggers and actions to take should they occur was for Individual #577 - aspiration.

g. Often, the IHCPs reviewed did not include PNMP monitoring, including the frequency, and/or monitoring of other aspects of the related plans. The exception was the IHCP for falls for Individual #35.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	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						
Comments: a. and b. Individual #35's IRRF/ISP did not provide clear justification for the continued necessity of the enteral nutrition. It also did not provide a plan to assist the individual to progress along the continuum to oral intake, or justification for not developing a plan.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Since the last review, the Center has continued to regress with regard to the timeliness of OT/PT assessments. Many problems existed with regard to the quality of OT/PT assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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	N/A	1/1	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.	100% 1/1		1/1							
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	25% 2/8	0/1	N/A	0/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
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;	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1

	• Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. through c. The following concerns were noted:

- On 5/22/17, Individual #15's IDT requested a PT evaluation to address walking/falls, and balance due to weakness. Although not submitted to the Monitoring Team, a PT conducted an evaluation. On 6/5/17, the IDT held an ISPA meeting related to PT orders. It was agreed the PT would provide direct PT two times per week for six weeks, and on 8/24/17, Individual #15 was discharged. According to the discharge summary, dated 8/25/17, he met all goals. As direct services were provided within the last year, at least an update should have been completed for the 2018 ISP meeting, on 5/9/18, but no assessment was completed. In addition, based on the documents provided, the Monitoring Team was not able to determine when the previous comprehensive evaluation was completed.
- For Individual #35, Individual #272, and Individual #142, the documentation submitted did not provide the last comprehensive assessment, and all of the updates since then, as requested. As a result, the Monitoring Team was unable to determine if the OT/PT conducted the correct type of assessment (i.e., update versus comprehensive).
- In addition, for Individual #272, an IPN, dated 3/20/18, documented that on 3/19/18, the PCP wrote an order for Orientation and Mobility (O&M) and OT therapy two times a week for six weeks for "staff training and assessment effectiveness for use of active learning center." Although it was unclear why this therapy was ordered or what it would entail, no evidence was found of an OT or O&M assessment to substantiate the need for therapy.
- For Individual #157, the Center submitted no evidence of an OT assessment, and only a PT screening. The screening documentation did not explain why an OT did not participate. The PT and/or OT provided no rationale for not providing an assessment versus a screening, despite the individual's extended hospitalizations during the last year.
- For Individual #577, the OT/PT only completed a screening, despite the fact that from 5/11/17 to 6/5/17, the PT provided direct PT services to address bilateral lower extremity range of motion, strength, and functional transfers. On 7/27/17, he was discharged from PT. He should have had a comprehensive evaluation or update, as indicated.

d. As noted above, for a number of individuals (i.e., Individual #15, Individual #35, Individual #272, Individual #142, Individual #157, and Individual #577), based on the documentation the Center provided, the Monitoring Team could not determine if a comprehensive assessment was warranted. The Monitoring Team reviewed comprehensive OT/PT assessments for three individuals. Overall, many problems were noted with the assessments reviewed. The following summarizes some of the problems noted:

- The individual's preferences and strengths were used in the development of OT/PT supports and services: Although assessors listed individuals' preferences and strengths, they did not incorporate them into the development of supports/services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: None of the assessments met this criterion;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and

services: For the three individuals, the assessors listed medications and potential side effects, but did not discuss whether or not they were potentially impacting an OT/PT problem(s);

- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living (ADLs): Assessments were missing, for example, assessment of fine motor skills, or a sensory assessment, despite the previous assessment identifying sensory issues;
- 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): For the two applicable individuals, the assessors did not discuss the fit and condition of one or more pieces of adaptive equipment;
- 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: This was not applicable to Individual #620, because he was newly admitted. Individual #588's assessment met this criterion. Individual #410's assessment stated that he had a decline in ADLs and increased risk of falls, but it was unclear how this compared to previous assessments. In addition, the assessors did not discuss the outcome of previous direct intervention by OT/PT;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: The assessments reviewed did not meet this criterion. Problems included a lack of monitoring findings, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: Problems included, for example, assessments that identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations, and/or a lack of assessment of identified deficits; 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, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs.

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: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/10	0/1	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	0% 0/3	N/A	0/1	N/A	0/1	0/1	N/A	N/A	N/A	N/A

Comments: a. Most ISPs reviewed did not include a description of the individual's functional motor skills. In other instances, current assessment information was not available to the IDT to provide an up-to-date description.

b. Simply including a stock statement such as "Team reviewed and approved the PNMP/Dining Plan" did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements. In its comments on the draft report, the State requested clarification and stated: "…This document is not a transcript, but a brief statement that the IDT reviewed the documents." Unfortunately, in the ISPs reviewed, the IDTs had not included "brief statements," but rather a pro forma phrase that did not provide individualized evidence of what the IDT reviewed (e.g., date of PNMP/dining plan), effectiveness of the plan based on monitoring results, as well as any revisions discussed and/or agreed upon.

c. and d. Examples of concerns included:

- Often, IDTs did not address individuals' OT/PT needs in ISP action plans, which was hampered by the lack of recommendations to address individuals' needs in the OT/PT assessments.
- Individual #620's IDT did not hold an ISPA meeting to discuss the results of his sensory evaluation, and/or the implementation of direct OT therapy to address his sensory concerns.
- Individual #410's IDT did not hold an ISPA meeting to integrate his PT interventions into his ISP.
- For Individual #272, an IPN, dated 3/20/18, documented that on 3/19/18, the PCP wrote an order for O&M and OT therapy two times a week for six weeks for "staff training and assessment effectiveness for use of active learning center." Although it was unclear why this therapy was ordered or what it would entail, no ISPA was found showing IDT discussion and/or incorporation of the therapy into the individual's ISP.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: A number of individuals for whom Speech Language Pathologists (SLPs) potentially should have completed comprehensive assessments only had updates or	Individuals:

screenings. In addition, the quality of communication comprehensive assessments needed significant improvement. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	ii. For an individual that is newly admitted and screening results 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.	13% 1/8	1/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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% 0/5	N/A	N/A	N/A	0/1	N/A	0/1	0/1	0/1	0/1
d.	Individual receives quality Comprehensive Assessment.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. The following provides examples of problems noted:

- For Individual #35, and Individual #272, the Center did not provide the last comprehensive assessment, and all of the updates since then, as requested. As a result, the Monitoring Team was unable to determine if the SLP conducted the correct type of assessment (i.e., update versus comprehensive).
- For Individual #410, the Center submitted no evidence of a communication assessment. His ISP stated that he communicated verbally, using one word responses, short phrases, and simple sentences. He required a sufficient amount of time to respond. From this description, it appeared that he required at least a screening, if not an assessment. This could not be determined without any form of assessment submitted.
- Similarly, for Individual #157, and Individual #588, the Center submitted no update, comprehensive evaluation, or screening.
- For Individual #142, and Individual #577, the SLPs completed screenings, but the screenings did not include rationales for why communication assessments were not needed/completed. For both individual, the SLP stated that the individual's skills had not changed since the previous year, but it was not clear how that was determined as no assessment was submitted.

d. As discussed above, for a number of individuals (i.e., Individual #35, Individual #410, Individual #272, Individual #157, Individual #588, Individual #142, and Individual #577), based on the documentation the Center provided, the Monitoring Team could not determine if a comprehensive assessment was warranted. The following describes some of the concerns with the two assessments reviewed:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Individual #620's assessment met this criterion. Individual #15's did not discuss his current health status, and provided a limited functional description of relevant communication findings and their relationship to his medical history and diagnoses;
- The individual's preferences and strengths are used in the development of communication supports and services: Neither assessment incorporated the individual's preferences and strengths into recommendations for services and supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Individual #620's assessment met this criterion. Individual #15's assessment listed the individual's medications and potential side effects, but lacked discussion of whether such side effects had been noted for the individual and/or how they potentially impacted his communication;
- 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 #620's assessment met this criterion. Individual #15's assessment provided limited discussion of his functional expressive and receptive communication skills and no discussion of expansion or development. It also provided no functional examples of his deficits in pragmatics or how they would address this issue;
- A comparative analysis of current communication function with previous assessments: For Individual #15, no comparative analysis from previous assessments was noted, except to say he made fair progress over the last year with direct speech therapy. This was not applicable to Individual #620's assessment, because he was newly admitted;
- The effectiveness of current supports, including monitoring findings: This was not applicable to Individual #620 who was

newly admitted. For Individual #15, results of monitoring/observations over the previous year were not cited, and no description was provided of previous supports, except references to direct therapy;

- 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 sufficient justification for why AAC was not considered/trialed;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence to show compliance with this sub-indicator was present for Individual #620. However, for Individual #15, the assessment included no evidence of collaboration; 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 thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

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 oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	N/A	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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: a. For most individuals reviewed, their ISPs did not provide complete functional descriptions of their communication skills, and/or a description of how others should communicate with them. For some individuals, without current screenings or assessments, IDTs did not have up-to-date information about their communication skills and needs.

b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap. For some individuals, without an assessment, it was unclear whether or not the individual needed a Communication Dictionary.

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: More individuals had more SAPs than at the last review; this was good to see. Across these four indicators, performance was about the same as at the last review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
2	The SAPs are measurable.	84% 21/25	3/3	2/3	0/2	2/2	3/3	3/3	2/3	3/3	3/3
3	The individual's SAPs were based on assessment results.	96% 24/25	3/3	3/3	2/2	2/2	3/3	2/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	48% 12/25	1/3	1/3	1/2	2/2	1/3	1/3	1/3	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	28% 7/25	0/3	0/3	2/2	0/2	3/3	1/3	0/3	1/3	0/3

Comments:
The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were two SAPs available for review for Individual #763 and Individual #143 for a total of 25 SAPs for this review.

2. Individual #143's use her headphones and turn on her CD SAPs, Individual #620's basketball SAP, and Individual #740's safe food handling SAP did not have a prompt level identified and, therefore, were scored as not measurable.

3. There was a substantial improvement in this indicator from the last review when 76% of SAPs were based on assessments. In this review Individual #15's reading lyrics SAP was the sole SAP scored as not based on assessment results, because his FSA indicated that he could independently read.

4. Individual #15's reading lyrics SAP was judged not to be practical or functional because he already possessed the skill (see indicator #3). Several SAPs were scored as not practical or functional because they were not clearly related to their ISP goals/vision statement

(e.g., Individual #15's shaving SAP). Other SAPs were scored as not practical or functional because they represented describing behaviors rather than demonstrating them (e.g., Individual #740's safe food handling SAP). Finally, a few SAPs were scored as not practical or functional because they appeared to represent a compliance task rather than the acquisition of a new skill (e.g., Individual #143's wear her headphones SAP).

5. Twenty-eight percent of SAPs had interobserver agreement (IOA) measures indicating that their SAP data were reliable. Ensuring the reliability of SAP data should be a priority for Mexia SSLC.

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: With sustained high performance, and with improved performance, indicators 11 and 12, respectively, might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
11. Individual #891's FSA and vocational assessments were not available to the IDT at least 10 days prior to his ISP.

12. Individual #891 and Individual #143's vocational assessments 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. At the last review, 19 of these indicators were moved to the category of requiring less oversight. For this review, six other indicators were added to this category, in restraints, behavioral health services, dental, and OT/PT.

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

Quarterly psychiatry reviews usually occurred as often as required, but due to staffing turnover, some were missed. Content of the written documentation of these clinics needed improvement/inclusion of additional components. The psychiatry clinics observed by the Monitoring Team were done very well.

There was no on campus neurology-psychiatry clinic. This made the collaborative process more challenging, but not impossible.

Behavioral health internal and external peer review were again occurring as required. Moreover, at the external peer review meeting observed by the Monitoring Team, there was presentation of data and good participation from attendees.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. 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.

Acute Illnesses/Occurrences

Three individuals in the review group had more than three crisis intervention restraints in a 30-day period. The requirements to address the variables around frequent restraint were not occurring. These are indicators 20-23 and should be regularly being met by now. PBSPs and CIPs were in place as required for some, but not all, individuals.

When individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action.

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system

complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

For acute care issues addressed at the Center, overarching concerns included a lack of medical plans for further evaluation, treatment, and monitoring; and a lack of needed follow-up. Although some improvements were noted with regard to assessment and treatment prior to individuals transferring to the ED or hospital, PCP/provider follow-up upon their return continued to be a significant problem.

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 often was not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

For the majority of individuals' chronic or at-risk conditions, PCPs working with IDTs had not conducted medical assessment, tests, and evaluations consistent with current standards of care, and had not identified the necessary treatment(s), interventions, and strategies, as appropriate. Moreover, IHCPs frequently did not include a full set of action steps to address individuals' medical needs. Sometimes documentation was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. However, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Some progress was noted, and the Center should continue 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.

Since the last review, improvement was noted with regard to the provision of prophylactic care, x-rays, and fluoride treatments. Timely restorations continue to be an area requiring focused efforts. In addition, the ISPs of individuals receiving suction tooth brushing should define the frequency as well as the level of monitoring required to address their levels of risk.

Improvement is needed with regard to the quality of the lab sections of the Quarterly Drug Regimen Reviews (QDRRs), and the related recommendations. In addition, providers need to implement agreed-upon recommendations.

Adaptive equipment was generally clean. As a result of the Center's sustained performance in this area, the related indicator will move to the category of less oversight. Proper fit was often still an issue, though, which requires attention.

Based on observations, there were still numerous instances (61% of 41 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., environmental issues, competence, accountability, etc.), and address them.

Psychiatrist participation in the development of the PBSPs declined to 0%.

There was a need for more thorough justification for polypharmacy regimens for more of the individuals. The regimens were reviewed in polypharmacy committee, which was good to see, however, a more in depth discussion of these regimens was needed in this forum.

Behavioral health services progress notes were in place and contained commentary on progress for all individuals. Graphs existed for all individuals, but for some individuals, they were not done for all of the required months of implementation and/or the graphs did not allow for the assessment of progress.

The behavioral health data system for several individuals' PBSP data was not individualized and did not adequately measure their behavior (e.g., moderate to high frequency target behaviors had data only collected once a shift).

The Center's behavioral health data reported that some individuals were making progress. For instance, five individuals were reported to have met their goals. When Center data showed no progress, actions were proposed and taken for only one of five individuals.

PBSP summaries again were in place for all individuals. Ensuring all staff were trained remained at low performance.

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: PBSPs and CIPs were in place as required for some but not all individuals. This should be corrected in order for indicators 24, 25, and 27 to remain in the category of requiring less oversight after the next review. Similarly, indicators 20-23, regarding evaluation of setting and maintaining variables remained below criteria when, at this point, these aspects should be occurring regularly for all individuals. Teams were meeting sufficiently, and had been for the three previous reviews, too. Therefore, indicator 19 will be moved the category of	Individuals:

requiring less oversight. All of the other indicators will remain in active monitoring.											
#	Indicator	Overall Score	740	15	620						
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	67% 2/3	0/1	1/1	1/1						
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	0/1	1/1	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?	0% 0/3	0/1	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	0/1	1/1	0/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).										
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

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.	100% 3/3	1/1	1/1	1/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 3/3	1/1	1/1	1/1						

Comments:
18-29. The scoring of indicators 18-29 was based on a review of Individual #740's 5/23/18 ISPA, Individual #15's 5/3/18 ISPA, and Individual #620's 5/15/18 ISPA documenting a meeting for more than three restraints in 30 days.

18. Individual #15's fourth restraint occurred on 4/28/18, an ISPA to address more than three restraints in 30 days occurred on 5/3/18. Similarly Individual #620's fourth restraint occurred on 5/3/18 and an ISPA to address more than three restraints in 30 days occurred on 5/15/18. Individual #740's fourth restraint occurred on 4/26/18, however, an ISPA meeting to address more than three restraints in 30 days did not occur until 5/23/18.

20. Individual #15's IDT suggested that his history of trauma and abandonment affected his restraints, and the IDT documented that these issues would be addressed in counseling. Individual #740's ISPA discussed several psychosocial issues that may have contributed to his restraints (e.g., not having recent contact with his family, reported injuries/death of family members, etc.), however, no action to address these potential contributing events (e.g., formal or informal consulting, etc.) was documented. Individual #620's ISPA documented several psychosocial issues that potentially could affect his behavior, however, it was not clear that the IDT hypothesized that any of these issues affected these particular restraints, nor were there any documented actions to address them.

21. Individual #740's ISPA indicated that the IDT did not believe that setting events affected his restraints. Individual #15's ISPA indicated that noise may have contributed to his restraints, however, no action was documented to address this potential contributor. The effect of setting events on restraints was not discussed in Individual #620's ISPA.

22. The role of antecedent events on the dangerous behaviors that provoked restraint was not discussed in Individual #740's ISPA. Individual #15's ISPA discussed a list of antecedent events identified in his functional assessment, however, it was not clear that the IDT hypothesized that any of those affected the restraints discussed in this ISPA. Individual #620's ISPA identified demands as an antecedent to his restraints, however, no action to address this contributing event was documented.

23. Individual #15's ISPA identified staff attention as maintaining the dangerous behaviors provoking his restraints. Additionally, the ISPA documented suggestions of modifying the PBSP to better specify how and when Individual #15 would get ongoing staff attention. The potential role of maintaining variables on Individual #740's restraints was not documented in his ISPA. Individual #620's ISPA included a discussion hypothesizing that negative reinforcement was maintaining his restraints, however no actions to address this potential contributing event was documented.

24. Individual #740's PBSP was dated 10/26/16

25. Individual #740 did not have a CIP.

27. Individual #15's CIP was three pages long and not clear. It did not clearly state when he should be restrained.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
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.											
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.											
Comments:												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: As Mexia SSLC makes creates indicators and goals for reduction and for improvement of individuals' psychiatric disorders, data can be collected, and progress determined. Even so, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685	
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	
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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
Comments:												

8-9. Without measurable goals for either reduction or increase, progress could not be determined.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments, changes in the living environment, and alterations to non-pharmacological interventions) were developed and implemented.

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

Summary: Psychiatrist participation in the development of the PBSP declined to 0%. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
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.	67% 6/9	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. The psychiatric documentation generally referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in six examples.

There were some inconsistencies as the diagnoses noted for Individual #15 and Individual #891 in that those in the functional assessment were inconsistent with those reported in the psychiatric documentation. For Individual #740, the behavioral health assessment was outdated as it was performed in 2016 and, therefore, did not include the current/correct diagnoses.

24. There was no documentation of psychiatric participation for the individuals who had a PBSP.

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: These indicators did not apply to any individuals in the review group. However, two of the individuals in the review group would benefit from this collaboration. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

26	Frequency was at least annual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
25 and 27. These indicators did not apply to any of the individuals in the review group.

While some individuals were prescribed medications to address a seizure disorder, these medications were not identified as dual purpose medications, but probably should have been. Mexia SSLC had nine individuals who were identified as being prescribed medications for a dual purpose (i.e., seizure activity and psychiatric symptoms). None of these individuals were in the review group.

There was a need for improvement with regard to neurology consultation and collaboration.

- Individual #620 had a history of seizures and was prescribed two antiepileptic medications with an indication of bipolar mood disorder. Currently, the treating psychiatrist was managing these medications. There was a need for neurological consultation, but this was hampered by this individual's refusal to travel to see a neurologist. This situation was discussed in detail during the monitoring visit.
- Individual #966 was not identified as being prescribed medications for a dual purpose, although he had a diagnosis of Schizoaffective disorder and was prescribed the mood stabilizing antiepileptic medication, Lamictal. There was documentation of review of neurological information in the psychiatric record, however, and this was good to see.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: Quarterly psychiatry reviews usually occurred as often as required, but due to staffing turnover, some were missed. Content of the written documentation of these clinics needed improvement/inclusion of additional components. It was good to observe well-done psychiatry clinics. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
33	Quarterly reviews were completed quarterly.	75% 6/8	1/1	1/1	0/1	1/1	1/1	0/1	N/A	1/1	1/1
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.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:
33. There were delays in the completion of quarterly reviews for two individuals. There was turnover in psychiatric treatment providers and some reliance on locum tenens providers, which may have contributed to this issue. Individual #620 was recently admitted (January 2018), so it was too soon to determine a pattern of regular quarterly reviews.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components. The evaluations were missing from three to seven of the required elements.

35. During the monitoring visit, psychiatry clinics were observed for four individuals, one of these individuals was in the review group. All of the psychiatry clinics observed were good in that there was a good amount of input and discussion between the team members. Both providers made attempts to establish rapport with the individuals. Behavioral health staff provided data to the psychiatrists, but the focus was on behavioral challenges, not specific identified symptoms or psychiatric indicators. As discussed above, there is a need for improvement in the consistency of diagnoses across documents, the consistent identification of indicators, the operational definition of indicators and the provision of data regarding said indicators for use in medication decision making by psychiatry.

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

Summary: Side effect monitoring was not occurring quite as often as required, but even so, required prescriber reviews were not done timely. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
36. There were delays in both the completion of the assessment and the prescriber review of the assessments. Per a discussion with the psychiatrists during the monitoring visit, some of the delays in prescriber reviews were due to staff turnover.

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

Summary:			Individuals:								
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										

Comments:
38. There was a follow-up clinic requested for Individual #143 at the quarterly review in November 2017. The documentation indicated she was to follow-up in three weeks, but she was not seen again until February 2018.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
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.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	10/1	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: 42. Individual #442 and Individual #740 were prescribed psychotropic medication, but their behavioral treatment programs were outdated (i.e., more than one year old). The plan for Individual #740 was dated 10/26/16. It was updated right before the onsite review week (i.e. 7/10/18, almost two years) and shown to the Monitoring Team. The plan for Individual #442 was dated 4/27/17 (more than one year old). The Center reported that it was updated on 7/10/18, but was not shown to the Monitoring Team. It was good to see that both plans were updated.											

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: Individuals were reviewed at polypharmacy committee, however, the committee was not doing a robust review of the regimens. Thorough justification of polypharmacy was evident for one-third of individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	33% 2/6	N/A	0/1	0/1	1/1	N/A	0/1	0/1	N/A	1/1
45	There is a tapering plan, or rationale for why not.	50% 3/6	N/A	0/1	1/1	1/1	N/A	0/1	0/1	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	83% 5/6	N/A	1/1	1/1	1/1	N/A	1/1	0/1	N/A	1/1

Comments:
44. These indicators applied to six individuals. Polypharmacy justification was appropriately documented in two examples. There was a need for improvement with regard to the justification of the medication regimens that met criteria for polypharmacy.

45. There was documentation for thee individuals showing a plan to taper various psychotropic medications or documentation of why this was not being considered. This documentation was located either in the psychiatric documents or in the polypharmacy meeting minutes.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for the five individuals meeting polypharmacy criteria. One individual, Individual #620, was admitted in January 2018. While his name was included in the polypharmacy list, there was no documentation of a review of his regimen.

The polypharmacy committee meeting was observed during the visit. The polypharmacy committee meeting was more of a case review and less of a review of the justification for the medication regimen. This meeting should be a brisk discussion of the polypharmacy regimen with the committee members challenging the psychiatrist to justify their prescribing.

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: Without data that met criteria with indicator 5, progress could not be determined by the Monitoring Team. The Center's data, however, reported that some individuals were making progress. In fact, the Center's data showed that five individuals had met their goals, though there were no updates to goals or creation of new goals. When Center data showed no progress, actions were proposed and taken for one of five individuals. This set of indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/5	N/A	0/1	0/1	0/1	N/A	0/1	N/A	0/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	20% 1/5	N/A	0/1	N/A	0/1	1/1	N/A	N/A	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:

6. Individual #143, Individual #620, Individual #15, and Individual #891 were making progress, however, their data were not demonstrated to be reliable (see indicator #5), so they were scored as zero for this indicator. Individual #740, Individual #763, Individual #966, Individual #442, and Individual #685 were not making progress toward their targeted behavioral objectives.

7. According to the Center's own data, Individual #740's physical aggression and inappropriate verbal behavior objectives were achieved in February 2018, but were not updated by May 2018. Individual #143's physical aggression and pulling her g-tube objectives were achieved in March 2018, but were not updated by May 2018. Individual #763's inappropriate verbal behavior objective was achieved in March 2018 but was not updated by May 2018. Individual #15's inappropriate sexual behavior objective was achieved in January 2018 but was not updated by May 2018. Individual #442's stalking objective was achieved in April 2018 but was not updated by May 2018.

8. Individual #966 was not making progress, however, his progress note indicated that staff would be retrained on his PBSP to address the lack of progress. On the other hand, Individual #740, Individual #763, Individual #442, and Individual #685 were also not making progress, however, there was no evidence in their progress notes of actions to address the absence of progress.

9. This plan was implemented for Individual #966.

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

Summary: PBSP summaries again were in place for all individuals. Therefore, indicator 17 will be returned to the category of requiring less oversight. Ensuring all staff are trained (indicator 17) remained at low performance (though slightly improved from 0% since the last review). Indicators 16 and 18 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
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.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
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.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

16. Individual #763, Individual #15, and Individual #685 had documentation that at least 80% of direct support professionals (DSPs) implementing their PBSPs were trained on its implementation. Although this represents an improvement from the last review when none of staff had documentation of PBSP training, assuring that all DSPs are trained in the implementation of PBSPs should be a priority for the facility.

17. PBSP summaries were present for all individuals.

18. Individual #891 and Individual #740's PBSPs were not written by a behavioral specialist who was enrolled in, or had completed, BCBA coursework.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

Summary: Progress notes were in place and contained commentary on progress for all individuals. Graphs existed for all individuals, too, but for some they were not done for all of the required months of implementation. Internal and external peer reviews were again occurring as required. Moreover, at the external peer review meeting observed by the Monitoring Team, there was presentation of data and good participation from attendees. As a result, indicator 23 will be returned to the category of requiring less oversight. With sustained high performance, indicator 19 might be moved to this category after the next review. Indicators 19 and 20 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
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.	67% 6/9	0/1	0/1	1/1	1/1	0/1	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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
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:

19. All nine individuals' progress notes commented on progress. This represents an improvement from the last review, when 75% of the individuals had monthly progress notes.

20. Individual #740's most recent data were not graphed. Individual #966's graph only contained three months of data. Individual

#891's graphs only contained one month of data. In these examples, data were not being graphed regularly and consistently. Ensuring that PBSP data are graphed in a manner that contributes to data based decisions should be a priority for Mexia SSLC. The behavioral health services department was aware of the need for this to improve.

23. The Monitoring Team observed Individual #620's external peer review. The peer review included several members from state office and directors from other SSLCs. Individual #620 was reviewed in peer review because he had not been progressing as expected. His peer review included the review of his functional assessment, PBSP, and current PBSP data. There was participation and excellent discussion by the behavioral health services team and the members of the external peer review team.

There was documentation at that internal peer review meetings were consistently occurring weekly, and that external peer review meetings were occurring monthly. This represents another improvement from the last review when there was not documentation of weekly internal and monthly external meetings.

Outcome 8 – Data are collected correctly and reliably.

Summary: Data collection systems existed for all individuals. The system for PBSP target behaviors was the same for all individuals (i.e., record once a day at end of the shift). This is adequate for some individuals' behaviors, but not for others. The system for PBSP replacement behaviors was adequate as has been the case for the last three reviews (with two exceptions at the last review). Due to this overall sustained high performance, indicator 27 will be moved to the category of requiring less oversight. Indicators 26 and 30 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	67% 6/9	1/1	0/1	0/1	1/1	1/1	0/1	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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26. Individual #620 and Individual #442's data collection system was individualized to measure their target behaviors.

The target behavior data collection system for the remaining individuals specified that target behaviors that were recorded at least once

a shift.

- For some individuals (e.g., Individual #891), whose targets occurred at a low frequency, this system represented an adequate measure of their target behaviors.
- For others, who had some target behaviors that were occurring at moderate to high rates (i.e., Individual #143, Individual #15, Individual #740), recording data only once a shift may result in an underestimate of the target behavior, therefore, these data systems were scored as 0.

Ensuring that the data system adequately measures all individuals target behaviors should be established as a priority for the behavioral health services department.

27. Replacement behaviors were collected hourly. These data collection systems adequately measured the target behaviors.

30. Goal frequencies and levels of IOA and treatment integrity were achieved for all individuals. Data collection timeliness, however, was not collected for any individuals. Therefore, this indicator was scored 0 for each individual. 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 clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	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 #15 –											

other: Vitamin D deficiency, and polypharmacy/side effects; Individual #620 – other: intracranial hypertension, and seizures; Individual #35 – respiratory compromise, and other: hyperthyroidism; Individual #410 –constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures, and diabetes/metabolic syndrome; Individual #157 – cardiac disease, and skin integrity; Individual #588 – GI problems, and cardiac disease; Individual #142 – diabetes/metabolic syndrome, and respiratory compromise; and Individual #577 – other: adrenal insufficiency, and respiratory compromise).

Individual #157's goal/objective related to skin integrity (i.e., to "improve hygiene" as evidenced by less than three instances of skin integrity problems requiring antibiotic use) was clinically relevant, but because "improve hygiene" had not been functionally defined, it was not measurable. As a result, the related data could not be used to measure the individual's progress or lack thereof.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals with data and analysis of the data often were not available to IDTs. 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 medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.

Summary: In comparison with the last review, the scores for the provision of preventative care improved. Improvement also was noted, but more work is needed to ensure medical practitioners review and address, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	75% 3/4	N/A	N/A	1/1	N/A	0/1	N/A	N/A	1/1	1/1
	iii. Breast cancer screening	50% 1/2	N/A	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A
	iv. Vision screen	100% 7/7	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	vi. Osteoporosis	67% 4/6	1/1	N/A	1/1	N/A	0/1	N/A	1/1	1/1	0/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	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.	44% 4/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1

Comments: a. The following problems were noted:

- Center staff had documented little information regarding Individual #620's vaccination status. He had refused vision and hearing screenings numerous times.
- For Individual #272:
  - On 9/4/14, she had two polyps removed during a colonoscopy. No pathology was documented. As a result, it was unclear whether she had undergone the proper screening, because the frequency of follow-up is largely based on the pathology of the polyps.
  - In August 2016, a recommendation from a mammogram was to follow up in 2017, but documentation was not submitted to show this occurred.
  - On 2/4/16, a DEXA scan showed osteoporosis with follow-up needed in one year. However, documentation was not submitted to show this occurred.
- For Individual #577, on 6/4/15, a DEXA scan showed osteopenia. However, documentation was not submitted to show that follow-up occurred.

b. For a number of individuals reviewed, the PCP had not discussed metabolic syndrome in the annual medical assessment, even when the individual had risk factors and/or met criterion.

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 continue in active oversight.

#	Indicator	Overall Score	Individuals: 15	620	35	410	272	157	588	142	577
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	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: a. On 10/15/15, Individual #577's legally authorized representative (LAR) signed a DNR Order. The form did not appear to be properly completed. The Center provided no clinical justification for accepting the DNR as one staff would implement.

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

Summary: For acute care issues addressed at the Center, overarching concerns included a lack of plans for further evaluation, treatment, and monitoring; and a lack of needed follow-up. Although some improvements were noted with regard to assessment and treatment prior to individuals transferring to the ED or hospital, follow-up upon their return continued to be a significant problem. The remaining indicators will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	20% 2/10	0/1	1/1	0/1	N/A	N/A	0/2	0/1	1/2	0/2
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.	30% 3/10	0/1	1/1	1/1			0/2	0/1	1/2	0/2
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.	73% 8/11	1/1	1/1	2/2	2/2	1/1	0/1	0/1	N/A	1/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	88% 7/8	1/1	1/1	2/2	2/2	N/A	0/1	N/A		1/1
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.	82% 9/11	1/1	1/1	2/2	2/2	1/1	0/1	0/1		2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 5/5	N/A	N/A	2/2	N/A	1/1	1/1	N/A		1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency	20% 2/10	0/1	0/1	1/2	0/2	0/1	1/1	N/A		0/2

	consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.										

Comments: a. For six of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #15 (right great toe nail avulsion on 4/28/18), Individual #620 (tinea cruris on 1/12/18), Individual #35 (pressure ulcer/blood blisters on 6/4/18), Individual #157 (hidradenitis suppurativa on 2/26/18, and nail avulsion on 1/6/18), Individual #142 (choking on 12/29/17, and allergic rhinitis on 2/22/18), and Individual #577 (respiratory infection on 4/20/18, and respiratory infection on 5/16/18).

PCPs assessed the following acute issues according to accepted clinical practice, and conducted necessary follow-up assessments at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #620 (tinea cruris on 1/12/18), and Individual #142 (allergic rhinitis on 2/22/18).

Overarching concerns included a lack of plans for further evaluation, treatment, and monitoring; and a lack of needed follow-up. The following provide examples of concerns noted:

- On 4/28/18, nursing staff documented that Individual #15 kicked a trash can and injured his right foot. When the nurse examined the foot, the nail of the right great toe was partially avulsed. On 4/29/18, a nurse documented that the toenail was removed. It was not clear if the nurse removed the toe nail, or if it was removed prior to the nurse's follow-up. On 4/30/18, a nurse documented wound care. It was noted that the PCP was aware of the injury. On 5/1/18, a nurse documented that the nail bed was beefy red and local wound care continued. The records did not include any documentation to show that the PCP conducted an evaluation. On 5/9/18, the PCP documented a podiatry consult note for an appointment on 5/9/18. The summary did not address the toe nail avulsion.
- On 6/3/18, nursing staff documented that the direct support professional discovered a blister on Individual #35's right great toe. On 6/4/18, the PCP documented that the individual had a subungual hematoma, as well as a blood-filled blister related to trauma and diabetes. Habilitation Therapies was consulted due to "frequent pressure blisters on right foot." Another PCP completed follow-up, and noted the blisters were healed and no further treatment was warranted. There was no documentation of a plan to prevent further pressure ulcers for this individual with diabetes and recurrent foot ulcers.
- On 2/26/18, nursing staff documented that Individual #157's right axilla had open areas. The PCP was notified and prescribed antibiotics. On 2/27/18, the PCP evaluated the individual. The PCP documented that there was no history of nausea, vomiting, or abdominal pain. The exam was pertinent for a draining lesion in the right axilla. Oral antibiotics and topical antibiotics were continued. The PCP completed and/or documented no follow-up for hidradenitis suppurativa. The next PCP evaluation was on 3/7/18, and this was related to abdominal pain.
- On 12/29/17, nursing staff documented that Individual #142 choked on a nacho chip. He reportedly turned blue and grabbed his throat. Three abdominal thrusts relieved the obstruction. The PCP assessed the individual approximately two hours later, and noted that he experienced a choking episode and was "doing well despite some coughing and wheezing." The plan was to provide nebulizer treatments and place the individual on a clear liquid diet. Dysphagia was listed as a diagnosis, but there was no plan to address it or the choking episode. The speech language pathologist's (SLP's) evaluation documented that there was no evidence of dysphagia. However, the individual was impulsive, and the recommendations were to slow the pace of eating, and for the IDT to consider whether the individual would benefit from a dining plan.

On 12/30/17, the PCP assessed the individual and again documented bilateral wheezing and scattered rhonchi. The diagnosis was acute bronchitis/cough variant asthma, status post (S/P) choking. Augmentin was prescribed. The PCP did not order a chest x-ray for this individual who continued to wheeze after a choking episode. On 12/31/17, the individual reportedly had improved. Auscultation of the lungs revealed occasional scattered rhonchi. The assessment was acute bronchitis, allergic rhinitis and dysphagia, but there was no plan to address dysphagia or choking. The next PCP note was on 1/25/18, and it addressed urinary issues.

- The acute event related to Individual #588 potentially swallowing baby oil is discussed below.
- On 4/19/18, a nurse documented that Individual #577 experienced an increase in coughing. "Cough syrup" and nebulizer treatments provided no relief. On 4/20/18, the PCP evaluated the individual and documented that the lungs were clear. An antibiotic and Tessalon Perles were prescribed. The plan was to follow up in three days. The diagnoses of "Upper Respiratory/Persistent hacking cough" was not clear and not consistent with the International Classification of Diseases (ICD) nomenclature.

  On 4/23/18, the PCP evaluated the individual and noted that his cough had improved, but the lungs had some crackles. The plan was to complete the course of antibiotics and continue the Tessalon Perles. The PCP stated: "No need to follow-up." In addition to being inconsistent with current guidelines, closer follow-up for an infectious process was warranted.

  Nursing staff continued to document an intermittent cough. On 5/16/18, another PCP evaluated the individual, and noted that he had a productive cough, as well as a recent history of pneumonia and treatment with multiple antibiotics. A chest x-ray was obtained and showed bilateral effusions and basilar atelectasis versus pneumonia. The PCP did not conduct and/or document follow-up or the chest x-ray findings.

  On 6/2/18, Individual #577 was transferred to the ED for respiratory distress and returned to the Center. On 6/6/18, he was hospitalized with aspiration pneumonitis.

c. For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #15 (right leg cellulitis on 5/19/18), Individual #620 (evaluation of IIH), Individual #35 (aspiration pneumonia on 1/11/18, and hypoxia on 1/18/18), Individual #410 (altered mental status on 4/11/18, and altered mental status on 4/25/18), Individual #272 (humerus fracture on 12/7/17), Individual #157 (pancreatitis on 2/14/18), Individual #588 (aspiration pneumonia on 3/22/18), and Individual #577 (influenza on 1/20/18, and pneumonia on 3/21/18) .

c. through e., g., and h. The following provide examples of the findings for these acute events:

- It was positive to see that the following individual displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #35 (hypoxia on 1/18/18).
- On 5/19/18, the direct support professional reported that Individual #15 complained of right leg swelling and pain. The nursing assessment demonstrated right lower leg swelling. The PCP was notified and gave an order to send the individual to the ED for evaluation. The individual refused transfer. The PCP then ordered that 1 gram (gm) of intramuscular (IM) Rocephin be administered and the individual be scheduled for sick call.

On 5/20/18, the PCP evaluated the individual. The physical exam showed erythema and edema of the dorsal right foot extending into the calf. There were no obvious open lesions, but the PCP commented that the individual had erythema at the tip of the right great toe with a toenail that "appears to have been cut really short." Also, the PCP documented that the individual had extremely callused and cracked feet, worse on the right. The diagnosis was cellulitis of the right lower extremity with minimal response after parenteral broad spectrum antibiotics. The individual was referred to the ED for evaluation.

He was evaluated in the ED and returned to the Center. On 5/21/18, the PCP (another PCP) conducted a follow-up assessment. The assessment did not mention that the individual was seen in the ED or the outcome of the assessment. The physical exam of the right extremity only mentioned that there was redness. Antibiotics were to continue. The next PCP documentation was on 5/25/18. The exam of the extremity only stated that the individual had a blister with swelling of the right lower leg. The plans were to follow up in two weeks and continue the antibiotic. On 6/4/18, the PCP documented the cellulitis had resolved.

- On 2/2/18, Individual #620 returned from the ED. Although the PCP documented follow-up assessments on 2/3/18, and 2/4/18, none of the follow-up assessments documented the mental status or neurologic status of the individual, which was the primary reason for having the ED evaluation.
- On 4/11/18 at approximately 6:47 a.m., nursing staff documented that Individual #410: "looked clammy, sleepy and sweaty took his vs [vital signs] asked him questions he denied pain trouble breathing said he felt fine [sic]." At approximately 10:00 a.m., the PCP assessed the individual and noted that the individual was oriented, but groggy, ataxic, cranky, and oppositional. The Physical exam was "LUNGS AND COR AT BASELINE." [The Monitoring Team assumed "COR" referred to heart.] He was transferred to the ED by state vehicle for evaluation of altered mental status. At approximately 1:10 p.m., the individual returned to the Center. The PCP did not conduct and/or document an evaluation after the individual's return from the ED. However, the PCP wrote a note documenting a discussion of the ED findings and a plan for nonslip shoes. On 4/16/18, the first medical documentation was done. While the PCP noted the follow-up was for altered mental status, the PCP did not provide documentation related to mental status or a neurologic exam. The plan was limited to referral to psychiatry and follow-up in one week.

  Nursing and Habilitation Therapies staff continued to document that the individual was unsteady and had documented falls. The PCP did not conduct and/or document follow-up in one week. On 4/25/18, the PCP made an IPN entry. This note documented that the CT scan of the head, completed on 4/20/18, was normal. At around 7:00 p.m., the PCP documented that the individual was seen for confusion, altered mental status, and not ambulating well. His blood pressure was also elevated. At approximately 8:00 p.m., he was transferred by Center vehicle to the ED for evaluation. At approximately 11:55 p.m., he returned.

  On 4/26/18, the PCP evaluated the individual. The assessment was fluctuating sensorium and gait instability. The plan was to obtain a neurological consult as soon as possible, and check an ammonia level. Again on 4/26/18, the PCP assessed him. It was not clear if his altered mental status had improved. It was noted that he was being treated for an otitis media. It was not until 5/1/18, that the PCP evaluated him again.

  Even though a great deal of information was provided (i.e., IPN entries often contained unnecessary information, such as allergies, social history, etc.), the actual clinical status of the individual relative to the immediate problem of altered mental

status was not clearly stated. The PCP provided no comments related to worsening or improvement of the individual's mental status.

- On 12/7/17, at approximately 6:49 a.m., direct support professionals noted Individual #272 had an injury to her left arm. At approximately 7:20 a.m., a nurse assessed her, and at approximately 8:00 a.m., she transferred to the ED for evaluation of a possible fracture. She was evaluated in the ED, and at around 2:00 p.m., she returned to the Center.

  At approximately 3:45 p.m., the PCP assessed the individual, and noted that she was evaluated in the ED and was diagnosed with a comminuted fracture of the left upper humerus. The plan was to continue immobilization with a sling, provide pain medication, and follow-up with orthopedics in three to five days.

  The PCP conducted no further follow-up of this serious injury. On 2/19/18, over two months later, the PCP conducted the next assessment. This assessment was due to a bruise that was reported on her left upper arm. The assessment was that there was no new injury. The examination was incomplete as it did not include the appropriate components for thorough assessment. The exam should have documented inspection, palpation, and range-of-motion of the extremity, but it did not.
- On the morning of 2/13/18, Individual #157 complained of abdominal pain, and at approximately 9:00 a.m., the PCP evaluated him. The assessment was diffuse abdominal pain. It was also documented that he experienced emesis earlier that morning. A KUB was ordered and laxatives were prescribed. The individual continued to complain of abdominal pain, but the PCP did not complete a re-assessment of his abdomen that day. On 2/14/18, nursing staff documented that the individual was clammy and complained of dizziness. The nursing note indicated: "Individual stated I am hurting. I feel like I'm dying." The PCP did not evaluate him, but at approximately, 8:35 a.m., a state vehicle transported him to the ED. He was diagnosed with septic shock, pancreatitis, acute renal failure, and dehydration. He was transferred to another hospital due to the need for intensive care unit (ICU) level care.

  On 2/18/18, he underwent a cholecystectomy due to gallstone pancreatitis. On 2/19/18 at 5:30 p.m., he returned to the Center. At approximately 12:21 a.m. on 2/20/18, he was transferred again to the ED due to low oxygen saturations, tachypnea, fever, and abdominal pain. He was admitted to the hospital with necrotizing pancreatitis.

  On 2/22/18, he returned to the Center, and on 2/23/18, the PCP saw him. On 2/24/18, another PCP saw him, and documented the assessment as Acute pancreatitis "doing as expected." There was no specific plan of care or plan for monitoring and follow-up. On 2/27/18, the next PCP assessment related to follow-up of hidradenitis suppurativa.
- On 3/18/18 at 9:40 p.m., nursing staff documented that Individual #588 was suspected of ingesting an unknown amount of baby oil. The note stated: "near empty bottle of baby oil on counter in room." The nurse placed him on the suspected pica incident protocol, requiring nursing assessment every four hours for 72 hours. The nurse did not notify the PCP.

  On 3/19/18, at 1:00 p.m., nursing staff documented that two of the Center's PCPs were notified regarding the need see the individual on sick call. The PCP's response was that there was "no need to be seen on sick call," but that nurses should monitor Individual #588 for signs and symptoms of aspiration.

  On 3/20/18, there was one nursing note that indicated the individual was sleeping. Therefore, nursing staff had not completed

and/or documented any assessments.

Based on documentation reviewed, at no point did any PCP contact Poison Control for guidance on ingestion of a non-edible liquid. A phone call or use of the Poison Control online tool would have alerted the health care providers to the possibility of toxicity. Baby oil is a hydrocarbon that poses an increased risk of aspiration due to its slippery nature.

On 3/22/18, at 6:45 a.m., nursing staff reported Individual #588 was in respiratory distress with a respiration rate of 45 and oxygen saturations of 84 to 86%. The PCP was contacted and the individual was transferred to the ED for evaluation.

A chest x-ray done in the ED showed right upper lobe and right perihilar pneumonia. The individual experienced respiratory distress and was air-flighted to a higher level of care. He was admitted to the ICU. The chest x-ray showed bilateral pneumonia. He experienced respiratory distress and was intubated. He required Pressors for blood pressure support. He failed attempts at extubation, and, therefore, bronchoscopy was performed. Cultures were negative and the secretions were reported as thick. He developed acute respiratory distress syndrome (ARDs) and multi-organ failure. The parents elected to withdraw ventilator support. On 3/28/18, he died.

- On 1/20/18, nursing staff documented that Individual #577 "has been coughing all shift." The nurse noted his lungs were clear. A nebulizer treatment was given along with Robitussin. During sick call, the PCP evaluated the individual and documented that the cough did not improve with Robitussin. The assessment was chronic cough in individual with history of chronic cough and aspiration. The cough was considered "baseline." On 1/21/18, the PCP reevaluated the individual due to a productive cough, fever, and lethargy. The physical exam was pertinent for a respiratory rate of 35 and crackles evident on the lung exam. The individual was transferred to the ED for evaluation due to overall clinical deterioration, hypoxia, and tachypnea.

  He was diagnosed with Influenza and returned to the Center. On 1/22/18, the PCP saw him, and noted that Tamiflu was prescribed. Droplet precautions were implemented. On 1/24/18, the PCP documented that the individual appeared to feel better. Bilateral wheezing was present on the lung exam. The plan was to continue Tamiflu and nebulizer treatments, and follow up as needed. Even though the PCP documented wheezing on the 1/24/18 exam, the PCP did not conduct additional follow-up.

  Nursing staff completed ongoing documentation of a cough, sometimes during mealtimes. On 3/19/18, a nurse documented assessment of the individual following coughing during mealtime. On 3/21/18, a nurse again documented coughing during lunch. On 3/27/18 at around 6:10 a.m., the individual had three loose stools, was very weak with oxygen saturation of 83%, and a respiration rate of 43. At 7:15 a.m., the individual vomited, had another loose stool, had oxygen saturation of 78%, and a respiration rate of 40 to 42. It appeared that the PCP was notified and requested that Individual #577 be placed on sick call. At approximately 7:30 a.m., two other PCPs appeared to have been notified of the individual's condition. Emergency Medical Services (EMS) was contacted, and at approximately 8:05 a.m., the individual was transferred to the ED.

  The individual was admitted to the hospital with pneumonia, and on 4/1/18, returned to the Center. The PCP wrote a very brief assessment noting the individual had bilateral pneumonia due to aspiration. There was no documentation of how the

pneumonia was treated in the hospital or what specific antibiotic treatment would continue at the Center.

On 4/2/18, the PCP saw Individual #577, documented the treatment provided during hospitalization, and noted that antibiotic treatment wound continue. The plan for aspiration was "aspiration precautions."

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	71% 10/14	1/2	N/A	2/2	2/2	2/2	0/2	N/A	1/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	71% 10/14	1/2		1/2	2/2	1/2	2/2		1/2	2/2
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.	57% 8/14	0/2		2/2	2/2	2/2	0/2		1/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	85% 10/13	1/2		2/2	2/2	2/2	2/2		1/1	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A		N/A	N/A	1/1	N/A		N/A	N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #15 for podiatry on 5/9/18, and podiatry on 2/14/18; Individual #35 for hematology/oncology on 3/22/18, and renal on 3/17/18; Individual #410 for neurology on 3/27/18, and gastroenterology (GI) on 1/25/18; Individual #272 for neurology on 1/11/18, and eye on 3/13/18; Individual #157 for dermatology on 4/12/18, and podiatry on 4/12/18; Individual #142 for eye on 12/4/17, and eye on 6/7/18; and Individual #577 for endocrinology on 4/4/18, and podiatry on 2/28/18.

a. For many of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements. The exceptions were the consultations for Individual #15 for podiatry on 2/14/18 (for which no PCP IPN was found); Individual #157 for dermatology on 4/12/18, and podiatry on 4/12/18; and Individual #142 for eye on 6/7/18 (for which no PCP IPN was found).

b. Four of these reviews did not occur timely, including for Individual #15 for podiatry on 2/14/18 (for which no PCP IPN was found), Individual #35 for hematology/oncology on 3/22/18, Individual #272 for neurology on 1/11/18, and Individual #142 for eye on 6/7/18 (for which no PCP IPN was found).

c. Approximately half of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exceptions were for Individual #15 for podiatry on 5/9/18, and podiatry on 2/14/18; Individual #157 for dermatology on 4/12/18, and podiatry on 4/12/18; Individual #142 for eye on 6/7/18; and Individual #577 for endocrinology on 4/4/18.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exception of the following: For Individual #577, the PCP agreed with the important recommendation related to increasing the medication dose during times of stress/illness, but did not implement the recommendation. In addition, because PCPs had not written notes for two consultations, it was unclear whether or not they agreed with the recommendations.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Summary: For the majority of individuals' chronic or at-risk conditions reviewed, medical assessment, tests, and evaluations consistent with current standards of care had not been completed, and/or the PCP had not identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 15	620	35	410	272	157	588	142	577
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.	44% 8/18	1/2	0/2	1/2	2/2	1/2	1/2	1/2	1/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #15 – other: Vitamin D deficiency, and polypharmacy/side effects; Individual #620 – other: intracranial hypertension, and seizures; Individual #35 – respiratory compromise, and other: hyperthyroidism; Individual #410 –constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures, and diabetes/metabolic syndrome; Individual #157 – cardiac disease, and skin integrity; Individual #588 – GI problems, and cardiac disease; Individual #142 – diabetes/metabolic syndrome, and respiratory compromise; and Individual #577 – other: adrenal insufficiency, and respiratory compromise).

a. For the following individuals' chronic or at-risk conditions, 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: Individual #15 – other: Vitamin D deficiency; Individual #35 – other: hyperthyroidism; Individual #410 – constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures; Individual #157 – skin integrity; Individual #588 – cardiac disease; and Individual #142 – respiratory compromise. The following provide examples of concerns noted:

- Individual #15 was treated with a number of medications for his medical and psychiatric diagnoses. He received two second-generation antipsychotics, which increased his risk for metabolic and endocrine problems. He was overweight. He had vitamin D deficiency, which was treated, had long-term proton pump inhibitor (PPI) use, and long-term antiepileptic drug (AED) use, thereby increasing the risk for osteoporosis. He was prescribed lithium. The creatinine levels were at the upper limit of normal for this 33-year-old individual. This should be monitored very closely and further assessment of renal function might

be warranted.

- According to Individual #620's AMA, he was "recently diagnosed with intracranial hypertension, so hypertensive encephalopathy and was put on a medication called Diamox…" However, intracranial hypertension and hypertensive encephalopathy are two distinct syndromes. The use of Diamox was consistent with the diagnosis of idiopathic intracranial hypertension (IIH). The PCP provided no information about how the diagnosis was made. Moreover, in the AMA, there was no documentation to suggest that the PCP planned to obtain the medical records related to this diagnosis. IIH is diagnosed according to the modified Dandy criteria:
    - Symptoms and signs of increased intracranial pressure;
    - No other neurologic abnormalities or impaired level of consciousness;
    - Elevated intracranial pressure with normal cerebrospinal fluid (CSF) composition;
    - A neuroimaging study that shows no etiology for increased intracranial pressure; and
    - No other apparent cause of intracranial hypertension.

  The psychiatrist appeared to manage both the seizure disorder and the IIH. Upon the individual's admission in January 2018, there was no documentation of referral to a neurologist.

  In the AMA or interim medical review, the PCP did not discuss any of the signs or symptoms of IIH that should be monitored. The individual and/or staff could report some signs and symptoms, including headache, visual changes, dizziness, balance problems, and nausea/vomiting. The IHCP did not include action steps related to educating the individual and/or staff, and reporting symptoms should they occur.

  On 2/1/18, the PCP made an IPN entry stating that he contacted the office of a neurologist who had seen the individual. A staff member at the office relayed the recommendations from the neurologist. The recommendation was to transfer the individual to the ED for evaluation, completion of a computed tomography (CT) scan of the head, and possibly a spinal tap. The PCP noted this was needed to evaluate "Intracranial Hypertension Encephalopathy." There was no additional discussion of how the PCP would clarify this diagnosis.
- Individual #620 had the diagnosis of seizure disorder. His last reported seizure was four to six months prior to his admission in January 2018. In the AMA, the PCP documented that the individual was prescribed Tegretol and Depakote. There was no information related to seizure classification and seizure activity. The interim medical review provided no additional information. Unfortunately, the PCP did not outline any plan for further evaluation or to obtain previous medical records.
- According to Individual #35's IRRF, on 10/13/17, she was treated at the Center for aspiration pneumonia. Her IDT rated her at high risk for aspiration. The AMA did not include the diagnosis of aspiration pneumonia and did not discuss the aspiration risk. The PCP included no medical plans of care in the AMA.
- Individual #272 met the criteria for metabolic syndrome with abnormal high density lipoprotein (HDL) and triglycerides (TG) and increased waist circumference. The PCP had not documented this diagnosis in the active problem list, or the AMA. Based on a QDRR recommendation to assess lipid status and consider a statin, the PCP decided to obtain a nutrition consult and follow-up on the lipids.
- Individual #157 was prescribed Lotensin for management of hypertension. At the time of his AMA, his blood pressure was 148/88. This indicated poorly-controlled hypertension for a young adult. However, there was no plan to address the elevated blood pressure. Moreover, the blood pressure readings documented in IView were consistently greater than 130/80.

- According to the AMA, Individual #588 was treated with omega 3 fatty acids for hyperlipidemia. He also had a family history of cardiovascular disease and a body mass index (BMI) of 28.1. The PCP provided no discussion of the atherosclerotic cardiovascular disease (ASCVD) risk scores. The January 2018 QDRR documented an ASCVD risk score of 2.1%. It should be noted that this was based on lipids that were treated with fish oil.
- Per Individual #142's AMA, his A1c values were normal. However, all of the A1cs from late 2017 and 2018 were abnormal, in that they ranged from 5.7 to 6.2. Current American Diabetes Association (ADA) guidelines state that A1c values between 5.7 and 6.4 are diagnostic for prediabetes.

  The PCP acknowledged that the individual was at risk for metabolic disturbances based on the use of quetiapine. However, the PCP did not diagnose the individual with prediabetes; therefore, there was no plan to address the abnormal A1c values. According to ADA guidelines, all patients with prediabetes should have lifestyle modifications implemented. Moreover, for some individuals, pharmacologic therapy should be considered to reduce the risk of Type 2 diabetes mellitus.
- Individual #577's PCP prescribed hydrocortisone for management of adrenal insufficiency. The individual also had yearly assessment by endocrinology. For the most part, the PCP followed the recommendations of the endocrinologist; however, it did not appear that the cortisone dose was increased during illness. The AMA provided no additional information for this important diagnosis. This is a very serious condition, and the IDT should have been made aware of signs and symptoms of adrenal insufficiency.
- Following multiple hospitalizations and episodes of apparent aspiration, Individual #577's PCP appeared to provide little to no interventions to address the aspiration. Antibiotics and nebulizer treatments were prescribed for the multiple episodes of pneumonia. However, the etiology of the lung injury/pneumonia was not addressed. That is, the PCP did not adequately address the cause of the pneumonia/pneumonitis.

  Following the individual's June 2018 hospitalization, the PCP (different from previous PCPs) attempted to address the concern of aspiration of oral secretions through the use of a scopolamine patch. Even so, it was not clear that that oral secretions were the etiology of the aspiration pneumonitis. Pneumonitis can be caused by aspiration of sterile gastric contents as well.

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. However, documentation was sometimes found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 15	620	35	410	272	157	588	142	577
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	44% 8/18	1/2	0/2	1/2	2/2	1/2	1/2	1/2	1/2	0/2

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 only sometimes were implemented. The IHCPs for which documentation showing completion of actions step included those for: Individual #15 – other: Vitamin D deficiency; Individual #35 – other: hyperthyroidism; Individual #410 – constipation/bowel obstruction, and other: hyperthyroidism; Individual #272 – seizures; Individual #157 – skin integrity; Individual #588 – GI problems; and Individual #142 – respiratory compromise.

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	15	620	35	410	272	157	588	142	577
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (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: Improvement is needed with regard to the quality of the lab sections of the QDRRs, and the related recommendations. In addition, providers need to implement agreed-upon recommendations. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
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;	44% 8/18	0/2	2/2	2/2	0/2	0/2	0/2	2/2	0/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	83% 10/12	2/2	0/2	N/A	2/2	N/A	2/2	2/2	2/2	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	50% 3/6	0/1	1/1	N/A	N/A	1/2	1/2	N/A	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. For a number of individuals, the Clinical Pharmacist had not commented on and/or made recommendations related to abnormal lab values.

Individual #272 met criteria for metabolic syndrome, which the Clinical Pharmacist noted. However, the Clinical Pharmacist did not make a formal recommendation to review this for the diagnosis.

For Individual #620, the Clinical Pharmacist did not identify that he met two criteria for the diagnosis of metabolic syndrome (i.e., triglycerides at 150, and high density lipoprotein at 34).

d. When prescribers agreed to recommendations for the individuals reviewed, half of the time documentation was presented to show they implemented them. The following describes problems noted:

- In response to a recommendation to assess Individual #15's elevated lipids, the PCP indicated a referral to the nutrition clinic would be made. No evidence was presented to show this occurred.
- The January QDRR for Individual #272 identified the need for follow up on lab values, dated 11/7/17, but the PCP did not

address them until 5/8/18.

- Individual #157's QDRR, dated 2/9/18, recommended that the MOSES, which was last done on 3/14/17, should be updated. It should be updated every six months, but evidence was not presented to show implementation of this recommendation.

e. As noted with regard to Outcome #1, 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 and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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: 15	620	35	410	272	157	588	142	577
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7	0/1	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% 0/7	0/1	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% 0/7	0/1	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% 0/7	0/1	0/1		0/1	0/1	0/1	0/1	0/1	

Comments: a. and b. Individual #35 was edentulous, and was part of the outcome group, so a limited review was conducted. Individual #577 was edentulous, but was part of the core group, so a full review was completed for him.

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

The Monitoring Team talked with State Office about this issue with the hope that State Office will provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds

leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. 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 maintain optimal oral hygiene.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R	N/R	N/R	N/A	N/R	N/R	N/R	N/R	N/R	N/A

Comments: Individual #35 and Individual #577 were edentulous.

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 and/or implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Since the last review, improvement was noted with regard to the provision of prophylactic care, x-rays, and fluoride treatments. Timely restorations continue to be an area requiring focused efforts. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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.	86% 6/7	1/1	0/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
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.	86% 6/7	1/1	0/1		1/1	1/1	1/1	1/1	1/1	

d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 5/5	1/1	N/A		1/1	1/1	1/1	N/A	1/1	
e.	If the individual has need for restorative work, it is completed in a timely manner.	33% 1/3	0/1	N/A		0/1	N/A	N/A	N/A	1/1	
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	N/A		N/A	1/1	N/A	N/A	1/1	

Comments: a. through f. Individual #35 and Individual #577 were edentulous.

e. On 6/2/17, the dentist identified that Individual #15 required multiple restorations. On 7/19/17, he was accepted for completion of 10 restorations at the local hospital. On 2/1/18, he refused to attend the appointment for the restorations. At the time of the Monitoring Team's onsite review, he had 12 areas needing restoration, and needed an extraction of a tooth that had broken off at the roots.

At the time of Individual #410's 3/27/17 dental exam, he had five areas of decay. His 4/20/18 dental summary showed he had six fillings completed, but 15 areas of decay remained, and his periodontal disease had progressed.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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 the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced dental emergencies.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/1	N/A	N/A	N/R	N/A	N/A	N/A	N/A	N/A	0/1

b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1									0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 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% 0/1									0/1
Comments: a. though d. Individual #35 had good oral hygiene and was edentulous. She was part of the outcome group, so a limited review was conducted. However, of concern, she did not have an IHCP related to dental, so no measurable action step was in place. Similarly, Individual #577 received suction tooth brushing, but his IHCP did not address it.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had an assessment to determine the appropriateness of dentures, including clinically justified recommendations (Round 11 – 86%, Round 12 – 100%, and Round 13 - 86%), Indicator a will move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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	0/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. Individual #588 had three missing teeth, only one of which was a third molar, but the dentist indicated "N/A" for the assessment for dentures.											

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: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from	Individuals:

standard practice and needs to be corrected. The Monitoring Team recognizes that Center staff were working with State Office to correct this issue. These indicators will remain in active oversight.											
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
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.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team has discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to work with State Office to correct this issue.											

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 clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577

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.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	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/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: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #15 – dental, and infections; Individual #620 – constipation/bowel obstruction, and seizures; Individual #35 – diabetes, and GI problems; Individual #410 – falls, and weight; Individual #272 – circulatory, and fractures; Individual #157 – skin integrity, and cardiac disease; Individual #588 – aspiration, and GI problems; Individual #142 – choking, and osteoporosis; and Individual #577 – respiratory compromise, and infections).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #410 – weight.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. 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: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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% 0/11	0/2	N/A	N/A	0/2	0/1	N/A	0/2	0/2	0/2
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).	6% 1/18	0/2	0/2	1/2	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs 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, or that nursing interventions were implemented thoroughly. The exception was for the IHCP related to GI issues for Individual #35.

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- An ISPA, dated 3/12/18, related to restraint, indicated that: "According to staff, [Individual #15] was on his home upset because he wanted Dental to remove a tooth. Dental informed that his tooth was not an emergency at the time and if removed, [the hospital] will have to perform the procedure." The IDT held an ISPA meeting, dated 5/24/18, to review action plans. This ISPA stated: "Dental Note - 4/10/18: Referred to [hospital] for exam with necessary x-rays." Records indicated that he refused to go to the hospital for dental care. However, the ISPAs did not show IDT discussion of action steps to facilitate Individual #15's receipt of the dental care that the dentist indicated he needed.
- On 5/20/18, Individual #15 went to the ED and was diagnosed with cellulitis of his right lower leg and foot. No ISPA was found showing IDT discussion of possible additional supports related to his affected limb, and the soft tissue infection.
- In April 2018, Individual #410 fell on 4/5/18, 4/6/18, 4/12/18 (x3), 4/13/18, 4/20/18, and 4/23/18. Although his IDT held ISPA meetings on 4/9/18, 4/12/18, and 4/30/18, the IDT missed opportunities to assess his fall risk and fall risk scores. Other than the introduction of a gait belt, the IDT made no changes to the IHCP, and did not document discussion regarding what was working or not working, and/or items that needed more measurable action steps.
- Individual #410's nutritional assessment, dated 4/19/18, noted he had a "largely unplanned weight gain of 24 pounds last year, he started to gain wt. in approximately July 2017." An ISPA to address his weight changes was not found.
- On 12/7/17, Individual #272 experienced a serious injury, which was diagnosed as a comminuted fracture of the left humerus and second rib fracture. On 12/7/17, her IDT held an ISPA meeting, but did not conduct a review of the IRRF or IHCP. The IDT developed no follow-up actions related to the fractures themselves.
- On 3/18/18, staff reported that Individual #588 potentially ingested an unknown amount of baby oil. Nursing staff did not immediately notify the PCP/on-call provider of the individual's possible ingestion of a hydrocarbon, which poses an increased risk of aspiration due to its slippery nature. Based on documentation submitted, the IDT also did not hold an emergency ISPA meeting to discuss needed actions for this individual with a history of pica and a high risk for aspiration. Moreover, nurses did not complete and/or document ongoing nursing assessments to address the increased risk that the ingestion posed. As discussed elsewhere in this report, on 3/22/18, Individual #588 was hospitalized, and air-lifted to an ICU. The chest x-ray

showed bilateral pneumonia. On 3/28/18, he died.

- On 12/29/17, at 11:59 a.m., a nursing IPN noted a "stat" call related to Individual #142 experiencing a choking event. Reportedly, he choked on a nacho chip, and required three abdominal thrusts to remove the obstruction. The IDT did not hold an ISPA meeting to review and/or revise the IRRF and/or the IHCP, as needed (e.g., strategies to slow his pace of eating).
- Individual #577 experienced many instances of coughing episodes, some associated with mealtime, including one during the Monitoring Team's medication administration observation. On 3/27/18, he was hospitalized for respiratory distress/aspiration pneumonia, and on 6/6/18, he was hospitalized for aspiration pneumonia. Although the IDT met for post-hospitalization ISPAs, the IDT appeared to focus on the hospitalization, and then, did not delve into whether or not interventions in the IHCP were meeting the individual's needs.

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

Summary: During the Monitoring Team's onsite observations of medication administration, numerous problems were noted. For example, problems were found with medication administration according to the nine rights, PNMP implementation, infection control, and lung assessments, for individuals needing them. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
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).	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	0/1
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/A									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A	0/1

	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.	75% 6/8	1/1	1/1	1/1	0/1	0/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	75% 6/8	1/1	1/1	0/1	1/1	1/1	1/1		1/1	0/1
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 eight individuals, including Individual #15, Individual #620, Individual #35, Individual #410, Individual #272, Individual #157, Individual #142, and Individual #577.

c. For the following individual, nursing staff did not follow the nine rights of medication administration:

- The medication nurse did not provide Individual #577's medication according to the correct route. More specifically, the nurse mixed Robitussin with a full cup of thickened liquid as opposed to mixing it with thickener in a smaller cup. Had the individual refused to consume the entire cup of liquid, the nurse would have been unable to determine whether or not he received the correct amount of medication.

d. The following concerns were noted:

- For Individual #35, who had been hospitalized on 1/2/18 for aspiration pneumonia, the IHCP did not include a measurable action step related to nurses completing lung sounds, but rather referenced a physician's order.
- For Individual #272, the nurse overfilled the maroon spoon, and after the first spoonful, the individual began coughing and her eyes teared up. Although the medication nurse conducted lung sounds, the nurse did so on top of the individual's clothing. The Program Compliance Nurse, who was present with the Monitoring Team member, raised the back of the individual's shirt to facilitate the correct completion of a lung sound assessment.
- For Individual #577, the nurse put Robitussin 10 milliliters (ml) in a full cup of honey-thickened liquid as opposed to mixing it with thickener in a smaller cup. After receiving several spoonsful, the individual began coughing. The Program Compliance Nurse prompted the medication nurse to complete a respiratory assessment. In accordance with the Center's policy, the medication nurse was immediately sent for retraining.

f. Medication nurses did not adhere to the following individuals' PNMPs:

- For Individual #410, the nurse did not use a spoon to administer medication (because she did not have one in the medication cart), but rather used a tongue blade; and
- For Individual #272, the nurse did not alternate bites and sips of fluid, and did not raise the weighted blanket to check to make sure the wheelchair was in the most upright position, and the individual was positioned correctly in the chair.

g. For the individuals observed, nursing staff did not follow infection control practices in the following instances:

- Prior to the administration of medications for Individual #35 and Individual #577, the medication nurses did not follow proper hand hygiene procedures.
- In addition, for Individual #35, before, and during medication administration, the medication nurse did not follow aseptic techniques.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Improvements are needed with regard to IDTs referring individuals to the PNMT, when needed, and/or the PNMT making self-referrals. In addition, overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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% 0/13	0/1	0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	15% 2/13	1/1	0/2	0/1	0/1	0/1	1/2	0/2	0/2	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/1	0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/1	0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/1	0/2	0/1	0/1	0/1	0/2	0/2	0/2	0/1
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 or reviewed by the PNMT, as appropriate;	43% 3/7	0/1	N/A	1/2	0/1	1/1	N/A	N/A	N/A	1/2
	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;	20% 1/5	0/1		0/1	1/1	1/1				1/1
	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 13 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: weight for Individual #15; falls, and GI problems for Individual #620; falls for Individual #35; choking for Individual #410; aspiration for Individual #272; weight, and falls for Individual #157; falls, and aspiration for Individual #588; choking, and falls for Individual #142; and falls for Individual #577.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. 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: weight for Individual #15; and weight for Individual #157.

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 goals/objectives were included. These areas of need included: falls for Individual #15, aspiration for Individual #35, falls for Individual #410, fractures for Individual #272, and aspiration for Individual #577.

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

- Although Individual #15 did not meet the specific criteria for referral to the PNMT for falls, the frequency of his falls over a number of months should have triggered at least a PNMT review of his status. Based on document review, he experienced a varying number of falls depending on the sources. However, at a minimum, it appeared he fell the following number of times per month: September 2017 – 2, October – 1, November – 1, December – 3, January 2018 – 1, February – 6, May – 3, and June – 3.

  In its comments on the draft report, the State disputed this finding, and stated: "The PNMT followed the established criteria. In this case [sic] a lack of resident compliance contributed to trip falls. In addition, many of the identified falls were classified as behavioral and controlled descent. Behavioral Health addressed these concerns." Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a minimum</u> according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. Over several months, this individual's falls continued to place him at significant risk of harm. The Monitoring Team's original finding stands: At a minimum, the PNMT should have conducted a review. Had the PNMT conducted a review, documentation might be available to support the State's contentions about the factors contributing to the individual's falls, and/or additional supports might have been developed and implemented to the benefit of the individual, including supports coordinated between Habilitation Therapies, Behavioral Health, as well as Residential Services staff.
- According to Individual #35's IRRF, on 10/13/17, she was treated at the Center for aspiration pneumonia. No evidence was found to show that her IDT referred her to the PNMT, or that the PNMT made a self-referral. On 1/11/18, she was hospitalized, and again, diagnosed with aspiration pneumonia. On 1/16/18, the IDT made a timely referral to the PNMT for the second aspiration pneumonia.
- Although Individual #410 did not meet the specific criteria for referral to the PNMT for falls, the frequency of his falls over a number of months should have triggered at least a PNMT review of his status. At a minimum, it appeared he fell the following number of times per month: August 2017 – 3, September – 3, October – 3, December – 2, January 2018 – 2, and April – 9. The PNMT minutes stated that he had not had any falls since 4/27/18, after an Ativan reduction on 4/27/18. However, the PNMT conducted no actual assessment to determine if the medication potentially impacted his falls since August, or merely was the potential cause for the increase in April.

  In its comments on the draft report, the State disputed this finding, and stated: "The PNMT followed the established criteria. A number of these reported falls related to the individual's lack of compliance to use the gait belt. Additional falls were actually controlled descents. Behavioral Health addressed these concerns." As stated above, although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined <u>at a</u>

minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. Over several months, this individual's falls continued to place him at significant risk of harm. The Monitoring Team's original finding stands: At a minimum, the PNMT should have conducted a review. Had the PNMT conducted a review, documentation might be available to support the State's contentions about the factors contributing to the individual's falls, and/or additional supports might have been developed and implemented to the benefit of the individual, including supports coordinated between Habilitation Therapies, Behavioral Health, as well as Residential Services staff, for example, to address the individual's unwillingness to use prescribed supports.

- From 9/15/17 to 9/20/17, Individual #577 was hospitalized for aspiration pneumonia. His IDT chose not to make a referral to the PNMT. Reportedly, the PNMT conducted a review. It was unclear why the PNMT did not make a self-referral. On 3/27/18, the individual was admitted to the hospital with pneumonia, and on 4/1/18, returned to the Center. The PCP wrote a brief assessment noting the individual had bilateral pneumonia due to aspiration. On 4/6/18, the PNMT conducted a review and stated that they "found" he had a previous pneumonia and would complete an evaluation that was due 4/30/18. On 6/2/18, Individual #577 was transferred to the ED for respiratory distress and returned to the Center. On 6/6/18, he was hospitalized with aspiration pneumonitis.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: falls for Individual #410.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of clinically relevant and measurable goals/objectives, integrated progress reports with data and analysis of the data generally were not available to IDTs. 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	15	620	35	410	272	157	588	142	577
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% 0/18	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 increased or there was a change in status, there is evidence the team took immediate action.	0% 0/9	0/2	N/A	0/1	0/1	0/1	N/A	0/2	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

	between the PNMT and IDT.										

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, often, documentation was not found to confirm the implementation of the PNM action steps that were included in IHCPs.

b. The following provide examples of findings related to IDTs' responses to changes in individuals' PNM status:

- Reportedly, Individual #15 gained four pounds from February to March, and seven pounds from March to April 2018. However, the IDT did not meet to discuss this unplanned weight gain.
- No evidence was found to show Individual #15's IDT held ISPA meetings to identify the underlying cause(s) and address the frequency of his falls by developing and implementing strategies for prevention. Rather, the IDT merely reported that he had falls. Based on document review, he experienced a varying number of falls depending on the sources. However, at a minimum, it appeared he fell the following number of times per month: September 2017 – 2, October – 1, November – 1, December – 3, January 2018 – 1, February – 6, May – 3, and June – 3.
- At a minimum, it appeared Individual #410 fell the following number of times per month: August 2017 – 3, September – 3, October – 3, December – 2, January 2018 – 2, and April – 9. The IDT had not identified the etiology(ies) for his falls, which would have been the first step in developing a set of strategies to address them, and prevent them to the extent possible.
- Individual #588's IDT appeared to be addressing his falls, as well as behavioral concerns, primarily through one-to-one supervision. An ISPA stated that if he did not have peer-to-peer aggression or fall in a 30-day period, one-to-one staffing would decrease by 30 minutes per day. The IDT had not identified the etiology(ies) for his falls, which would have been the first step in developing a set of strategies to address them, and prevent them to the extent possible.
- On 3/18/18, staff reported that Individual #588 potentially ingested an unknown amount of baby oil, which poses an increased risk of aspiration due to its slippery nature. Based on documentation submitted, the IDT also did not hold an emergency ISPA meeting to discuss needed actions for this individual with a history of pica and a high risk for aspiration. As discussed elsewhere in this report, on 3/22/18, Individual #588 was hospitalized, and air-lifted to an ICU. The chest x-ray showed bilateral pneumonia. On 3/28/18, he died.
- On 12/29/17, Individual #142 reportedly choked on a nacho chip, and required three abdominal thrusts to remove the obstruction. Based on documentation submitted, the IDT did not hold an ISPA meeting to review and/or revise the IRRF and/or the IHCP, as needed (e.g., strategies to slow his pace of eating or completely chew his food, as the SLP recommended).

c. On 8/25/17, Individual #577's IDT held an ISPA meeting with the PNMT to discuss the assessment completed for aspiration pneumonia. They discussed recommendations, but no evidence was found to show the IDT revised the IHCP to include recommended strategies. From 9/15/17 to 9/20/17, the individual was hospitalized again for aspiration pneumonia.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. 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, including Habilitation Therapies as well as	

Residential and Day Program/Vocational staff, should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	39% 16/41	
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.	11% 1/9	

Comments: a. The Monitoring Team conducted 41 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during six out of 11 observations (55%). Staff followed individuals' dining plans during 10 out of 27 mealtime observations (37%). Staff completed transfers correctly during zero out of three observations (0%).

On the Tuesday of the onsite review week, lunch in the Martin residence was very concerning from a safety perspective. All of the individuals ate at or near the same time. The environment was loud, chaotic, and crowded, and staff implemented only two dining plans as written. During recent past reviews, individuals ate in smaller rooms, and evidently, the shift to a larger room occurred recently. Following the observation, the Monitoring Team member spoke with the Home Manager and reviewed the numerous concerns she observed. The Home Manager indicated that staff would implement a plan for individuals to eat in shifts on both sides of the dining room. Based on the Home Manager's request, the Monitoring Team member returned later in the week to observe dinner, and some improvement was noted (although formal rating of this meal did not occur). Although some of the reasons for making the change to the larger room might have had merit, it would have been essential that in making such a change that the residential and Habilitation Therapies team put in place a clear plan for ensuring individuals' safety. In addition, the Center should have conducted its own monitoring immediately upon the initiation of the new environment/procedures to identify problems, and correct any identified issues quickly. These activities did not appear to have occurred.

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: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
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						

Comments: a. None.

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: Most individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 4/18	0/1	4/5	0/1	0/6	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	28% 5/18	0/1	3/5	0/1	2/6	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/18	0/1	0/5	0/1	0/6	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/18	0/1	0/5	0/1	0/6	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/18	0/1	0/5	0/1	0/6	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #620 (i.e., using a rocker knife, cutting soft food with a fork, and using a fork to pierce food). Individual #620's goal/objective to bring pierced food to his mouth was clinically relevant, but not measurable.

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 #410's goals/objectives related to identifying scented products, and increasing his balance.

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. The Monitoring Team conducted full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: For the individuals reviewed, evidence was not found to show that OT/PT supports were implemented. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	0/2	N/A	N/A	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	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. QIDP reviews often stated that the individual met his/her goals without providing data to support such conclusions.

b. Some of the problems with regard to the termination of OT/PT services and supports included:

- Although in an ISPA meeting held on 3/10/18, Individual #620's IDT discussed discontinuing the interventions related to cutting foods. The IDT did not discuss and/or document the specific status of the goals, but rather stated only that he needed more practice and that staff should implement this during mealtime. It was not clear for what aspects of this skill he required continued support.
- The Center did not submit evidence to show IDT review and approval of the discontinuation of Individual #157's OT interventions.

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 had clean adaptive equipment (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator a will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's low scores (Round 11 – 73%, Round 12 – 42%, and Round 13 - 53%), Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**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	469	427	140	60	281	577	567	291	185
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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	53% 8/15	1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		494	160	297	35	61	202			
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		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	0/1	0/1	1/1	1/1	0/1			

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.

c. Based on observation of Individual #140, Individual #60, Individual #577, Individual #291, Individual #160, Individual #297, and Individual #202 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, dental, and communication. At the last review, three indicators were moved to the category of requiring less oversight. At this review, no other indicators will be moved to this category, but one indicator, in communication, will be returned to active monitoring.

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.

In the ISPs, given that all but one of the goals did not meet criteria with all three ISP indicators 1-3 (individualized, measurable, and data available), progress could not be determined. The one goal that met criteria with indicators 1-3 was progressing, which was good to see (same as at the last review).

ISP action steps were not regularly and correctly implemented. Going forward, IDTs need to monitor the implementation of all action plans and address barriers to implementation.

Direct care staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

Overall, there was improvement in the quality of SAPs. The majority of SAPs contained most of the necessary components for effective skill training. A focus on gaining reliable data and correct implementation of SAPs should be a priority for the Center. Most SAPs were not reviewed in the QIDP monthly review, and others were reviewed, but only one or two months of SAP data were presented.

The Center's own engagement scores (89%) were substantially higher than the Monitoring Team's engagement scores (11%, for the same individuals). In order for the Center to improve engagement, it is critical that the Center have a reliable measure of engagement.

Individuals had opportunities for community outings. Goals for outings for recreation and for skill training should be established and met.

Mexia SSLC maintained its long-standing positive working relationship with the Mexia ISD. Some additional efforts to integrate the ISP/IDT with the pubic school program remain needed and should be achievable by the IDTs.

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

Based on the Monitoring Team's observations to determine if individuals were using their AAC devices functionally, the Center regressed with regard to ensuring the devices were present and readily accessible to the individuals. As a result, the related indicator will move back to active oversight. In addition, the Center should focus on ensuring staff prompt individuals to use their AAC devices in a functional manner.

ISPs

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

Summary: Given that all but one of the goals did not meet criterion with all three ISP indicators 1-3 (individualized, measurable, and data available), the indicators of this outcome also did not meet criteria. The one goal that met criteria with these indicators was progressing, which was good to see (same as at the last review). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	891	15	620	685	35	272			
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	1/6			
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	0/6			
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	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.

For 16 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 for almost all of the goals (i.e., indicator 3).

The exception was Individual #272's great independence goal. Data indicated that she had made slight progress towards accomplishing her goal to independently turn on her music.

See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: Implementation of ISP action plans and steps needs to occur. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	891	15	620	685	35	272			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	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. Direct care staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

Staff, however, were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. Going forward, IDTs need to monitor the implementation of all action plans and address barriers to implementation.

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: A focus on gaining reliable data for SAPs will allow for a more robust review of these indicators. Given the available information, performance remained about the same at the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
6	The individual is progressing on his/her SAPs.	4% 1/24	0/3	0/3	0/2	0/2	0/2	0/3	0/3	1/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	67% 2/3	N/A	1/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A
8	If the individual was not making progress, actions were taken.	60% 3/5	0/1	1/1	1/1	N/A	N/A	1/1	N/A	0/1	N/A
9	(No longer scored)										

Comments:
6. Individual #442's budgeting SAP was rated as progressing (and had reliable data). Individual #966's work safety SAP had insufficient data to determine progress (i.e., less than three months of data), and was scored as N/A.

Several SAPs were not progressing (e.g., Individual #891's tracking money SAP). Some SAPs had insufficient data to determine progress, but were scored as 0 because their data were not demonstrated to be reliable (e.g., Individual #15's prepare a pizza SAP) or practical (e.g., Individual #966's kitchen safety SAP).

Some SAPs (e.g., Individual #740's state disease information) were reported by the Center to be progressing, however, they were scored as 0 because they did not have reliable data. Finally, other SAPs (Individual #966's use adaptive equipment SAP) were progressing, but scored as 0 because they were not practical or functional (indicator #4).

7. Individual #740's safe food handling SAP and Individual #442's budgeting SAP achieved the training step's objective and were moved to the next step. Individual #740's state disease information SAP, on the other hand, achieved the training step objective in November 2017, but he was not moved to the next step.

8. Individual #15's shaving, Individual #143's turning on the CD, and Individual #740's budgeting SAPs were not progressing, however, there was action to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Individual #442's identification of traffic signs and Individual #891's tracking money SAPs were also not progressing, however, there was no action to address their lack of progress.

Outcome 4- All individuals have SAPs that contain the required components.

Summary: Almost every SAP had most of the components. With additional attention, these missing components can be added to SAPs. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
13	The individual's SAPs are complete.	12% 3/25	0/3 23/29	0/3 21/29	0/2 16/19	0/2 18/20	1/3 28/30	1/3 28/30	0/3 25/30	0/3 24/29	1/3 24/27

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Three of the SAPs were judged to be complete (i.e., Individual #966's use of adaptive equipment SAP, Individual #15's read lyrics SAP, and Individual #685's sign "bathroom" SAP).

Even so, all of the SAPs contained the majority of these components. For example, 100% of the SAPs had a plan that included:

- a task analysis (when appropriate),
- relevant discriminative stimuli,
- specific consequences for incorrect responses, and documentation methodology.
- 24 of 25 SAPs had individualized consequences for correct responses, a substantial improvement from the last review.

Regarding common missing components:

- One common missing component was the absence of the identification of the training step on the SAP training sheets (e.g., Individual #966's work safety SAP).
- Another common missing component involved multiple step SAPs. The majority of multiple step SAPs indicated that once an individual achieves the objective on one step, they move to the next step. The instructions also state that when training steps, all previously mastered steps should also be presented. There were, however, no instructions as to how staff should respond or record situations when the individual needs additional training on a previously trained step (e.g., Individual #740's budgeting SAP).

Regarding other missing components:

- In some SAPs (e.g., Individual #763's math SAP) it was not clear if training should occur on one step or multiple steps at a time.
- Some SAPs, for example Individual #685's sign "eat" would likely benefit from multiple training trials.
- Some SAPs, for example Individual #891's identify lawn mower parts, did not include a clear plan for maintenance.
    - A complete plan for maintenance should include a plan for how a master skill will be maintained once training is completed.
- Some SAPs did not have clear objectives, either because no prompt level was provided (e.g., Individual #740's safe food handling SAP), or the objective was not clearly stated. For example the objective for Individual #891's tracking money SAP indicated that his objective was to save money, however that SAP taught him how to track his money.
- Finally, several SAPs targeted describing the desired behaviors, rather than targeting the demonstration of the skill. For example, Individual #966's kitchen safety SAP consisted of him answering questions, about kitchen safety, rather than actually requiring him to demonstrate the necessary kitchen safety skills. Being able to describe the steps of an activity does not necessarily result in performing the skill. Generally, it is most useful to directly teach individual's desired skills, such as kitchen safety.

Outcome 5- SAPs are implemented with integrity.											
Summary: Given the planning and development work that goes into creating SAPs, the Center should ensure that they are implemented correctly. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
14	SAPs are implemented as written.	50% 2/4	0/1	Not rated	Not rated	Not rated	2/3	Not rated	Not rated	Not rated	Not rated

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.	28% 7/25	0/3	0/3	2/2	0/2	3/3	1/3	0/3	1/3	0/3

Comments:
14. The Monitoring Team observed the implementation of four SAPs. Individual #966's using his adaptive equipment and kitchen safety SAPs were judged to be implemented and recorded as written. Individual #966's work safety, and Individual #891's identify lawn mower parts SAPs were not implemented as written. The Monitoring Team attempted to observe additional SAPs with other individuals, too, but due to individuals refusing to participate or not showing up for the session, those other SAPs were not observed by the Monitoring Team.

15. Mexia SSLC established that each SAP would have an integrity assessment at least once every six months, and a level of at least 80%. Twenty-eight percent of the SAPs had integrity checks; all of them had integrity measures of 100%. This represents a decrease in integrity and IOA measures of SAPs compared to the last review when 67% of SAPs had an integrity and IOA measure.

The integrity of SAP implementation should be a priority of Mexia SSLC.

Additionally, the discrepancy between the facility integrity scores and the Monitoring Team's scores (indicator 14), however, suggests that the facility's 100% integrity scores may be an overestimate of the accuracy of SAP implementation and recording.

In order for skill acquisition to be most successful, it is important that all staff implement SAPs exactly the same. In order for integrity assessments to be useful, SAP monitors need to critically evaluate if direct care staff are implementing and scoring SAPs as written, and retrain and reassess those staff whose implementation has drifted from the written plan.

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

Summary: Performance was lower than at the last review. Likely, QIDPs and/or SAP managers might need support in how to conduct a monthly review of SAPs and in how to make graphs. These two indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
16	There is evidence that SAPs are reviewed monthly.	26% 6/23	1/1	1/3	2/2	0/2	1/3	0/3	1/3	0/3	0/3
17	SAP outcomes are graphed.	78% 18/23	1/1	3/3	2/2	2/2	1/3	3/3	3/3	3/3	0/3

Comments:
16. The monthly reviews of six SAPs (in QIDP monthly reports) included a data based review (e.g., Individual #143's turn on her CD SAP). Individual #891's identify lawn mower parts and apply sunscreen SAPs had not been implemented at the time of this review and, therefore, were not included in scoring this indicator.

Other SAPs, however, were not reviewed in the QIDP monthly review (e.g., Individual #740's state disease information SAP), and others were reviewed, but only one or two months of SAP data were presented (e.g., Individual #15's read lyrics SAP), which did not allow data based decisions as to whether the SAP was improving or not.

17. The majority of available SAP data were graphed (e.g., Individual #442's budgeting SAP). The graphs did not, however, indicate when steps were achieved (e.g., Individual #740's safe food handling SAP), therefore, making the identification of improvement difficult. It is recommended that Mexia SSLC include indications of when training steps are achieved in their graphs.

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

Summary: Monitoring Team observations of engagement found low engagement and low scores (indicator 18). The Center was not regularly measuring engagement in all sites (indicator 19), which needs to occur if indicator 19 is to remain in the category of requiring less oversight after the next review. Similarly, the Center's own engagement scores might be inflated, leading to the need for this to be assessed (e.g., via inter observer agreement). Indicators 18 and 19 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 891	740	143	763	966	15	620	442	685
18	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found Individual #442 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19. Individual #442, Individual #966, Individual #763, Individual #143, and Individual #891's residences did not have engagement measures in each of the last six months.

21. The Center's engagement data indicated that only Individual #966 did not achieve his goal level of engagement in the month of April 2018. The facility's engagement scores (89% of individuals) were substantially higher than the Monitoring Team's engagement scores (11% of the same individuals).

In order for the facility to improve engagement, it is critical that they first have a reliable measure of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Individuals had opportunities for community outings. Goals for outings for recreation and for skill training should be established and met. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	891	740	143	763	966	15	620	442	685
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	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 #15's ISP indicated that he had a goal of at least two community outings per month, which he achieved for each of the last six months.

There was no evidence of community outings in the last six months for Individual #966.

The other individuals participated in community outings, however, there were no established goals for this activity. Mexia SSLC should establish a goal frequency of community outings for each individual, and demonstrate that the goal is achieved.

23. There was no documentation of the training of SAPs in the community in the last six months for any of the individuals. A goal for the frequency of SAP training in the 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 maintained its long-standing positive working relationship with the Mexia ISD. Nineteen individuals attended school; two of them on-campus at Mexia SSLC, the others in town at the public school campus. Some efforts to integrate the ISP/IDT with the pubic school program remain needed and should be achievable by the IDTs. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	763	620							

25	The student receives educational services that are integrated with the ISP.	50% 1/2	1/1	0/1							

Comments:
25. Individual #763 and Individual #620 were under 22 years of age and attended public school at the time of the onsite review. Individual #763's ISP indicated that his educational services were integrated into his ISP, and were shared with the IDT. Individual #620 did not have documentation that his educational services were integrated into his ISP or relevant ISPAs.

The Center reported, however, on various positive interactions and collaborative activities that were occurring between Mexia SSLC and Mexia ISD.

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.

			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	0/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3	0/1	0/1				0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3	0/1	0/1				0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3	0/1	0/1				0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1	0/1				0/1			

Comments: a. through d. For the three individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.

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: IDTs did not have a way to measure clinically relevant communication goals/objectives. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	11% 1/9	0/1	1/1	0/1	0/1	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% 0/9	0/1	0/1	0/1	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% 0/9	0/1	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The SLP Assistant was working with Individual #15 on a number of goals/objectives, which were different from the previous year. However, the communication assessment did not provide justification for the goals/objectives and/or the changes. As a result, their clinical relevance could not be confirmed. In addition, they were not integrated into the ISP. An ISPA, dated 5/24/18, presented the new goals, but provided no rationale for why the previous ones were dropped.

The goal/objective that was clinically relevant, as well as measurable was Individual #620's goal/objective to state his emotions.

SLPs had not completed assessments for a number of individuals, and had not provided sufficient rationales for not doing so.

c. The Monitoring Team completed full reviews due to a lack of sufficient assessment information to determine the need for communication supports; a lack of clinically relevant, achievable, and measurable goals; and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	620	35	410	272	157	588	142	577
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	0/1	0/1	0/1	N/A	N/A	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	N/A									

	meeting is held to discuss and approve termination.										

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. Examples of concerns included:

- No evidence was found that the QIDP conducted a review of the status of Individual #15's goals/objectives.
- The QIDP monthly reviews for Individual #620 did not provide information regarding his progress on his communication goals/objectives.
- According to Individual #35's QIDP monthly summary, dated 6/18/18, there was no evidence that staff purchased the bone conduction headphones since the need was identified for them during the ISP meeting, held 11/21/17.

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: Based on the Monitoring Team's observations to determine if individuals were using their AAC devices functionally, the Center regressed with regard to ensuring the devices were present and readily accessible to the individuals. As a result, Indicator a will move back to active oversight. The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 451	567	321	685					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance with this indicator, after Round 11, it moved to the category requiring less oversight. However, based on the Monitoring Team's observations for Indicator b, some individuals' AAC devices were not readily available to them. Therefore, this indicator will return to active monitoring.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/5	0/1	0/1	0/1	0/2					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	50% 1/2									

Comments: a. For some individuals, their AAC devices were not present and readily accessible to them. For example, Individual #567's communication wallet was not with him. Staff looked for Individual #685's vocabulary book, but could not find it.

b. It was concerning that in addition to the absence of some communication devices, when opportunities for using the devices presented themselves, staff did not 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, two will be moved to the category requiring less oversight. Progress was observed in a number of areas.

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.

Mexia SSLC's transition department was comprised of a stable, experienced, and active group of professionals. The Admissions and Placement Coordinator (APC), along with the Post Move Monitors, Transition Specialist, and Placement Coordinator were very responsive to feedback and suggestions from the Monitoring Team. They facilitated about 30 transitions since the last review. This is transitioning about three individuals every month. Transitions happened in a timely manner.

Notably, since the last review, a number of individuals experienced PDCTs and some had returned to live at the Center. The need for more thorough preparation of community providers regarding behavioral and psychiatric histories and support needs might have contributed to these occurrences.

Mexia SSLC continued to make progress in the development of pre- and post-move supports. Areas of particular needed focus are making the supports for training of provider staff very detailed regarding the way in which competency will be determined and that the method does indeed test those competencies. There continued to be some aspects of the individuals' lives that were not included in the content/list of post move supports. Transition assessments continued to need improvement and the APC had recently initiated a corrective action plan (CAP) to that end.

Post move monitoring continued to be done as required and thoroughly. Overall, post move monitoring criteria were met for some/many of the supports, but not for all/most of them.

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 continued to make progress. Areas of particular needed focus are making the supports for training of provider staff very detailed regarding the way in which competency will be determined and that the method does indeed test those competencies. There continued to be some aspects of the individuals' lives that were not included in the content/list of post move supports. These	Individuals:

indicators will remain in active monitoring.												
#	Indicator	Overall Score	829	990								
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: Twenty-three individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #829, Individual #990). Both individuals transitioned to community homes operated under the State's HCS program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Mexia SSLC Admissions and Placement staff.

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 individuals' needs and preferences will 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 any needed modifications.

At the time of the last review, the Monitoring Team found the Center had made progress, particularly in defining more specific criteria related to pre-move training, including identifying the staff to be trained and how it intended to confirm staff competency.

To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 10 pre-move supports for Individual #829 and five pre-move supports for Individual #990.
  - For Individual #829, most pre-move supports were for training key provider staff and then delegating responsibility to them for training the remaining provider staff. The supports described content in broad categories, including behavioral needs, communication strategies, food/medication interactions, and social history, but did not specify what knowledge or abilities would constitute competence in those areas. The supports relied on competency quizzes, but those did not cover all needed knowledge or competencies, based on Individual #829's assessments and needs, preferences and strengths in his ISP. For example, a pre-move training support indicated that behavioral health staff would inservice on Individual #829's forensic history, behavioral interventions, behavior support plan (BSP) targets, and environmental conditions that contribute to behaviors. Competency was to be determined by a written quiz. The written quiz did not address all these factors. While it focused on prevention strategies, it did not ask about interventions for challenging behaviors.
  - Individual #990's CLDP included five pre-move supports, four of which were for pre-move training in the areas of forensic/social history and his PBSP. In each case, the support called broadly for Mexia SSLC staff to provide training to either the group home or day habilitation staff, but did not indicate the topics to be included or provide any specific criteria by which provider staff knowledge and competency could be demonstrated.

- Post-Move: The respective IDTs developed 25 post-move supports for Individual #829 and 22 post-move supports for Individual #990. Many post-move supports were measurable, but this was not the case across all of the supports. For example:
    - For both CLDPs, the primary post-move supports that did not meet criterion were those for training any new staff. These supports again did not consistently describe competency criteria or describe adequate competency testing.
    - For Individual #829, a post-move support for behavioral health stated the provider should continue to use the Mexia SSLC PBSP until a new one was developed in the community, but did not provide any details about the PBSP that would have allowed the PMM to measure whether implementation had occurred as needed.
    - For Individual #990, a support called for at least two supervised visits with his mother and grandmother before unsupervised visits could take place. The IDT did not indicate purpose or requirements related to supervision or what needed to be observed in terms of making a determination that unsupervised visits were viable. Also, his overall supervision support did not reference the need to be supervised around children due to his history.

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. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history and needs. Findings included:
    - For both individuals, the IDT did develop some post-move supports related to current behavioral needs. This was positive, but these supports were not fully clear and/or comprehensive.
    - Neither IDT developed pre-or post-move supports that ensured provider staff had specific knowledge of the individuals' significant behavioral and psychiatric histories.
    - Individual #829's CLDP included a support to provide his new school with his communication strategies, but did not address the need to provide the school with behavioral strategies or offer any inservice.
    - Individual #990's CLDP included a support for staff to maintain line of sight supervision while on outings and be close enough to intervene if he exhibited behaviors. It also stated he should not enter or be left alone in restrooms or private areas without staff present. The IDT did not, however, provide a clear support requiring staff knowledge of his history of sexual molestation of a child and how that should be taken into account in his supervision requirements across the board.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in these areas. Both individuals had few elevated risks, but IDTs still needed to address known needs in these areas. The IDTs largely relied on a nurse-to-nurse support to convey information in this area, but these supports did not provide specific detail about what needed to be included. Likewise, supports for establishing care with the community PCP did not include specific expectations about needs for medical

monitoring. Other examples included:

- For Individual #829, the Quarterly Drug Regimen Review (QDRR) indicated he had three risk factors for Metabolic Syndrome and required ongoing monitoring, but CLDP supports did not include this need.
- Individual #990 was considered low risk for cardiac health, but he had a related Integrated Health Care Plan (IHCP) due to a diagnosis of first-degree atrioventricular (AV) block. He had not had any cardiac symptoms over the preceding year, but had received annual/quarterly/PRN nursing assessments and annual/PRN EKGs. The CLDP did not include any supports to ensure provider knowledge of this need. Another support called for establishing care with a new PCP within 30 days to refill medications re-order lab work and to make any referrals that are needed, such as neurology. It did not reference cardiology. The CLDP did not specify any requirement for nursing oversight in this area, such as periodic vital signs. Despite these omissions, it was positive that the community PCP identified the slow heart rate and ordered a cardiology referral.
- Individual #990's AMA indicated he had a sensitivity to aspirin and opioids and a food allergy to apples. The CLDP did not include any specific supports for provider staff knowledge. It would be particularly important for provider staff to have knowledge of the apple allergy because this is a food item that is commonly available.
- Individual #990's CLDP called for his mother and grandmother to have two supervised visits with him before having overnight visits, but the support did not provide any detail about the purpose or nature of the required supervision. It was also not clear upon whose authority this restriction was put in place.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. While both CLDPs did address some outcomes important to each individual, neither CLDP did so assertively. Examples included:
  - Individual #829's CLDP indicated important outcomes were more independent living and being closer to his family. The CLDP did include supports for encouraging family contact, but minimally addressed increased independent living.
  - Individual #829's ISP identified many things that were important to him, such as cooking; integration at school, participating on a basketball team or in other sports, being a member at a church, swimming at local pools, going to an arcade to play video games, fishing at local pond/lake and riding his bike along the bike trail at local parks, going to comic book stores, and taking driver's education. The CLDP did not address any of these.
  - For Individual #990, the CLDP indicated his important outcomes were to be in close proximity to his mother and moving a step close to living independently. Like Individual #829, the CLDP did not address moving toward independent living in an assertive manner.
  - CLDPs should include supports that formalized an expectation that transition will offer enhanced opportunities for an individual to partake in community life as well as the normal rhythms of day-to-day home life. For these two CLDPs, the IDT set minimal/no expectations for meaningful day activities that emphasized community participation and integration. For example, Individual #990's CLDP included two supports, to go out to eat at a restaurant of his choice within 45 days of this move and then monthly thereafter, and to participate in recreational activities of his choice within 45 days and then monthly thereafter. Neither of these provided any specificity about his preferences in these areas, and only monthly was not an assertive expectation in any event.

- Need/desire for employment, and/or other meaningful day activities:
  - Individual #829's IDT developed a post-move support for enrollment in school within seven days of transition.
  - Per Individual #990's ISP, he had a goal to be employed at a train yard within the next two to three years. His CLDP included two employment-related supports: the first was for an initial referral to the Texas Workforce Commission within 60 days. The second, to visit a train station and obtain information on the requirements to work there within six months of his move, was specifically related to his personal employment goal. This was positive, but the IDT should also consider developing supports that describe an actual outcome.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included some elements of positive reinforcement and other motivating components. Neither CLDP addressed this assertively with supports, either in the specific reinforcement techniques in the behavior support plans (PBSPs) or by including reinforcing and/or motivating activities.

- Teaching, maintenance, participation, and acquisition of specific skills: Neither individual had supports for specific teaching, maintenance, participation, and acquisition of specific skills.
  - Individual #829's assessments indicated he needed training with, among other things, combining coins and bills for purchases, verifying and counting change, measuring and following recipes, traffic safety signs, math, writing, and reading. The CLDP did not include any skill-related supports other than to have an assessment for self-administration of medication (SAMS) within seven days; even that had no specific expectation for implementation of a skill acquisition program.
  - Individual #990's CLDP had a broad support calling for him to be re-assessed for new skill acquisition and have plans implemented within 60 days of move, but it provided no information about his current skill levels, needs, or preferences for things he might want to learn.

- All recommendations from assessments are included, or if not, there is a rationale provided: Mexia SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Monitoring Team noted this process was often used very effectively to identify and rectify issues related to clarity, measurability, and comprehensiveness. Still for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification as described above.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Post move monitoring continued to be done as required and thoroughly. Overall, criteria were met for some/many of the supports, but not for all/most of them. The comments below, if addressed, should set the occasion for these indicators to move to meeting criteria. They will remain in active monitoring. With sustained high performance, indicator 3 might be moved to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall	829	990								

		Score									
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
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.	0% 0/2	0/1	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.	0% 0/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	N/A							

Comments:

3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, and occurred at all locations where the individual lived or worked.

4. The PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Findings included:

- As described above under Indicator #1, the language for staff knowledge supports did not specify the competency criteria the PMM needed to be able to accurately collect valid data.
- The PMM often provided comments that were succinct and yet also thorough, which was positive, but needed to continue to focus on ensuring comments included sufficient detail or relevant evidence that provider staff were fully knowledgeable of individuals' needs or that supports had been provided as required.
    - For Individual #829, the PMM did not document obtaining or reviewing the required behavioral data sheet checklist at any of the three PMM visits.
    - For Individual #829, the PMM did not interview new staff for knowledge/competency, but should have.
    - For Individual #990, the PMM documented interviewing staff regarding his social and forensic history at the time of the seven-day PMM visit. The comments indicated staff knew he should be supervised on outings and using public

facilities or anytime around young children. This was positive, but did not address staff knowledge of other factors in his social and forensic history. Again, the IDT did not define the required knowledge or competency criteria for this support, so the PMM did not have all the guidance she needed to obtain and document valid and reliable data in this area.

- Similarly, Individual #990 had another support that called for staff to be inserviced on his PBSP. The PMM documented interviewing staff about inappropriate sexual behavior, but did not reference the other targeted and monitored behaviors.

- The PMM sometimes relied on interview with the provider supervisory/management staff rather than with the direct support staff responsible for implementing the supports. For example, for Individual #829's seven-day PMM visit, the PMM only reported interviewing the provider QA manager about food and medication interactions, behavioral needs, and communication strategies.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP. The PMM found that all of Individual #990's support were in place or not yet due. She identified only two supports as not being in place for Individual #829. These included that had not had a visit with his mother at the time of the 45-day PMM visit, and at the time of the 90-day PMM visit, that day habilitation staff were not aware of his supports. As described above, however, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written and/or a lack of reliable and valid evidence that demonstrated if supports were in place as required.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still some exceptions in which the evidence provided did not clearly substantiate the finding, due to a lack of valid and reliable data. This is described in more detail above in Indicator #4. Those examples are applicable here and form the primary basis for the above scoring

- For Individual #829, a support called for a psychiatry consult within 30 days, which was due on 4/4/18. It was not completed until 4/17/18, but the PMM marked this as completed as required.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed-up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on measurability of the supports and the collection of valid and reliable data to substantiate a determination of compliance with support requirements. As described above, these continued to be areas of deficiency.

Still, it was positive the PMM took action toward resolution when she did identify supports were not in place. The Monitoring Team also encourages the PMM to ensure any needed follow-up is verified on a timely basis. For example, it was positive the PMM identified Individual #829's weight gain at the time of the 45-day PMM visit and requested follow-up by the provider, but verification of follow-up was not obtained until the 90-day PMM visit.

9. The Monitoring Team accompanied one of the post move monitors on the six-month post move monitoring review for Individual #330. Observation occurred at the individual's home. Overall, the PMM was diligent and attentive to detail. Her interaction style was

very pleasant and respectful with the individual and with the staff. She conducted the interview with the individual away from the staff members, which was a good strategy to see being used. She interviewed two direct staff. For future improvement, the PMM should also strive to avoid using leading questions when probing staff knowledge and/or individuals' responses. In addition to the PMM, present at the post move monitoring were two members of the Monitoring Team, the APC, and the Mexia SSLC QA department program auditor for transitions. Thus, there were many more people present than are typically at a post move monitoring visit.

There was one potentially significant discrepancy regarding medication that required a prompt from the Monitoring Team to recognize and act upon. The PMM checked the kitchen and bedroom, but she should also be sure to do a visual check of all of the areas of the home, such as the yard and bathrooms.

10. The PMM's report reflected what was observed by the Monitoring Team.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.

Summary: Both individuals exhibited negative/problem behaviors that resulted in readmission to the Center for one and injury, emergency room visit for the other. The need for more thorough preparation of community providers regarding behavioral and psychiatric histories and support needs might have contributed to these occurrences. The Center also needs to ensure thorough PDCT reviews are conducted. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	829	990							
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.	0% 0/2	0/1	0/1							

Comments:

11. Both individuals had at least one reported PDCT event:

- Individual #829 had experienced several such events, including psychiatric hospitalizations and law enforcement contact, and returned to live at the Center during the monitoring visit.
    - The first PDCT events, for law enforcement contact within 90 days and arrest or incarceration, occurred on 3/23/18, just a few weeks after transition. The group home was called to the school to pick him up because his bus route was not in the system. Group home staff picked him up, but he refused to go inside when they got home. Instead, he smashed the front windshield of staff's car, causing significant damage to the vehicle. He was taken to jail and then transported to juvenile detention. He was released back to the provider group home with extensive stipulations and

was placed on probation. Per the PDCT ISPA, the IDT attributed these events to his frustrated desire to live with his aunt. The provider expressed concern that Individual #829 had memorized his aunt's phone number and may make calls to her without provider's knowledge, so the provider and his mother agreed to schedule phone privileges, requiring that he earn two phone calls per day on Saturday and Sunday. The provider also asked if emergency restraints could be used with guardian consent and the Center agreed.

- The next set of events occurred on 5/17/18, which included an ER visit and a psychiatric hospitalization lasting until 5/24/18. During that stay, medication dosages were again increased and the provider reported behaviors had subsequently improved after he returned to the group home. The provider planned to continue a revised BSP that had been implemented on 5/9/18. The IDT agreed to meet with the provider on 7/11/18 to follow-up and assess progress and/or any additional issues.
- On 7/11/18, the IDT met to discuss additional concerns. Provider staff reported Individual #829 continued to have behavioral episodes and one, involving standing in the street, had resulted in additional police contact. In another, he engaged in property destruction and had contact with a mental health deputy. On the morning of the 7/11/18 meeting, he assaulted a staff member and was taken to the hospital. The IDT discussed that he was seeing the psychiatrist once a month, a counselor twice a month. He had also been seen by the community BCBA and additional revisions to the BSP had been made.
- One week later, on 7/18/18, the IDT and provider met to discuss Individual #829 returning to the Center. On that date, after another behavioral episode, law enforcement told the provider that Individual #829 could no longer attend the day habilitation and needed to be in a more restrictive environment. Per the provider, a revised BSP had been implemented approximately a week and a half before this meeting. He had been to the psychiatrist on 7/12/18 and medications were again adjusted. At that point, the provider and IDT agreed it would be on Individual #829's best interest to return to the Center.

The IDT did not document a robust team discussion regarding anything the Center may have done differently prior to and during transition that may have prevented the events from occurring. Such a discussion is an important part of the PDCT review process, both for purposes of making mid-course corrections, but also for performance improvement for future transitions. Some of the things the IDT should have considered are below:

- The lack of comprehensive behavioral supports, including a failure to establish clear criteria for provider staff knowledge of his BSP and the development of adequate competency-based training in that area.
- A subsequent failure to ensure provider staff could demonstrate competence in the implementation of the BSP.
- A lack of supports for meaningful community integration or supports that focused on what was important to him, as described under Indicator #2 above. The IDT did not document consideration of enriching his routine with preferred activities as a strategy for addressing his behaviors; instead, discussion often focused on restrictions and increases in medications. It was notable that Individual #829 told the PMM at one point that he hadn't expected living in the community to be so restrictive.

- Individual #990 experienced two PDCT events. On 6/19/18, he moved to a new home that was reported to be less restrictive, based on his successful adjustment post-transition. Per the IDT, this was not negative in nature. On 6/26/18, a peer-to-peer altercation resulted in an injury to Individual #990 and an ER visit. He subsequently required oral surgery. The ISPA for this

event indicated words had been exchanged between Individual #990 and another individual at the day habilitation program. Staff attempted to separate the two, but the other individual was still able to strike Individual #990 in the mouth. The PDCT ISPA indicated the two had lived in the same home since Individual #990 transitioned, so it was not clear whether the other also individual moved residences on 6/19/18, or if this was in error. In either case, the ISPA documentation did not indicate the IDT probed or considered whether Individual #990's history of inappropriate verbal behavior, a monitored behavior in his BSP, may have been a factor in this incident. As for Individual #829, the IDT had not developed assertive behavioral supports or otherwise ensure provider staff had knowledge of behavioral history and needed to evaluate whether that may have played a part.

Of the 23 individuals who transitioned since the last monitoring visit, eight (35%) had experienced at least one negative PDCT event. These included ER visits, arrests and incarcerations, two returns to the Center and one death. While the Monitoring Team did not complete a review of each of these and cannot comment on the specific circumstances, the Center should consider completing a careful review of these events to determine if there are common threads. If so, these might contribute to future process improvements in the transition planning processes.

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: Transition assessments continued to need improvement and the APC had recently initiated a corrective action plan (CAP) to that end. The Center continued to work well with the LIDDA. Thus, indicator 18 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	829	990							
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.	0% 0/2	0/1	0/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be	0% 0/2	0/1	0/1							

	trained and method of training required.										
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 dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
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. Assessments did not consistently meet criterion for this indicator. At the time of the last monitoring visit, transition staff had identified this as an area of need and were working toward improvement with various disciplines and through the pre-CLDP process. Overall, transition staff continued to consider this an area of need. The APC reported her office had completed campus-wide training on the requirements for assessments, including measurable, comprehensive and community-specific recommendations, but had not yet seen the desired outcomes. Consequently, the APC had taken the initiative to work with Quality Assurance staff to begin developing a corrective action plan (CAP) to ensure assessments are comprehensive and result in adequate and measurable recommendations. This was a pro-active step. The Monitoring Team considers the following four sub-indicators when evaluating compliance. Findings for each of these are provided below:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Those that did not meet criterion included:
  - The Center did not provide any assessment that addressed Individual #829's educational status, progress, or goals.
  - Vocational staff were not completing discharge assessments with recommendations for individuals' employment needs in the community, instead relying on the FSA update to address those. This translated to minimal employment supports in the CLDPs. Transition staff had identified this as a problem area and had raised the issue administratively.
  - The Center did not provide a copy of an updated Integrated Risk Rating Form (IRRF), but did document IDT review for any needed updates in the CLDP meeting. This was positive. The Center may want to consider formally updating the IRRF document, which could be a useful reference tool for provider staff knowledge. The IRRF was frequently used in provider staff training; in that case, an updated document would be essential.
  - The Center also documented review of the QDRR in the CLDP narrative, but did not discuss any of the needs described in those documents.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Many discipline assessments provided a summary of relevant facts in the available assessments, which was positive. An example of those that did not included Individual #990's social assessment, provided very little information about the nature of his relationship with his family at

present, such as how often he saw them or how he stayed in touch with them.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community and/or specifically addressed/focused on the new community home and day/work settings: Assessments did not consistently meet criterion in this area. Examples included:
    - Assessments did not provide recommendations that could be used to promote community participation and integration for either individual.
    - Both Individual #829 and Individual #990, the recommendations from the medical assessment were broad. For example, for Individual #990, the recommendations included occasional medical exams, tracking vitamin D, dental exams, and intermittent psychological evaluations. None of these included specific time frames.
    - For Individual #990, the FSA listed areas of need that included checking/savings account use, filling out documents, combining coins and bills, measuring, use of small appliances, safe use of large appliances, making appointments for self, reading simple word, writing simple sentences, spelling, and time knowledge. The assessment then made no recommendations for skill acquisition.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) 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: For both individuals, the Center maintained detailed Transition Logs.

These were helpful in understanding how the Center's transition processes ensured necessary participation. Section IV of the CLDP document, entitled Community Living, also provided details of transition activities that described the involvement of the individual and LAR/ family, the LIDDA and Center staff. As it related to whether the CLDP was reviewed with the individual to facilitate their decision-making about supports and services, the Monitoring Team did have some concerns, however. The documentation did not evidence that the IDTs provided the individuals with a clear understanding how/if their CLDPs actually laid out a path toward their stated goal of living independently.

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: Training provided to community provider staff did not yet meet criterion for these two CLDPs, as described below and in Indicator # 1 above. Findings included:

- The Center needed to continue to focus on the development of pre-move training supports that included the identification of competency criteria for provider staff and pre-move training and competency testing. These were needed so that the Center could verify that provider staff were capable of meeting individuals' needs – and particularly their health and safety needs – on the first day of transition. Comments are below:
    - The IDTs did not yet consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated.
    - Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs. The Center relied solely on written quizzes that did not cover many of the individuals' important needs. In addition to ensuring the quizzes were more thorough, the IDTs needed to consider other competency testing

methodologies, such as return demonstration, when appropriate. To continue to move towards compliance, the Center should ensure the written exams it relies on to demonstrate competency are constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs.

- Pre-move training supports often called for the IDT to train key provider staff who would, in turn, train provider direct support staff. While this could be a viable model, it would still require the Center to confirm overall staff competence prior to transition. This was not yet routinely occurring.
- The Center did not require that provider direct support staff be trained on the nursing needs covered in the nurse-to-nurse consultations, even though the DSPs should be aware of signs and symptoms that might need to be reported to the nurse for attention and follow-up.

- For Individual #829, post-move monitoring found that provider staff at the day habilitation program were not familiar with important supports and did not remember the training itself. This should prompt the IDTs and transition staff to re-evaluate the adequacy of their pre-move training strategies and make needed improvements.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Findings included:

- Both CLDPs included supports for nurse-to-nurse collaboration to occur, and the APC reported this positive practice was now standard for all transitions. The IDT should describe the needed content of the collaboration and how the Center can verify all needed information has been received, particularly when it was the basis for all further training for provider staff. The documentation of the nurse to nurse for Individual #829 included some detail, but did not demonstrate it covered all his needs, such as the risk for metabolic syndrome. The documentation for Individual #990 provided even less information, limited to a statement that it had occurred.
- In another positive development, the APC reported on an initiative for collaboration between the Center and community behavioral support staff for the purpose of developing a pre-move interim behavior support plan that would integrate elements of the Center's plan with community-specific requirements. The effective implementation of this initiative may require some technical support from State Office to address barriers to paying community clinicians to participate in the development process.
- The IDTs still needed to provide a clear and comprehensive statement describing their full consideration of any other collaboration needs as well. For example, Individual #829's CLDP Profile indicated he had a history of previous psychiatric medication combination trials that had failed or were not tolerated well, and that the current psychiatric medication combination regimen had been effective and well tolerated so far, so it was being sustained. It further stated that without effective psychiatric medication combination management, he was very prone to deteriorate and revert to dangerous behaviors. The IDT should have specifically considered whether this called for consultation between psychiatrists.

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, based on individual needs. The CLDPs included a reference in this area, but it was not sufficiently descriptive of the specific need for a settings assessment. For example, Individual #829's CLDP indicated in this section that a direct support staff (DSP) and a professional IDT

member accompanied him on his pre-selection visit and were able to engage with him in the new environment to see that he was comfortable in the setting. This was a positive activity, but did not address whether he had any specific need for a clinician to complete a settings assessment. Similarly, Individual #990's CLDP stated the behavioral health specialist (BHS) and registered nurse case manager (RNCM) visited the home and day hab, but did not indicate any specific purpose or outcome.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. 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. Both CLDPs indicated a DSP went on pre-selection visits and pre-move site review, which was positive. In the future, the IDT should also describe any interaction with provider staff.

18. The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the neither of these two PMSRs accomplished this. For both individuals, the PMM documented receiving the signed competency quizzes after the completion of the training, but the quizzes did not cover many of their important needs and were insufficient evidence that provider staff were competent. For Individual #829, it was positive that PMM documented not only receiving the competency test, but also in interviewing a staff member, but the related comments did not provide any specific evidence of competency.

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. This indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	829	990							
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. Both CLDPs met criterion for this indicator.
    - Individual #829 was referred on 6/15/17 and transitioned on 3/6/18. This exceeded 180 days, but the Transition Log documented adequate ongoing activity by transition staff and the IDT to locate an appropriate setting.
    - Individual #990 was referred 11/29/17and transitioned on 5/15/18. This also exceeded 180 days, but again the Transition Log documented adequate ongoing activity by transition staff and the IDT to locate an appropriate setting

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.
    - HHSC PI 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 within past two years, 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 HHSC PI 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
HHSC PI	Health and Human Services Commission Provider Investigations
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
PNA	Psychiatric nurse assistant
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