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.

Overall, even though there remains much that the Center needs to work on, the Monitoring Team was very encouraged by progress seen in a number of areas (as detailed in this report). This was likely due, at least in part, to a number of related factors observed by the Monitoring Team:

- Stable leadership from the Center Director, ADOP, DRS, Unit Directors, and Day program managers.
- Many positive interactions between direct support professionals and individuals.
- A focus on the reduction of peer to peer aggression. The Center took a comprehensive and long-term approach that included collecting and looking at data, utilizing IMRT, implementing Center-wide actions, and developing individual-specific interventions for aggressors and for victims.
- Compared to the last review, there were about half the number of serious injuries and other serious incidents (i.e., about 125 compared with about 65 when looking at tier 1 documents).
- A concurrent focus on engagement and activities. At IMRT, unit directors were required to present the day's upcoming activities. Unit morning meetings also included this topic (e.g., whiteboard on wall in Martin unit), and activities that involved many individuals (e.g., the two fashion shows).
- A similar improvement in day programming options on campus that engaged individuals, such as the culinary room, Creative Creations program, greenhouse, printshop, sewing area, and screen printing area.

There were some individual-specific topics that needed attention:

- Individual #381 was rated at high risk for cardiac issues. He had numerous diagnosed cardiac disorders. Consultation with a cardiac specialist was done last June 2018. While onsite, the Monitoring Team requested the notes from this consultation because it was done prior to the typical tier 2 document cut-off date (previous six months). The document was received right after we departed from the Center. The document suggested that the individual's relevant history and current status were not given to the specialist, perhaps rendering the consultation insufficient.
- Individual #924 was found to be prescribed a ground diet, but the team thought perhaps unnecessarily so. IDT members were pursuing a swallowing assessment and also determining what to do about when he consumed non-ground foods when he was not in the dining room and on routine supervision.

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, 22 of these indicators were in or were moved to the category of requiring less oversight. During this review, no other indicators were moved to the category of requiring less oversight.

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>
Overall, the census-adjusted rate of crisis intervention restraint was the lowest since the Monitoring Team began monitoring this measure in 2015. The average duration of a crisis intervention physical restraint was also the lowest seen at Mexia SSLC, at less than two minutes.

The data on the usage of non-chemical restraint, PTS, and TIVA needs to be better organized and analyzed. There were problems with documentation (and perhaps implementation) of medical restraint and PMR-SIB.

Overall, documentation continued to be done well. Some documentation regarding unit meeting review was not clear for some of the restraints.

It was good to see that for the restraints reviewed, nurses initiated monitoring in a timely manner. However, much improvement is needed with regard to the quality of the monitoring. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing follow-up for abnormalities noted in individuals' vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; ensuring that monitoring

plans are in place for individuals for whom medical restraint is used; and conducting and documenting skin assessments to check for restraint-related injuries.

Psychiatry department was attending to their relevant indicators when crisis intervention chemical restraint was used.

Restraint reduction committee continued to do a thorough review of all restraints. The meeting included video review and participation of IDT members who were involved in the restraint.

Abuse, Neglect, and Incident Management

Mexia SSLC continued to have a high volume of allegations and investigations; about the same number as at the last review (i.e., about 700 during the review period, about one-quarter unfounded, in the tier 1 document).

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.

The conclusions reached in each investigation were acceptable and documentation demonstrating completion of planned follow-up actions continued to be exemplary.

Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury (indicator 1). Staff who regularly worked with the individuals were knowledgeable about ANE and incident reporting. The Center put into place a new review authority protocol (in January 2019), to review HHSC PI and Center-only investigations.

Regarding peer to peer aggression, the Center continued to conduct daily (unit, IMRT), weekly (special presentation at IMRT), and monthly (written report, State Office meeting) reviews of peer to peer aggressive incidents.

Proper/timely reporting had improved. The Center took actions to address this since the last review, such as:

- If the time sequence of reporting was unclear, the UIR added notes at the end to identify this and try and reconcile data and make a final determination regarding timely reporting. This was a very good practice.
- Executive Safety Committee minutes showed that it was tracking reporting/late reporting (to DFPS Intake, and to the Center director/designee) and included data in its monthly reports. This was also a positive practice worthy of note.

There remained serious problems with the timely completion of investigations. Four of 10 by HHSC PI and two of four by the Center (i.e., six of 14) were not completed within the required timeline and/or had missing or incorrect extension requests.

Other

Regarding pretreatment sedation/TIVA, IDTs did not meet the requirements for review, discussion, and planning.

For the applicable individuals reviewed, staff did not report adverse drug reactions timely. Based on documentation submitted, the Pharmacy and Therapeutics (P&T) Committee did not review them. Primary care providers (PCPs) did take necessary clinical follow-up action.

The Drug Utilization Evaluations (DUEs) conducted did not address the issues they were designed to address. In addition, neither DUE resulted in action plans to address the findings/recommendations.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

Summary: Over the nine-month review period, the census-adjusted rate of crisis intervention restraint was the lowest since the Monitoring Team began monitoring this measure in 2015. The average duration of a crisis intervention physical restraint was also the lowest seen at Mexia SSLC, at less than two minutes. The data on the usage of non-chemical restraint, PTS, and TIVA needs to be better organized and analyzed. These indicators remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	797	816	381	595	80	157
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	92% 11/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (June 2018 through February 2019) were reviewed. Overall, across the nine-month review period, the census-adjusted rate of crisis intervention restraint usage at Mexia SSLC was the lowest since the Monitoring Team began monitoring this measure in 2015. Moreover, one-third of the crisis intervention restraints were for one individual (Individual #595).

The frequency of crisis intervention restraints paralleled the overall usage of crisis intervention restraints because most crisis intervention restraints were crisis intervention restraints. The average duration of a crisis intervention physical restraint was also the lowest seen at Mexia since the Monitoring Team began monitoring this measure in 2015. It was under two minutes.

There was infrequent usage of crisis intervention chemical restraint and no usages of crisis intervention mechanical restraint. No individuals were reported to be using protective mechanical restraint for self-injurious behavior (PMR-SIB), however, during the onsite week, it became apparent that the mittens for Individual #626 fell into this category. The Center planned to move forward and change the categorization of this to PMR-SIB. As a result, the Center did not have data regarding amount of time in/out of the device or a fading

plan.

The number of individuals who had one or more crisis intervention restraint each month showed a clear descending trend over the nine-month period, from about 20 per month to less than 10 per month. The Center reported no injuries during application of crisis intervention restraint (though see the outcome/indicators regarding nursing assessments post-restraint below).

The Center did not submit data regarding the use of non-chemical restraints to conduct medical or dental procedures and/or healing. The frequency of usage of pretreatment sedation for medical or dental procedures seemed low, though the Center submitted three graphs with conflicting data (though all of it was low usage). Further, the medical department was tracking data on pretreatment sedation and TIVA; they presented these data at QAQI Council. The Center, with collaboration between the medical and behavioral services departments, should improve the way it tracks the usage of non-chemical, pretreatment sedation, and TIVA/GA for medical and dental procedures.

Thus, facility data showed low/zero usage and/or decreases in 11 of these 12 facility-wide measures (i.e., usage of crisis intervention restraint; usage of crisis intervention physical, chemical, and mechanical restraint; duration of crisis intervention physical restraint; number of individuals with restraint each month; use of PMR-SIB; injuries during restraint; and pretreatment sedation and TIVA for medical and dental procedures).

Restraint reduction committee continued to be active. It was led by the director of behavioral health services. The group reviewed every occurrence of restraint, and looked at video if available. Attendees included direct support and other relevant staff who were involved in the restraint incident. The Monitoring Team attended the meeting during the onsite week. There was a lot of good discussion and decision-making. For instance, for one individual, the group discussed the possible benefits of a change to his day/work program. The team made the decision to make this change.

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. All six received crisis intervention physical restraints (Individual #431, Individual #626, Individual #797, Individual #595, Individual #157, Individual #816), one received crisis intervention chemical restraint (Individual #595), and one received what was described as medical restraint, but turned out to need to be re-categorized as PMR-SIB (Individual #626). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four of these individuals (Individual #431, Individual #626, Individual #797, Individual #816). The other three 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: Overall, Mexia SSLC maintained good performance on these indicators. However, for one individual (Individual #626), there were mistakes, missing entries, or missing restraint plans for the two of his restraints that were chosen for review. This had the result of zero scores for these indicators for Individual #626. Given the Center's history of sustained high performance on these indicators, they will remain in the category of less oversight, however, proper documentation of PMR-SIB and of consecutive restraints needs to occur correctly for these indicators to remain in this category after the next review. That being said, if indicator 11 sustains high performance, it might be moved to this category after the next review. Indicators 9 and 11 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	797	816	595	157			
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.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	50% 1/2					1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #431, Individual #626, Individual #797, Individual #816, Individual #595, Individual #157). Of these, seven were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a medical restraint (that turned out to be PMR-SIB). 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.

3-8 and 10. Both of Individual #626's restraints (1/14/19 physical, 2/4/19 medical/PMR-SIB) were not properly documented. The physical restraint was part of a series of consecutive restraints and the one chosen for review did not have all of the documentation completed, such as various portions of the IRIS template. For the other restraint, the Monitoring Team requested seven days of documentation, but it was not available, nor was a medical restraint plan or PMR-SIB plan in place or available.

This had the result of zero scores for these indicators for Individual #626. Given the Center's history of sustained high performance on these indicators, they will remain in the category of less oversight, however, proper documentation of PMR-SIB and of consecutive restraints needs to occur correctly for these indicators to remain in this category after the next review

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them. All supports were in place to have reduced the likelihood of the behaviors occurring that led to restraint for Individual #595. For Individual #157, there were problems with implementation of the PBSP and various other parts of his ISP.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	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: For two restraints (Individual #626 1/14/19, Individual #797 12/23/18), restraint monitor arrival was not entered or showed late arrival. This indicator (13) will remain in the category of requiring less oversight, but this should be corrected on future restraint documentation, as it had been in the past at Mexia SSLC.			Individuals:									
#	Indicator	Overall Score	431	626	797	816	595	157				
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	0% 0/1		0/1								

	those activities.										

Comments:
14. For Individual #626's medical restraint/PMR-SIB, without documentation, or a written plan, this could not be confirmed.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: It was good to see that for the restraints reviewed, nurses initiated monitoring in a timely manner. However, much improvement is needed with regard to the quality of the monitoring. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing follow-up for abnormalities noted in individuals' vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; ensuring that monitoring plans are in place for individuals for whom medical restraint is used; and conducting and documenting skin assessments to check for restraint-related injuries. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	431	626	797	816	595	157			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/9	0/1	0/2	0/1	0/1	0/3	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/9	0/1	0/2	0/1	0/1	0/3	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/9	0/1	0/2	0/1	0/1	0/3	0/1			

Comments: The restraints reviewed included those for: Individual #431 on 10/31/18 at 1:38 p.m.; Individual #626 on 1/14/19 at 2:55 p.m., and from 2/4/19 to 2/10/19 (medical restraint – mittens); Individual #797 on 12/23/18 at 9:15 p.m.; Individual #816 on 11/23/18 at 7:34 a.m.; Individual #595 on 1/9/19 at 4:55 p.m., 2/27/19 at 12:29 p.m., and 3/8/19 at 11:28 a.m. (chemical); and Individual #157 on 9/12/18 at 6:21 a.m.

a. through c. The following provide examples of findings related to these restraints:

- For each of the eight applicable restraints (i.e., this was not applicable for Individual #626's medical restraint), nursing staff began monitoring at least every 30 minutes from the initiation of the restraint. It was good to see this timely initiation of monitoring. As discussed in more detail below, problems were noted, though, with regard to nurses monitoring vital signs, and mental status.
- For none of the nine restraints reviewed did nurses document individuals' mental status in a way that described the individuals' behaviors in comparison with the individuals' specific baselines. Often, nurses simply made statements such as "no change from baseline."

- For Individual #431, nursing IPNs, dated 10/31/18, at 3:59 p.m., and 11/16/18 at 9:45 a.m. (addendum), indicated that the individual had a "bite mark to the lower right arm close and intact, scrape between right index and middle finger." The nurse did not indicate whether these injuries were the result of the restraint, or if this was unknown.
- For Individual #626's restraint on 1/14/19, the nursing IPN, dated 1/14/19 at 3:39 p.m. referred to the corresponding IView entry for pain and restraint documentation. However, the IView entry, at 2:55 p.m., did not include a pain or skin assessment.
- In response to the Monitoring Team's request for documentation related to the use of mittens as a medical restraint for Individual #626, Center staff submitted a statement indicating that the checklists could not be located for the following dates: 2/4/19, 2/5/19, 2/6/19, 2/9/19, and 2/10/19. An ISPA, dated 2/2/19, noted that on 10/1/18, medical restraint mittens were initiated, and on 12/19/18, the Medical Restraint Plan was discontinued. An ISPA, dated 1/14/19, stated that the Medical Restraint Plan was to be re-written. The ISPA, dated 2/2/19, stated that the PCP issued an order to reinstate the protective mechanical mittens. However, no medical restraint plan was found in the documents submitted for this individual, and his IHCP did not include a plan related to the use of the mittens. Although the PCP had issued physician orders, dated 2/4/19, 2/7/19, and 2/11/19, the orders did not delineate what nursing staff were to observe/assess, when the mittens should be removed, etc. Based on a review of documentation from 2/5/19 to 2/10/19, every 24 hours, nursing staff documented assessments of the individual's vital signs and pain. With regard to assessment of gait, balance, and coordination, the majority of the entries in IView indicated his gait was steady, and he ambulated independently. The majority of the entries included a statement regarding the nurses' assessment of the function/condition of the mittens. With regard to assessment of skin condition/injuries, the majority of the entries did not include assessment of his skin temperature, turgor, moisture, and/or integrity. The only documentation related to mental status indicated "no change from baseline. Center staff did not submit documentation to show the intervals at which the restraints were removed to allow for motion and exercise.
- At times, nurses had not conducted and/or documented skin assessments to check for injuries (e.g., Individual #797 on 12/23/18 at 9:15 p.m.; Individual #816 on 11/23/18 at 7:34 a.m.; and Individual #595 on 2/27/19 at 12:29 p.m.).
- For Individual #595's restraint on 1/9/19, a nurse documented his vital signs at 4:55 p.m., which corresponded with the time he was in restraint, but then no vital signs were documented until 1/10/19, at 8:37 a.m., which included a respiratory rate; and then on 1/10/19, at 8:19 p.m., noting that the individual refused a vital sign assessment, but the nurse documented a respiratory rate.
- For Individual #595's restraint on 2/27/19, in an IView entry, at 12: 50 p.m., the nurse documented abnormal vital signs (i.e., a low temperature of 36.2, and a high pulse rate of 103). At 1:26 p.m., the next IView entry documented that the individual's pulse was still high (i.e., 103). However, the next IView entry was not until 4:50 p.m., at which point, the individual's vital signs were within defined parameters.
- For Individual #595's chemical restraint, nurses followed standards of care with regard to assessing his vital signs, except when he refused a vital sign assessment at 11:38 a.m. At that point, nursing staff did not assess his respiratory rate, which did not require his cooperation.
- On 9/12/18, for the restraint at 6:21 a.m., Individual #157 refused vital signs three times. However, for two of these three refusals, the nurse did not document respirations, which do not require the individual's cooperation. In an IPN, the nurse documented an assessment from six to eight feet away, and concluded that the individual "had no visible injuries." However, the nurse did not describe what portions of the individual's skin were visible, particularly on his torso, given that staff had used a basket-hold technique to restrain him.

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: Some documentation regarding unit meeting review was not clear for some of the restraints (i.e., not entered timely into IRIS). Given the Center's past high performance, a return to high performance at the next review may result in indicator 16 moving to the category of requiring less oversight. Indicator 17 improved to 100%. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	431	626	797	816	595	157				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	63% 5/8	0/1	0/1	0/1	1/1	3/3	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 3/3	1/1		1/1			1/1				
Comments: 16. For three restraints, IMRT review was timely, but unit review was not documented timely or correctly in the IRIS documentation. The Center provided minutes from the daily unit meetings showing that the restraints were on the agenda. Criteria for this indicator also requires proper (timely) documentation in IRIS (usually the unit director's entry).												

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 psychiatry staff completed the require consult and review form. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	595									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1									
48	Multiple medications were not used during chemical restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
49	Psychiatry follow-up occurred following chemical restraint.											
Comments:												

47. The above indicators applied to a crisis intervention chemical restraint regarding Individual #595. The Administration of Chemical Restraint: Consult and Review form was completed within the required timeframe. The medical record also indicated psychiatry follow-up regarding the administration of chemical restraint.

Abuse, Neglect, and Incident Management

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

Summary: For the second consecutive review, all of the investigations/incidents chosen for review showed that supports were in place to reduce the risk of ANE and to reduce the likelihood of the incident occurring in the first place. Protocols for individuals identified by APS for streamlined investigations, and individuals identified by the Center as spurious callers, were being followed. This indicator remains in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	595	80	157	451	706	638
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 14/14	1/1	3/3	2/2	2/2	1/1	2/2	1/1	1/1	1/1

Comments:
The Monitoring Team reviewed 14 investigations that occurred for nine individuals. Of these 14 investigations, 10 were HHSC PI investigations of abuse-neglect allegations (four confirmed, four unconfirmed, one clinical referral, one administrative referral). The other four were for facility investigations of serious injuries, fracture, and fire setting.

About one-quarter of the 723 allegations during the review period were deemed for streamlined investigations due to the frequent unfounded allegations made by specific individuals (and the investigation determinations were that the allegations were unfounded). This was about the same number of allegations as at the last review. The number of serious injuries and other serious incidents, however, declined compared with the last review, that is, from about 125 to about 65.

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 #431, UIR 19-1940, HHSC PI 47499553, unconfirmed allegation of neglect, 10/13/18
- Individual #626, UIR 19-0263, HHSC PI 47581909, confirmed allegation of neglect, 1/7/19
- Individual #626, UIR 19-0222, HHSC PI 47553732, unconfirmed allegation of neglect, 12/11/18
- Individual #626, UIR 19-1861, witnessed laceration, elbow, 9/28/18
- Individual #885, UIR 19-0320, HHSC PI 47605763, clinical referral of an allegation of neglect, 1/24/19
- Individual #885, UIR 19-1945, HHSC PI 47501327, confirmed and inconclusive allegations of physical, emotional, and neglect,

10/31/18

- Individual #595, UIR 19-0336, HHSC PI 47610622, confirmed allegation of physical abuse category 2, 1/28/19
- Individual #595, UIR 19-0253, HHSC PI 47578263, unconfirmed allegation of physical abuse, 1/3/19
- Individual #80, UIR 19-1887, HHSC PI 47467826, facility/administrative referral of an allegation of exploitation, 10/8/18
- Individual #157 and Individual #381, UIR 19-0366, HHSC PI 47633739, confirmed allegation of neglect, 2/13/19
- Individual #157, UIR 19-1855, HHSC PI 47448740, unconfirmed allegation of physical abuse and neglect, 9/24/18
- Individual #451, UIR 19-034, discovered fracture, arm, 2/6/19
- Individual #706, UIR 19-0310, fire setting, 1/20/19
- Individual #638, UIR 19-1823, choking, 9/12/18

1. For all 14 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all 14, all four sub-indicators were met. For the four Center-only investigations of serious injury and other serious incidents, PBSPs or PNMPs were in place, and were being implemented. For the one of the four that needed revision, the revision was done and implemented (Individual #638).

Peer to peer aggression: Mexia SSLC continued to regularly review and take actions regarding peer to peer aggression. Overall, the Center had taken a serious and Center-wide approach to addressing these occurrences and reducing possible future likelihood. Actions included daily review of occurrences at morning unit meeting and IMRT meetings, a weekly detailed discussion at IMRT of the week's peer to peer aggression, regular data review, a weekly phone review with State Office, noticeable improvements to day programming and evening/weekend activities, and the taking of individual-specific actions and programmatic changes.

Streamlined investigations and spurious caller protocols: APS identified four individuals at the Center for streamlined investigations. For two of these individuals, the APS approval/designation process was documented and the SSLC requirement to address the behavior via a plan (e.g., PBSP, PSP) was in place for both individuals (Individual #157, Individual #101). Mexia SSLC also had its own spurious caller policy and list of individuals to whom that policy applied. There were 14 names on this list. For two of these individuals (Individual #157, Individual #462), the Center documented its implementation of its own protocols (e.g., notification of APS, annual review by IMC, documentation of implementation, such as of alleged perpetrator monitoring).

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.	
Summary: The Center engaged in some good practices to monitor and address timely reporting (see comments below). Most incidents were reported in a timely manner that met criteria for this indicator. Of the three that did not, two were beyond the one hour time limit (three minutes, 22 minutes), and one had conflicting	Individuals:

and unreconciled information. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	595	80	157	451	706	638
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	79% 11/14	1/1	2/3	1/2	1/2	1/1	2/2	1/1	1/1	1/1

Comments:

2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other three 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.

- For Individual #626 UIR 19-0263, the reporting of the event followed a typical/logical sequence, but was slightly beyond the one hour time requirement, that is, a 7:56 pm occurrence and a 9:10 pm report (i.e., one hour and 22 minutes).
- For Individual #885 UIR 19-1945, the HHSC PI reports stated the incident occurred at 7:00 pm and DFPS Intake received notification more than one hour later, at 8:29 pm. Though, the UIR stated a 7:30 pm incident occurrence (i.e., in which case, the 8:29 would be within the one hour requirement). The UIR also acknowledged the lack of explanation of these time differences.
- For Individual #595 UIR 19-0336, the incident occurred at 11:41 pm and was reported to DFPS Intake at 12:44 am, three minutes beyond the one hour requirement. The facility director/designee, however, was notified within the one hour, that is, at 12:31 am.

The Center engaged in some good practices regarding timely reporting:

- If the time sequence of reporting was unclear, the investigator/staff were adding notes at the end of UIR to identify this and try and reconcile data and make a final determination regarding timely reporting
- Executive Safety Committee minutes showed tracking of late reporting (including separately looking at reporting to DFPS Intake and to the Center director). These data were included in their monthly reports.

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: For two individuals, the ISP did not contain typical information showing that ANE and reporting information was shared with the individuals and LAR (Individual #626, Individual #80). That indicator (4), however, will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
3	Staff who regularly work with the individual are knowledgeable	Due to the Center's sustained performance, these indicators were moved to the									

	about ANE and incident reporting	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: With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	595	80	157	451	706	638
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 14/14	1/1	3/3	2/2	2/2	1/1	2/2	1/1	1/1	1/1
	Comments:										

Outcome 5– Staff cooperate with investigations.

Summary: In two investigations, there were problems with staff cooperation, but there was nothing in the UIR that identified these problems or took any action. One was for Individual #626 UIR 19-0222 in which an extension request was made because witnesses were unavailable for interview. The other was for Individual #885 UIR 19-1945 in which an extension request reported difficulty in attempts to speak to the speech pathologist and that witnesses had not been cooperative with the investigator. The Center needs to always follow-up and take action if staff are not cooperative with the investigation. This indicator will remain in the category of requiring less oversight.

#	Indicator	Overall Score	Individuals:								
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: All investigations met criteria for these indicators regarding the quality of the investigations' content and analysis, including the one investigation that was a clinical referral back to the Center. With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	595	80	157	451	706	638
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.	100% 14/14	1/1	3/3	2/2	2/2	1/1	2/2	1/1	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% 14/14	1/1	3/3	2/2	2/2	1/1	2/2	1/1	1/1	1/1
Comments:											

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Lack of completion of many investigations within the required time frame re-appeared as a problem during this review for about half of the investigations. The Monitor will leave this indicator (12) in the category of less oversight, but this needs to be improved in order for it to remain in this category after the next review. The Center's investigation review process might specifically look at whether the most frequently occurring two variables needed commentary (i.e., late reporting, late completion of investigation). Indicator 13 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	595	80	157	451	706	638
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were 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/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1)	43% 6/14	1/1	2/3	0/2	0/2	0/1	1/2	0/1	1/1	1/1

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

Comments:

12. Six investigations were not completed within the required time frame and/or did not have extensions or appropriate extensions. In some cases, various investigation activities were not initiated timely, such as staff interviews. This was the case for four HHSC PI investigations:

- Individual #626 UIR 19-0222
- Individual #885 UIR 19-0320 (the Center's UIR completion was late, the HHSC PI investigation was completed on time)
- Individual #595 UIR 19-0336
- Individual #595 UIR 19-0253

And for two Facility-only investigations:

- Individual #626 UIR 19-1861
- Individual #451 UIR 19-034

13. The supervisory review did not detect the various problems in the investigations as noted above (e.g., late reporting, late completion of investigation). 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.

On the other hand, some investigation review were very thorough and provided information on any issues with the investigation (e.g., Individual #626 UIR 19-0263, Individual #638 UIR 19-1823.

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: Serious injury audits were done for all individuals and they were done very well. None of the individuals in the review group required a non-serious injury investigation. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	595	80	157	451	706	638
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

15. None of the individuals required an non-serious injury investigation.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.											
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.											
Comments: 17. Six investigations included a confirmation of physical abuse category 2. For five of these, the confirmed staff member's employment was terminated. In the other, the alleged perpetrator was unknown.												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. The Center improved its set of data for tracking and trending, thus, indicator 19 was scored positively. 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.	Yes										
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. All seven data sets were tracked and trended.

20-23. The trend analysis did not look at any possible inter-dependent variables (e.g., shift, unit, day of week of injuries). There was no discussion regarding action plans; there were no action plans for incident management. Narrative summaries of data, however, were improved.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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	0/1	N/A	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. As discussed in the last report, the Center's policies with regard to "medical clearance" for TIVA, still needed to be expanded and improved. Although the PCP conducted an evaluation of this individual to "clear" him for the procedure, the medical policy needed to be expanded and updated to ensure quality reviews are completed of individuals in preparation for procedures utilizing TIVA. The term "medical clearance" incorrectly implies the procedure carries no risk for the individual. Dental surgery is considered a low-risk procedure; however, the individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation also should address perioperative management, which includes information on perioperative management of the individual's routine medications. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

For this use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and pre- and post-operative vital sign flow sheets were submitted showing that nurses followed the monitoring requirements.

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 for dental procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: 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 for medical procedures.											

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: IDTs did not meet the requirements for pretreatment sedation/TIVA review, discussion, and planning. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/2			0/1						0/1
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.	0% 0/2			0/1						0/1
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.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									
Comments: The scoring of these indicators was based on a review of Individual #885's 11/28/18 TIVA procedure and Individual #157's 3/13/19 TIVA procedure											

1. Available documentation did not reflect a discussion of either individual's need for PTS or supports needed for the procedure.

2-6. No treatments or strategies to minimize the need for PTS were documented.

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	511								
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.	100% 1/1	1/1								
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 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% 0/1	0/1								
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/1	0/1								
e.	Recommendations are followed through to closure.	0% 0/1	0/1								

Comments: a. Since the last review, one individual died. Specifically, on 3/5/19, Individual #511 died at the age of 55 with causes of death listed as aspiration pneumonia, and cerebral palsy.

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of the individual's healthcare, 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. Even when the nursing, psychiatric, and medical reviews identified relevant clinical recommendations, the administrative and/or clinical death reviews did not adopt the recommendations for implementation. For example:

- The medical review identified problems with regard to missing interval medical reviews, and the lack of a clear plan for an acute diagnosis, but these were not adopted for implementation.
- The nursing review identified four clinically relevant recommendation related to retraining of nursing staff on: 1) diarrhea

guidelines and documentation in IRIS; 2) vomiting guidelines for individuals with enteral nutrition and related documentation; 3) when to initiate an acute care plan; and 4) notifying respiratory therapy when an individual is diagnosed with aspiration pneumonia.

- As illustrated in this report, the Monitoring Team identified a number of problems with the provision of care for Individual #511, but the reviews Center staff completed in response to her death did not identify and/or address many of these issues.

In its comments on the draft report, the State disputed the finding that the "Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative & clinical death reviews," and stated: "TX-MX-1904-II.104.C Nursing recommendations were listed on the Nursing Exhibit G template and the Mortality Review Recommendation Log." The Monitoring Team recognizes that the nursing clinical death review the State referenced in its comments included some nursing recommendations. However, the basis for the monitoring team's finding was that the quality of the nursing death review completed was substandard, and, therefore, the death review did not identify the full scope of problems with the nursing care provided to the individual. Therefore, the recommendations identified were incomplete. Moreover, the clinical and administrative death reviews are the meetings at which the mortality review team should discuss and adopt agreed-upon recommendations. The related documentation should include a complete and final list of recommendations.

e. As noted above, the recommendations identified in the death reviews were not adopted as part of the administrative and clinical death reviews. In addition, the documentation submitted did not show implementation/completion dates for the recommendations referenced above.

In its comments on the draft report, the State disputed this finding, and stated: "TX-MX-1904-II.104.J Mortality Review Recommendation log showed implementation date of nursing recommendations." Based on the Monitoring Team's review of the documentation provided on site, there was no column designation for "Date Completed" for any of the recommendations. The document to which the State referred in its comments read: "Pending at this time," but during the onsite review, the Monitoring Team reviewed the log to which it referred in the draft report.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the applicable individuals reviewed, staff did not report adverse drug reactions timely. Based on documentation submitted, the Pharmacy and Therapeutics Committee did not review them. PCPs did take necessary clinical follow-up action. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	ADRs are reported immediately.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the	100%					1/1		1/1		

	individual.	2/2									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2					0/1		0/1		
d.	Reportable ADRs are sent to MedWatch.	N/A									

Comments: a. and b. In April 2018, Individual #638's white blood cell count began to decrease. On 12/1/18, the critical value was reported [i.e., white blood cell count (WBC) of 1.8, and an absolute neutrophil count (ANC) of .4]. He was sent to the ED for evaluation. It was not until 12/6/18, that the potential ADR due to paliperidone was reported. The pharmacy assessment was dated 12/7/18. The PCP's/Medical Review Committee's (MRC's) assessment was dated 1/17/19. The PCP tapered and discontinued the medication. The individual was referred to hematology/oncology for evaluation. The individual was to have labs and follow-up in two weeks. There was no documentation of follow-up with hematology/oncology.

In its comments on the draft report, the State disputed the finding related to the timeliness of reporting of Individual #638's suspected ADR, and stated: "TX-MX-1904-II.21 The critical lab (ADR) was reported to the PCP and acted on immediately (Saturday). The low lab value was reported to the provider on the day the value was obtained. Actions were taken appropriately (as scored in indicator b.). The pharmacy ADR report was completed within one week. This indicator relates to the reporting of the reaction to the provider so that appropriate action can be taken, not the completion of a retrospective report summarizing the events." The State's interpretation is incorrect in that "reporting" refers to the ADR report. As indicated in the audit tool, the data source for determining compliance with Indicator a is the Final ADR form.

For Individual #511, on 9/14/18, the PCP started Loratadine, and on 9/26/18, the PCP discontinued it due to possible intolerance thrombocytopenia, hypocalcemia, and hyperglycemia. On 10/10/18, it appeared the provider was made aware that this should be reported as a suspected ADR. MRC assessment was on 10/17/18.

With regard to timeliness of reporting, the State provided the same rationale as noted above. For the same reason cited above, the Monitor has not changed the finding.

c. For both of these potential ADRs, the P&T Committee meeting minutes documented that ADRs were previously reported. However, the minutes documented that the ADR discussions occurred in the MRC meeting. Thus, there was no documentation of a thorough discussion of the ADRs in the P&T Committee meetings.

In its comments on the draft report, the State disputed this finding, and stated: "TX-MX-1904-II.21 [Individual #511] Page 4 of 5 'P&T Review Comments/Discussion Agreed with MRC 12-10-2018' TX-MX-1904.II.21 [Individual #638] Page 3 of 5 'Physician Response Review MRC Probable 1-17-20' 'P&T Review Comments/Discussion Yes 3-15-20.' This shows P&T reviewed the data and disagreed with MRC's assessment." It remained unclear to the Monitoring Team how these State believed these references to the ADR forms constituted evidence of a thorough P&T Committee discussion of the potential ADRs. If the group discussed specifics from the MRC meeting, then the P&T Committee should have quoted the discussion in its minutes and/or on the ARDR forms, or, at a minimum, included the MRC minutes as an attachment.

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: The DUEs conducted did not address the issues they were designed to address. In addition, neither resulted in action plans to address the findings/recommendations. Both indicators will remain in active monitoring.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

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

- A DUE on selective serotonin reuptake inhibitors (SSRIs) that was presented to the Pharmacy and Therapeutics (P&T) Committee on 9/14/18. According to the DUE, the Pharmacy Director presented the DUE to the P&T Committee on 9/14/18. However, the minutes documented that the meeting occurred on 9/24/18. The staff pharmacist presented the DUE and the Pharmacy Director was absent from the meeting.

  In its comments on the draft report, the State provided the following clarification: "The slides and DUE title page were not changed from the originally scheduled P&T meeting date of 9/14/18. The meeting was postponed to 9/24/18 and the Pharmacist in Charge was out on medical leave." The Monitoring Team appreciates the additional information.

  One of the objectives was to assess the appropriateness, effectiveness, and clinical response of SSRIs. None of the conclusions/recommendations actually addressed this issue. The recommendations were to continue to monitor QT interval while on citalopram and continue monitoring seizure disorder progress on SSRI. There was no action plan to address the recommendations; and
- A DUE on anticholinergic burden (ACB) that was presented to the P&T Committee on 12/10/18. The study stated: "Rational [sic] includes, but is not limited to (1) evaluation of justification for choice of medication; (2) adverse reactions associated with medications; and (3) whether or not there is the presence of scheduled monitoring." The conclusions were:
  - Most individuals showed little correlation between fall rates and high ACB score and psychiatric or constipation polypharmacy.
  - Constipation polypharmacy was not consistent with all individuals with total ACB score > 3.
  - Since ACB might increase the potential for an individual to experience anticholinergic side effects, it is warranted to consider individual ACB potential when the individual's total ACB score is increased.

  The conclusions did not appear to answer the issues stated in the objectives. No plan of correction to address the conclusions/recommendations was submitted.

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, 21 of these indicators were in or were moved to the category of requiring less oversight. For this review, five other indicators were moved to this category, in ISPs, psychiatry, and behavioral health services.

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 attended annual ISP meetings, ISP preparation meetings, ISPA meetings, and a variety of other meetings during which individuals' services and supports were discussed. All individuals were visited at their homes and in their day programs.

The Monitoring Team observed many positives interactions between staff and individuals. Many individuals reported that they were content with their programming, enjoy their jobs, being involved in a variety of activities that they enjoyed, and that staff treated them well and provided needed support.

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.

<u>Assessments</u>
For ISPs, about half of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting. The timely submission of assessments had been identified as an issue that the facility needs to address in the QA/QI Council meeting minutes. Action plans were developed by the facility to address the timeliness of behavioral and psychiatric assessments.

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, 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.

Psychiatric CPEs sustained high performance in terms of format. But, all of the CPEs (but one) were missing components. Psychiatric annual evaluations/assessments and quarterly reviews did not contain all of the required minimum content. One aspect was rationale for diagnoses. That is, these assessments did not show how the individual met the diagnostic criteria.

In behavioral health, there were current, and complete annual behavioral health update for all individuals; current functional assessments for almost all individuals; and complete functional assessments for about two-thirds of individuals. It was good to see that IOA assessments were done and were 80% or higher. Ensuring data collection timeliness (DCT) would then bring indicator 5 into meeting criteria.

Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. In addition, it is essential that Medical Department staff take steps to improve the quality of the annual medical assessments. Four of the nine reviewed were of particularly poor quality.

The Center needs to take steps to ensure the timely completion of dental exams and summaries. The related indicators are at risk of returning to active oversight. The Center should continue its focus on improving the quality of dental exams and summaries. Only two of the nine dental exams met criteria, and none of the dental summaries met individuals' needs.

For all nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, which was good to see. However, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments.

In addition, work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. Improvement is also needed with regard to the details of physical assessments, including, for example, waist circumference measurements, and follow-up on abnormal findings. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice.

It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the Physical and Nutritional Management Team (PNMT) discussed the results. Since the last review, the scores during this review generally showed incremental improvement with regard to timely referral of individuals to the Physical PNMT, and timely completion of reviews and assessments, but work is still needed. The Center should focus on continuing its progress in these areas, as well as completing PNMT reviews for individuals who need them, and improving the quality of the PNMT comprehensive assessments.

The timeliness and quality of Occupational Therapy/Physical Therapy (OT/PT) assessments continue to be areas on which Center staff need to place considerable focus.

Significant work continued to be needed to improve the quality of communication assessments and updates in order to ensure that Speech Language Pathologists (SLPs) provide IDTs with clear understandings of individuals' functional communication status; alternative and augmentative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports is objectively evaluated.

On a positive note, some steps reportedly are underway to improve OT/PT and communication assessments. New assessment templates were in place statewide, which hopefully will assist therapists to improve assessment content and readability. In addition, the Center's Habilitation Therapy Director was auditing every assessment prior to submission to the IDTs. Based on discussions on site, the Habilitation Therapy Director appeared to have a good understanding of the audit tool criteria and was on point with his expectations for assessments. Hopefully, this process will result in constructive feedback to therapists, which will in turn result in improved assessments that meet individuals' needs.

The individual's FSA, PSI, and vocational assessments; These assessments included recommendations for skill acquisition.

Individualized Support Plans

Mexia SSLC showed that personal goals that were meaningful and individualized could be developed for each individual for from two to five personal goal areas (none had goals that met criterion in the health/wellness area). Goals need to be implemented with reliable data collected.

Although many individuals had full meaningful days, this was not reflected in their ISPs. Goals, for the most part, were randomly assigned and did not show a coordinated path to living and working more independently.

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

In psychiatry, there was some progress in that more individuals had psychiatric indicators for reduction identified than at the last review. About half were related to the individual's diagnosis and about one-third were written in observable terminology. There were psychiatric indicators for increase identified for one individual. Goals for psychiatric indicators were not created for any of the individuals.

Signed consent forms were missing for some medications for two of the nine individuals. This needs to be improved in order for indicator 28 to remain in the category of requiring less oversight after the next review.

Behavioral health goals were again written in measurable terms. PBSPs were implemented timely and were updated. The content of PBSPs maintained high performance

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.

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.

All individuals had SAPs, they were mostly measurable and based on assessments. Even so, many (one-third) were not practical, functional, and meaningful. Most did not have reliable data.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

Summary: Mexia SSLC showed that personal goals that were meaningful and individualized could be developed for each individual for from two to five personal goal areas (none had goals that met criterion in the health/wellness area). Overall, performance improved slightly from the last review (from 18 to 20 goals meeting criteria with indicator 1). Goals need to be implemented with reliable data collected. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	381	595	626	885	724	638			
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	3/6	3/6	5/6	4/6	2/6	3/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #381, Individual #595, Individual #626, Individual #885, Individual #724, and Individual #638. 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 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.

The Mexia SSLC's IDTs continued to work toward developing individualized, aspirational goals. For this review period, none of the six ISPs contained individualized goals in all areas; therefore, none had a comprehensive set of goals that met criterion. Still, Mexia SSLC continued to make progress in this area, as described below.

Twenty personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. This was a slight improvement from the number of goals at the last review that met criterion, 18.

The personal goals that met criterion were:

- Leisure goals for all six individuals. Examples included:
    - Individual #381's goal to learn to ride a bike.
    - Individual #626's goal to join a Special Olympics swimming team.
    - Individual #724's goal to attend a Longhorn game with his girlfriend.
- Individual #626's relationship goal to communicate with his family through letters and phone calls met criterion. For Individual #626, the ISP indicated that maintaining a relationship with family was important and something that he could learn to do independently. Also, he was a relatively new admission to this SSLC.
- Relationship goals did not meet criterion included:
    - Individual #595's goal to have a friend or correspondent in the community was not individualized based on his preferences.
    - Individual #885 did not have a relationship goal. His ISP indicated that he had few relationships in his life and often interacted inappropriately with his peers. The IDT needs to focus on helping Individual #885 develop skills that might lead to healthy relationships.
    - Individual #724's goal to continue his relationship with his girlfriend was not aspirational. It was continued from the previous ISP, even though he had met this goal.
    - Individual #638's goal to start a new relationship with someone in the Barnett unit was not individualized or clearly defined.
- Work/School/Day goals for Individual #381, Individual #626, and Individual #885. All had goals to obtain employment based on their specific identified interest.
- These work/school/day goals did not meet criterion:
    - Individual #595 did not have a work goal and had not had a goal for three years. This was particularly concerning because he was 27 years old. His IDT should be focused on supporting him to gain skills that might lead to employment in the near future.
    - Individual #724's vocational assessment indicated that his goal to work at Wal Mart as a custodian was based on the fact that he liked to go to Wal Mart. There was no evidence that he had opportunities to explore other jobs and job

settings to determine possible work preferences. His goal was continued from the previous ISP without any progress towards obtaining a job.
    - Individual #638's work goal to earn up to $10 weekly did not support learning new skills that might lead towards meaningful employment at a job that matched his preferences.
- Independence goal for Individual #595, Individual #626, Individual #885, and Individual #638 met criterion.
    - Individual #381's goal to pop popcorn in the microwave was not a long term goal. SAP data indicated that he was able to independently achieve this goal within the first month of implementation. Training continued without revision eight months into the ISP year.
- Living options goals for all six individuals were aspirational and individualized.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. In order to meet criterion for measurability, personal goals must be measurable in a stand-alone manner, that is, a review of the ISP and action plans is not needed to make this determination. The outcome of the goal must be observable and measurable, and the goal must be specific, clearly defining the conditions under which the goal would be achieved. Vague terminology, such as participation, does not describe actions on the part of the individual working toward goal-achievement.

Of the 20 personal goals that met criterion for indicator 1, none met criterion for measurability.

- Some of the goals did not include measurable behavioral objectives. For example, it was not clear what Individual #638 would have to do to complete his goal to participate in Special Olympics basketball. For instance, depending of staff interpretation, completion might mean playing in one game or might be practicing and playing with a team during a complete season.
- Goals did not include timelines for completion. Many of the goals that should have been achievable within a year had been carried over from the previous ISP without addressing barriers to implementation. IDTs appeared to have no sense of urgency regarding the completion of goals, thus, little action was taken when there was a continued lack of implementation of action plans. Setting a clear timeline for achievement should prompt the IDT to address barriers prior to the next ISP when individuals are not making progress. For example, Individual #724 had a goal to attend a Longhorn game that was not completed the previous year, so was carried over into the current ISP. The IDT should have a clear understanding that this activity is to occur within the current ISP year.
    - For 12 of these 20 goals, the only aspect missing from the goal to meet criteria for measurability was a timeline/ target date for meeting the goal.

3. Because none of the goals were measurable, this indicator was not evaluated. QIDP monthly reviews and SAP data sheets indicated that a majority of the action plans were never implemented. For those that were implemented, consistent data were not available to determine progress towards goals. In most cases, service objectives lacked specific staff instructions for implementation, thus, staff lacked guidance needed to implement action plans. Some examples included:

- For Individual #885's goal to compete in Special Olympics baseball, there were little data that might determine progress towards his goal. QIDP monthly reviews simply noted that he played catch with staff daily.
- Individual #381's ISP indicated that the IDT would develop a safety awareness SAP to support his goal to ride a bike independently. His ISP was developed in July 2018. Through December 2018, the QIDP monthly review indicated that the SAP

was never developed, then the action plan was discontinued in December 2018 without explanation.

- Individual #595's ISP indicated that he would be assessed by the recreation department, then a SAP would be developed to teach him how to play flag football. His ISP was developed in July 2018. The SAP was not developed and implemented until February 2019.

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 reliable 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.

Note: The Monitor initiated a special focused monitoring project to provide additional monitoring of the development of an ISP from the ISP preparation activities, through to the annual ISP meeting, and for the subsequent three months of initial implementation and IDT/QIDP review. In collaboration with State Office and the Monitoring Team, a specific set of activities and a schedule were developed. The project will focus upon one individual, Individual #381. While onsite, the Monitoring Team attended his ISP preparation meeting, provided some general feedback to the team immediately after the meeting, and then met with some members of his IDT, Center QIDP department staff, and State Office to provide more detailed monitoring feedback on the initial proposed set of personal goals.

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

Summary: Performance across this set of ISP quality characteristics remained about the same as at the last review. That is, scores were low, though there were some examples of criteria being met or close to being met. All indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 381	595	626	885	724	638			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	1/6	3/6	1/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	1/1	0/1	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	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

	adaptive needs.										
14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	1/1	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.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
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	0/6			

Comments:

8. Twenty 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 (i.e., for this indicator 8). 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.

Five of 20 goals had action plans that supported the achievement of those goals. These were:

- Individual #595's greater independence goal.
- Individual #626's relationship, work, and greater independence goals.
- Individual #885's greater independence goal.

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. Many action plans stated what staff would do, but not what action the individual would take to show progress towards accomplishing his/her goal. Thus, data often indicated how many times staff had implemented the plan instead of measuring specific progress of the individual towards the goal. IDTs still needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related.

Examples of goals that did not have action plans that would lead to achievement of the goal included:

- Individual #724 had a goal to work at Wal-Mart as a custodian. Action plans to support that goal were (1) continue employment at CEC, (2) when he goes shopping at Wal-Mart, staff will show him the location of where to apply for employment quarterly, and (3) he will go shopping at Wal-Mart monthly.
- Individual #885 had a goal to work as a janitorial assistant at Mexia SSLC. Supporting action plans were (1) Set a timer for 30 minutes when asked "are you ready to work?," (2) routine supervision, and (3) he will exhibit no more than two episodes of aggression to others per month.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. For the most part, goals and action plans

were based on individual preferences, however, opportunities for making choices were limited. Action plans ensuring opportunities for work and day programming based on preferences and supported by exposure to new activities were particularly limited.

IDTs were generally not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, tv, and activities routinely offered at the facility.

Opportunities to make meaningful choices were limited. Expanding choices may result in discovering new preferences.

10. One of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. Individual #626 had a goal to open a bank account in the community. One of the related action plans was to visit various banks, then choose one. This was a wonderful opportunity to ensure that he was making an informed decision about where he preferred to bank.

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 not included in action plans for five individuals in any substantial way.

Self-advocacy activities can be incorporated into ISPs, too. Self-advocacy committee had been meeting regularly since the last review. A few days before this onsite visit, however, the human rights officer left the Center and a new one was not yet appointed. Therefore, self-advocacy committee was not held during the onsite week.

11. One of the ISPs met criterion for this indicator to support the individual's overall independence. Individual #626 had action plans to learn to address an envelope, so that he could send mail to his family, fill out a job application, and practice his interview skills. Examples of ISPs that did not include action plans to promote greater independence in a meaningful way were:

- Individual #381 had action plans for independently popping popcorn and riding a bike. Data indicated that he could pop popcorn independently. While learning to ride was something that he expressed interest in, it was unlikely to lead towards greater independence. His IDT should consider prioritizing skills that would be more beneficial for living and working in the community (two of his other goals).
- Individual #885 had action plans to cook chicken strips in the microwave and tie his shoes. While these might give him some measure of greater independence, they did not address more significant barriers to independence such as improving communication skills, learning to brush his teeth or bathe independently, or gaining skills that might lead towards employment.
- Similarly, Individual #595's ISP noted that he could use training in grooming and toileting. These skills were not addressed. His action plan to learn to pop popcorn in the microwave was his sole action plan for 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 routinely 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. For example,

- Individual #595 had IHCP action plans to address his risk for dental disease due to inadequate oral hygiene. The IDT did not

consider developing action plans that might support him to complete his oral hygiene more independently.

- Individual #626 had a BMI of 37 that placed him at high risk for cardiac disease, diabetes, and other serious conditions. His IHCP indicated that he should be encouraged to participate in physical activity 35 to 40 minutes daily to manage his lipids and promote weight loss. Another IHCP goal was to encourage him to make healthy food and beverage choices. These recommendations were not integrated into action plans to support his long term goals.
- Individual #638's history of DVTs and edema should have prompted the IDT to integrate support strategies with input from his physician into action plans for work and other activities where he may be spending extended time either standing or sitting in the same position.

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. While IDTs were attempting to integrate behavioral objectives into action plans to support goals, for the most part, they became stand alone action plans and were not truly integrated into action plans for functional skill building. For example,

- Individual #885 had a stand alone action plan to have two or less incidents of aggression towards others monthly to support his goal to participate in Special Olympics. The IDT should consider action plans that provide opportunities for him to have positive interactions with peers and then integrate positive behavioral support and communication strategies to teach that skill. Additionally, Individual #885's communication assessment recommended that the IDT provide visual representation of the steps involved in cooking chicken in the microwave. His SAP did not include using visual representation.
- Individual #724 had a greater independence goal to use handicap accessible ramps to safely navigate. This should have been a support strategy integrated into action plans to achieve his aspirational goals, such as working in the community.
- Individual #595 had stand alone action plans based on his behavioral and habilitation therapy assessments to address his aggressive behavior through a sensory program. It was not evident that these two disciplines had worked together to develop a functional plan that might build on his skills while addressing his behavior.

ISPs summarized assessment results, however, assessments offered few recommendations for supporting new skill development. When there were recommendations, they were rarely integrated into action plans for learning new skills. This was particularly true for communication skills.

14. One of the ISPs included action plans to support meaningful integration into the community.

- Individual #626 had an action plan to bank in the community.

Although individuals had goals to live and work in the community, action plans did not support community integration. Aside from Individual #626's one action plan, 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 movies, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. One of the ISPs documented the IDT's consideration of opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #626 indicated to the IDT that he would like to work at Wal-Mart as a

stocker. Action plans were developed that might lead towards employment.

For the other five individuals, action plans did not address preferences in regard to work/day programming. Action plans were not present that would support skill development which might lead to work/day programming in a less restricted setting. Vocational assessments were not adequate for identifying preferences outside of the limited vocational opportunities offered at the facility and assessing skills that might lead towards work in a more integrated setting.

Individual #724 and Individual #381 also had goals to work in the community, however, it was not clear that job choices were based on an adequate assessment that included exposure to a variety of jobs to determine their preferences. Additionally, neither had action plans that were likely to lead to employment in the community.

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. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests, then build on skills related to those preferences. .

- Individual #381 was observed during the day engaged in both culinary class and work. Both offered great opportunities to learn new skills, however, his ISP did not reflect his day or include action plans to learn new skills in either setting.
- Individual #595 did not have a work goal. He was observed at various times and days of the week wandering around the facility not engaged in any meaningful activity, though at some times he was observed engaged with staff or in an activity.
- Individual #626's ISP did address work and learning new work skills, however, he currently resided in a locked home and spent his day on the home. His ISP had not been revised to ensure that he spent a majority of his day engaged in meaningful activity.
- Observations did not support that Individual #885 was meaningfully engaged throughout his day. It appears that he spent much of his day in his room or outside playing with a ball.
- Individual #724 and Individual #638 were both observed working at the Center's sheltered workshop, however, their ISPs did not provide opportunities for training that might lead towards new skill development or a job in a less restrictive setting.

Also, attention needs to be paid to the programming and supports for the individuals with autism spectrum disorder living on the Martin unit. A special work group at the Center, led by the ADOP, was looking at this, but additional collaboration/consultation with behavior analysts with autism experience is suggested. See additional commentary in the skill acquisition/engagement section under domain 4 of this report.

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 had not been implemented, or the individual failed to make progress, were continued from the previous ISP without addressing barriers. None of the ISPs addressed identified barriers to community transition in a meaningful way.

18. None of the goals had a set of action plans with enough detail to ensure consistent implementation, data collection, and review. 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.

Although IDTs had created some goals that were more individualized and based on known preferences, few had specific teaching strategies to ensure staff were implementing them and measuring success consistently. Additionally, few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The Center needs to focus on barriers that are preventing individuals from achieving their goals and develop action plans to address those barriers.

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

Summary: During observed ISP meetings, the individual's preferences about where to live were described and in written ISPs, the ISP included a statement of the IDT's staff members. This has been the case for this and the last two reviews, too, with one exception in two of these three reviews. Therefore, indicators 20 and 21 will be moved to the category of requiring less oversight. For the other indicators, some scored higher than at the last review, and some lower.

#	Indicator	Overall Score	Individuals: 381	595	626	885	724	638			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	1/1	0/1	1/1	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									
21	The ISP included the opinions and recommendation of the IDT's staff members.	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	1/1	1/1	0/1	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.	0% 0/1									
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently	50% 3/6	1/1	0/1	0/1	1/1	0/1	1/1			

	referred, to transition.										
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									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Five ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT. The other one did not:

- Individual #885's IDT determined that he should live in an "autistic based group home." His ISP stated that the IDT determined that he would like to live at home with his father. There was no documentation that described his preferences in regard to his living environment.

20. The Monitoring Team attended the annual ISP meeting for Individual #924. His preferences for where to live were described; he participated in this discussion.

21. Five of the ISPs included the opinions and recommendations of staff members, along with a summary statement of those recommendations. Individual #724's staff consensus statement indicated that he could live in the community and IDT members recommended referral to the community, however, a majority of the team members individually stated that they did not recommend referral to the community.

22. Five ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. Individual #638's consensus statement did not include his desire to live in the community near his family. Similarly, Individual #595's consensus statement did not include his desire to live in the community.

23. Two of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. (Individual #381, Individual #724). The other four ISPs did not indicate that the IDT had considered other living options that specifically supported their preferences and support needs.

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

- Individual #381's ISP indicated that his psychiatric diagnosis could be a barrier, but further noted that they were not sure if the diagnoses were accurate.
- Individual #885's ISP noted that behavioral problems were a barrier, however, did not identify which specific behaviors were barriers.

25 and 27. For the annual ISP meeting for Individual #924, barriers to transition and plans to address them were not discussed.

26. Three of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. For Individual #381, Individual #885, and Individual #638, the IDT identified specific behaviors that were considered barriers to referral. Those specific behaviors were addressed in their positive behavior support plans and action plans related to their living option goal.

28. Individuals 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. ISPs included action plans for the individual to attend a provider fair and group home tours, however, these were not individualized based on the individual or LAR's current knowledge regarding living options or specific to living options that could provide identified supports needed in the community.

29. Barriers were identified to referral for all individuals.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

Summary: Individuals attended their ISP meetings for this and the previous reviews at Mexia SSLC, with some exceptions, usually the individual's personal choice to not attend. Therefore, indicator 33 will be moved to the category of requiring less oversight. Also similar to previous reviews, ISPs were not implemented in a timely manner, and one or more important IDT members were missing from each individual's annual ISP meeting. Indicators 32 and 34 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 381	595	626	885	724	638			
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.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

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 #626's ISP indicated that he chose not to attend his 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. The psychiatrist attended one of the ISP meetings. All individuals reviewed had psychiatry diagnoses that significantly impacted their daily functioning and were noted to be barriers to achieving goals. Input from the psychiatrist would have been beneficial for developing supports. Additionally, Individual #638's PCP did not attend his meeting. He had many complex medical support needs to address his history of DVTs, neutropenia, hypokalemia, hypothyroidism, idiopathic parkinsonian syndrome, and morbid obesity.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: Some progress was seen in indicator 36 regarding arranging and obtaining assessments. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 381	595	626	885	724	638			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	20% 1/5	0/1	0/1		1/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	50% 3/6	0/1	0/1	0/1	1/1	1/1	1/1			

Comments:

35. One IDT considered 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 #381's IDT did not identify his need for a cardiac assessment prior to his ISP meeting. His cardio health could have a significant impact on his daily functioning.
- Individual #595's IDT requested a recreational and sensory assessment at his ISP meeting. Consequently, the IDT waited months for the assessments to be completed prior to developing action plans to support his goals In addition, the IDT needs to consider an in-depth vocational assessment to determine his work preferences.
- Individual #724 and Individual #638 also needed a comprehensive vocational assessment that included work exploration to determine his preferences.

36. Three of the IDTs arranged for and obtained all needed, relevant assessments prior to the IDT meeting.

The timely submission of assessments had been identified as an issue that the facility needs to address in the QA/QI Council meeting minutes. Action plans were developed by the facility to address the timeliness of behavioral and psychiatric assessments.

- Individual #381 did not have a comprehensive communication assessment prior to his ISP meeting.
- Individual #595's nursing and behavioral assessment were not submitted 10 days prior to his ISP meeting for team review.
- Individual #626's medical and nutritional assessment were not completed 10 days prior to his ISP meeting.

Without relevant assessments for the IDT to review, comprehensive supports and services were not developed, and all risks were not addressed. Having information from assessments would greatly assist the IDTs in developing meaningful goals with action plans to address needed supports. The facility needs to continue to make obtaining assessments a priority going forward.

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

Summary: IDT meetings (i.e., ISPAs) were occurring. Regular review of goals, action plans, and progress was not occurring. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 381	595	626	885	724	638			
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. The IDT met at least monthly and reviewed supports, services, and serious incidents during ISPA meetings. IDTs did not routinely revise supports or goals or address barriers when progress was not evident. For some individuals, monthly reviews were not timely For example:

- Individual #381's ISP preparation meeting was observed. It was noted that the IDT had not reviewed his cardiology consultation from June 2018. The IDT has not addressed the lack of progress on his goal to ride his bicycle. His goal to pop popcorn independently was not revised when met. The IDT did not address barriers to calling his mother weekly. IDT members indicated that they did not have a current phone number for his mother. None of his team took responsibility for trying to find her number.
- In addition, Individual #381's monthly reviews were not completed in a timely manner to ensure that the IDT took immediate action when supports were not implemented and/or not effective. Implementation for October 2018 was not reviewed until 12/3/18. November 2018 implementation was reviewed on 1/3/19, December 2018 implementation was reviewed on 1/28/19, and January 2019 implementation was reviewed on 3/7/19.
- Individual #595's QIDP monthly review indicated that the IDT waited months for assessments to be completed prior to developing action plans to support his goals. Although the QIDP continued to document and follow-up on the assessments, progress on goals was delayed for months. There was no evidence that the IDT met to discuss lack of implementation of his action plans.
- Individual #626's QIDP monthly reviews and ISPAs indicated that a majority of his action plans were on hold while he was living in a locked home. The IDT did not meet to revise his action plans to support activities that he could participate in while unable to leave his home.
- Individual #885's QIDP monthly reviews did not indicate that data were not available for a majority of his goals for several months, including attending cooking class, setting a timer, using tongs, and playing catch with staff.

- Individual #724's QIDP monthly reviews did not summarize specific progress towards goals. Review of his supports and services in October 2018 did not occur until 11/30/18. A review of November 2018 implementation was not submitted to the Monitoring Team.
- Individual #638's QIDP did not submit a monthly review for the first month of implementation of his new ISP (March 2019).

As noted in other sections of this report, data were rarely available to assist the IDT in decisions regarding revising the ISP.

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

For the most part, monthly reviews were completed (though often late) and included a cursory review of all services. They 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 rarely included 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.

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 changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	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	0/2	0/2	2/2	1/2	2/2	1/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #595 – respiratory compromise, and gastrointestinal (GI) problems; Individual #381 – choking, and diabetes; Individual #291 – respiratory compromise, and infections; Individual #469 – dental, and constipation/bowel obstruction; Individual #638 – circulatory, and choking; Individual #276 – respiratory compromise, and GI problems; Individual #511 – aspiration, and seizures; Individual #724 – weight, and falls; and Individual #528 – aspiration, and GI problems].

a. For the risk areas reviewed, the IDTs did not effectively use supporting clinical data, use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs 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 #595 – GI problems; Individual #469 – dental, and constipation/bowel obstruction; Individual #638 – circulatory; Individual #276 – respiratory compromise, and GI problems; Individual #511 – seizures; Individual #724 – weight; and Individual #528 – GI problems.

Psychiatry

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

Summary: There was some progress in that more individuals had psychiatric indicators for reduction identified than at the last review. Still, about half were related to the individual's diagnosis and about one-third were written in observable terminology. There were psychiatric indicators for increase identified for one individual. Goals for psychiatric indicators were not created for any of the individuals. Some measurement was done with rating scales, but it was unclear of their direct relationship to those psychiatric indicators that were identified. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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	0/2
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 has 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. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

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 an individual's 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 and normed for this population.

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 some progress in this area as all individuals in the review group had one or more indicators related to the reduction of psychiatric symptoms. For five of these nine, the indicators were related to their diagnosis (Individual #431, Individual #885, Individual #797, Individual #816, Individual #80). For three of the nine, the indicators were described in observable terminology (Individual #626, Individual #797, Individual #381). Moreover, because most of the indicators were not described in observable terminology, it was difficult to determine how the indicators related to the individual's psychiatric diagnosis (as well as how they should be described for the specific individual). For example, Individual #80 had diagnoses of bipolar and related disorder due to a medical condition, and anxiety disorder related to another medical condition. Indicators were identified as crying, depression, and sleep disturbance. Because crying was not specifically defined for her, there were issues with data. This was seen in psychiatry clinic

where data were of questionable reliability and validity due to the need for staff to discern between crying and whining.

One individual in the review group, Individual #885, had a psychiatric indicator for increase in positive/desirable actions identified and it was related to his diagnosis; it was not, however, written in measurable terminology. The Center psychiatrists will need identify psychiatric indicators for increase, and document their rationale of how the positive/desirable actions relate to the diagnosis.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for one individual in the review group and for none of the individuals for psychiatric indicators for increase.

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 acceptable goals written regarding psychiatric indicators for reduction or for increase for any of the individuals in the review group.

There were notations indicating that in some instances, data would be collected via direct care staff or behavioral health services and while this seemed reasonable, the indicators will need to be clearly described in observable terminology in order for them to be accurately identified. As the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered. Currently, the facility psychiatrists were identifying the ADAMS (Anxiety, Depression, and Mood Scale), the BPRS (Brief Psychiatric Rating Scale), and the Vanderbilt ADHD rating scale for use in determining the presence of indicators. Although these were identified, data presented in psychiatry clinic and reviewed in the quarterly psychiatry clinical documentation did not reveal the results of these assessments.

Thus, both sub-indicators were not met for any of the individuals for goals for reduction or for goals for increase.

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 for reduction and increase were not developed, therefore, none were incorporated into the Center's overall documentation system, the IHCP.

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, data were reported for behavioral challenges and identified target behaviors. In many examples, the data provided at psychiatry clinic were stale in that they were only reported through the previous month. During the clinical encounters observed during the monitoring visit, the psychiatrists had requested sleep data and asked to review said data. But, in several observations, these data were not available for use in clinical decision-making.

The collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as Mexia SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors/replacement behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs sustained high performance in terms of format. Thus, indicator 13 will be moved to the category of requiring less oversight. All of the CPEs (but one) were missing components required for a positive scoring on indicator 14. This indicator and 15 and 16 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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	100% 9/9	1/1	1/1	1/1	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	1/1	0/1	0/1	0/1	0/1	0/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 1/2		1/1		0/1					
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	56% 5/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1

	documentation.										

Comments:
13. Nine individuals required CPEs. All were completed and formatted as per Appendix B.

14. The Monitoring Team looks for 14 components in the CPE. One CPE included all of the required components (Individual #797). The other evaluations were missing one to five elements. Three evaluations were missing one element, two evaluations were missing two elements, two evaluations were missing three elements, and one evaluation was missing five elements. The most common deficient element was the bio-psycho-social formulation. This was incomplete in eight CPEs.

15. Individual #797 and Individual #626 were admitted in the two years prior to the onsite review. Individual #626 was admitted to the facility 8/23/18 and the CPE was completed 8/30/18. The AMA was completed on the day of admission and there was an IPN from nursing on the day of admission. This was good to see. In the other example, regarding Individual #797, who was admitted to the facility on a Tuesday, 10/10/17, the AMA/physical examination was completed on the day of admission and the CPE was completed 10/17/17, the week following his admission. Although multiple nursing IPN were provided for review, there were none dated the day of or the day following the admission.

16. There were four individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #885, Individual #797, Individual #816 and Individual #157. For Individual #157, the AMA included a diagnosis of PTSD, however, this was not included in the psychiatric diagnoses. Given this individual's significant trauma history, this should be a diagnostic consideration because his symptoms of SIB are strongly suggestive of trauma sequelae. For Individual #885, the AMA included a diagnosis of mood disorder, not otherwise specified. This diagnosis was changed by psychiatry in 2017 to Bipolar Mood Disorder.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: These three indicators scored about the same as at the last review, indicating the need for improved psychiatrist involvement in the ISP process. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	25% 2/8	0/1		1/1	0/1	0/1	0/1	0/1	1/1	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.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	The final ISP document included the essential elements and showed	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	evidence of the psychiatrist's active participation in the meeting.	0/9										

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Two of the annual evaluations, regarding Individual #80 and Individual #885, contained all of the required elements.

The remaining five annual evaluations were missing one to 13 of the required elements. One evaluation was missing one element, one evaluation was missing two elements, two evaluations were missing seven elements, and one evaluation was missing 13 elements.

The two evaluations that met all the criteria were well done. The evaluations that were missing one or two elements were generally thorough, with the exception of the missing element/elements.

20. The psychiatrist attended the ISP meeting for one 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. In all examples, 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:			Individuals:									
#	Indicator	Overall Score										
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.	
Summary: Signed consent forms were missing for some medications for two of the nine individuals. This needs to be improved in order for indicator 28 to remain in	Individuals:

the category of requiring less oversight after the next review. Various other aspects of the consent process did not meet criteria for indicators 29, 30, and 31. Note, however, that all three indicators were met for two individuals (Individual #431, Individual #797). These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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.	22% 2/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	44% 4/9	1/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
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 of the individuals included in the review group. Individual #431 was prescribed Seroquel, but there was no consent form provided for this medication. The medication consent forms regarding Individual #157 expired 3/20/19.

29. The consent forms included adequate medication side effect information in two examples (Individual #431, Individual #797).

The consent forms for Individual #885 and Individual #626, regarding the anti-depressant medication, Zoloft, did not include information regarding the risk of increased suicidal ideation and self-injury for individuals ages 16 to 25. They were both within this age range.

The consent forms for Individual #816, and Individual #381, regarding the second generation antipsychotic medication, Abilify, did not include the potential for increase of behaviors, such as gambling and/or sexual activity.

The consent forms for Individual #80 and Individual #595 regarding benzodiazepine medications did not include the risk of dependence.

30. The risk versus benefit discussion was not included in the consent forms in five examples.

31. The consent forms for seven of the individuals in the review group included alternate, individualized, non-pharmacological interventions in four examples.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Behavioral health goals were again written in measurable terms. Therefore, indicator 3 will be returned to the category of requiring less oversight. It was good to see that IOA assessments were done and were 80% or higher. Ensuring data collection timeliness would then bring indicator 5 into meeting criteria. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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.									
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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: 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: All criteria were met for six of the individuals (i.e., two-thirds). With sustained high performance, indicators 10 and 11 might be moved to the category of requiring less oversight after the next review. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157

10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	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.	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
Comments:											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs were implemented timely and were updated; an improvement since the last review. The content maintained high performance, which if sustained at the next review might result in indicator 15 being moved to the category of requiring less oversight. All three indicators will remain in active monitoring			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

13. Individual #797's consents were completed on 10/18/18, however, his PBSP was not implemented until 11/14/18. Timely implementation of PBSPs has substantially improved from the last review when 44% were implemented within 14 days of attaining all necessary consents.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Individual #885''s PBSP was rated as incomplete because the use of positive reinforcement was not evident, and the replacement behavior was not functional.

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	595	381	291	469	638	276	511	724	528
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.	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.	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
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: 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: It is essential that Medical Department staff take steps to improve the quality of the annual medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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 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. Of concern, none of the annual medical assessments reviewed included all of the necessary components, including thorough plans of care for the selected chronic diagnoses or at-risk conditions. Problems varied, but some of the AMAs were of particularly poor quality (e.g., for Individual #381, Individual #638, Individual #276, and Individual #724).

It was positive that as applicable to the individuals reviewed, all annual medical assessments included lists of medications with dosages at the time of the AMA. Most, but not all included, as applicable, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, pre-natal histories, family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #595 – constipation/bowel obstruction, and diabetes; Individual #381 – cardiac disease, and diabetes; Individual #291 – diabetes, and other: Stage 3 chronic kidney disease; Individual #469 – other: iron deficiency anemia, and osteoporosis; Individual #638 – other: chronic deep vein thrombosis, and cardiac disease: hypertension; Individual #276 – gastrointestinal (GI) problems, and other: hyperthyroidism; Individual #511 – other: hyperlipidemia, and seizures; Individual #724 – cardiac disease: hypertension, and other: hyponatremia; and Individual #528 – other: hypothyroidism, and infections].

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: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. In fact, many of the IHCPs reviewed contained no medical interventions. These indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	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 IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	pathways/guidelines.										
	Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #595 – constipation/bowel obstruction, and diabetes; Individual #381 – cardiac disease, and diabetes; Individual #291 – diabetes, and other: Stage 3 chronic kidney disease; Individual #469 – other: iron deficiency anemia, and osteoporosis; Individual #638 – other: chronic deep vein thrombosis, and cardiac disease: hypertension; Individual #276 – GI problems, and other: hyperthyroidism; Individual #511 – other: hyperlipidemia, and seizures; Individual #724 – cardiac disease: hypertension, and other: hyponatremia; and Individual #528 – other: hypothyroidism, and infections). None of the IHCPs reviewed included action steps sufficient to address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations. In fact, many of the IHCPs reviewed contained no medical interventions. 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 needs to take steps to ensure the timely completion of dental exams and summaries. The related indicators are at risk of returning to active oversight. The Center should continue its focus on improving the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight. However, Indicator a.ii and a.iii are at risk of returning to active 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.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	0%	0/1	0/1	N/R	0/1	0/1	0/1	0/1	0/1	0/1

		0/8									

Comments: Individual #291 was edentulous and was part of the outcome group, so a limited review was conducted.

a. Although Indicator a previously moved to less oversight, Indicators a.ii and a.iii are at risk of returning to active oversight. As the Monitoring Team reviewed other aspects of the dental exams and summaries, it noted that three dental examinations were late (or the Center did not submit documentation to confirm the previous exam date), and two dental summaries were late.

b. It was positive that for two 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;
- Sedation use;
- A summary of the number of teeth present/missing;
- Treatment provided/completed; and
- An odontogram.

Most, but not all included:

- Information regarding last x-ray(s) and type of x-ray, including the date; and
- Periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.

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

- A treatment plan to address the individuals' needs.

c. None of the dental summaries included all of the necessary components. 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; and
- Recommendations for the risk level for the IRRF.

Most, but not all included:

- Recommendation of need for desensitization or another plan; and
- Provision of written oral hygiene instructions.

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

- A description of the treatment provided (i.e., treatment completed);
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues; and

• Treatment plan, including the recall frequency;

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: For all nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments, which was good to see. However, problems were noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	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.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a.i. and a.ii. Although it was positive that the nine individuals reviewed had timely annual nursing record reviews and physical assessments, most individuals had not had timely quarterly nursing reviews and assessments.											

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. Improvement is also needed with regard to the details of physical assessments, including, for example, waist circumference measurements, and follow-up on abnormal findings. In addition, when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528

a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	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
d.	Individual receives a quality quarterly nursing record review.	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 quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining 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
g.	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.	11% 1/9	0/1	0/2	0/2	N/A	1/1	N/A	0/1	0/1	0/1
Comments: a. It was positive that all of the annual or new-admission nursing record reviews the Monitoring Team reviewed included, as applicable, the following: • Procedure history; • Social/smoking/drug/alcohol history; • List of medications with dosages at the time of the annual nursing assessment (ANA);											

- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

Most, but not all included, as applicable:

- Active problem and diagnoses list updated at the time of the ANA; and
- Tertiary care.

The components on which Center staff should focus include:

- Family history;
- Immunizations; and
- Allergies or severe side effects to medication.

b. and e. Most of the annual and quarterly physical assessments reviewed did not include individuals' waist circumferences. In addition, nurses often did not follow up on abnormal findings.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 specific risk areas, and the IHCPs, as available, to address them (i.e., Individual #595 – respiratory compromise, and GI problems; Individual #381 – choking, and diabetes; Individual #291 – respiratory compromise, and infections; Individual #469 – dental, and constipation/bowel obstruction; Individual #638 – circulatory, and choking; Individual #276 – respiratory compromise, and GI problems; Individual #511 – aspiration, and seizures; Individual #724 – weight, and falls; and Individual #528 – aspiration, and GI problems).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Nurses often had not included status updates in annual and quarterly assessments, including relevant clinical data; analyzed this information, including comparisons with the previous quarter or year; and/or made 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.

d. Improvements were needed across all of the sub-indicators for quarterly nursing record reviews, including ensuring that timely and up-to-date information is included regarding:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Family history;
- Procedure history;
- Social/smoking/drug/alcohol history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention;
- Tertiary care; and
- Allergies or severe side effects to medication.

g. The following is a positive example of a nurse following relevant nursing standards in addressing an individual's change of status:

- On 9/12/18, Individual #638 required two abdominal thrusts to dislodge what was described as sausage. A nursing IPN, dated 9/12/18, at 9:01 a.m., showed the nurse followed nursing guidelines/standards of care for assessing an individual with respiratory distress/aspiration (choking), including notifying the physician.

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:

- A nursing IPN, dated 3/14/19, at 9:00 p.m., and IView entries, dated 3/14/19, at 9:00 p.m., indicated that Individual #595's temperature was low (i.e., 97.5). The IPN indicated "Dsp [direct support professional] complained of individual coughing. Individual drowsy didn't state any complaints," but did not provide the time of the report. In the IPN, the nurse indicated that the individual was not coughing, and the lungs were clear. The nurse referenced IView for additional assessment information. However, the IView entries did not include any additional data for lung sounds. The nursing entries in the IPN and IView also were problematic in that they did not provide more history about the individual's coughing (e.g., frequency, production of sputum, coughing before or during a meal). With regard to mental status, the IView entry stated: no change from baseline, but the nurse did not explain his baseline elsewhere. The nurse also did not provide an assessment for level of consciousness (LOC). In addition, the initial nursing assessment/IView entries did not include the date/time of the nurse's report to the physician. According to a medical IPN, dated 3/15/19, at 2:04 p.m., based on an assessment and x-ay findings, the PCP ordered an intramuscular (IM) injection of an antibiotic followed by 10 days of oral antibiotics. On 3/15/19, the x -ray report stated the individual had worsening left lower lobe pneumonia.
- On 11/9/18, Individual #381 started Metformin to address an elevated A1c, and the individual's dosage of Fenofibrate increased to 48 mg for dyslipidemia. In the interval medical review, dated 3/19/19, the PCP documented a new diagnosis of pre-diabetes. However, nurses did not document assessments of the individual regarding the new medication, the medication increase, or the new diagnosis.
- On 11/2/18, the Licensed Vocational Nurse (LVN) notified the Resisted Nurse (RN) that Individual #291 "was using her accessory muscles to breathing [sic] and was having a difficult time." Based on review of the nursing IPN, dated 11/2/18, at 9:06 p.m., and the IView entry, dated 11/2/18, at 8:20 p.m., the individual's pro re nata (PRN or "as needed") respiratory treatment did not relieve her symptoms, and the nurse notified the PCP. The PCP ordered transport to the ED by Emergency Medical Service (EMS). The IPN described a nurse-to-nurse report with the receiving ED. The nurse implemented portions of the nursing protocol for respiratory distress, but omitted an abdominal assessment, and skin assessment, including turgor, color, and temperature.
- Based on a nursing IPN, dated 9/21/18, at 11:15 a.m., and IView entries, dated 9/21/18, at 11:15, when Individual #291 presented with a skin impairment, the nurse followed the related nursing guidelines with regard to documenting measurements, pain status, and the location. However, the nurse did not document the time staff reported the skin integrity issue, and the nurse did not stage the wound. The nurse notified the PCP, and although it did not appear the PCP saw the individual, the nurse documented "received wound care orders." The orders included dressing and application of Bactroban (topical antibiotic).
- An IView entry, dated 2/1/19, at 11:30 p.m., indicated that Individual #511 had an abnormal pulse rate of 126 (high), an abnormal blood pressure reading of 159/90 (high), an oxygen saturation rate of 88 (low), and irregular respirations. According to a nursing IPN, dated 2/2/19, at 7:08 a.m., and an IView entry showing an assessment on 2/2/19, at 12:00 a.m., with physician notification at 12:05 a.m., the nurse did not follow guidelines/standards of care for respiratory distress in

alignment with the individual's signs/symptoms that included vomiting. More specifically, the nurse did not conduct an abdominal assessment, review residuals, or follow the Situation, Background, Assessment, Recommendation (SBAR) format for PCP reporting. A nursing IPN, dated 2/2/19, at 10:19 a.m., noted the individual was transferred out.

- On 12/13/18, Individual #528 experienced respiratory distress. Based on a nursing IPN, dated 12/13/18, at 6:35 a.m., and an IView entry, dated 12/13/18, at 4:45 a.m., the nurse did not follow nursing standards of care for respiratory distress, including following documentation standards using the subjective, objective, assessment, and plan (SOAP) format, and completing an abdominal assessment. The nurse did document PCP notification in accordance with standards of care.

Outcome 5 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last several 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: 595	381	291	469	638	276	511	724	528
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. The IHCPs reviewed were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause or etiology of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of

the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

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: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. Since the last review, the scores during this review generally showed incremental improvement with regard to timely referral of individuals to the PNMT, and timely completion of reviews and assessments, but work is still needed. The Center should focus on continuing its progress in these areas, as well as completing reviews for individuals who need them, and improving the quality of the PNMT comprehensive assessments. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 3/6	0/1	N/A	1/1	N/A	0/1	N/A	0/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 3/6	0/1		1/1		0/1		0/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	75% 3/4	N/A		1/1		N/A		0/1	1/1	1/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6	0/1		0/1		0/1		0/1	1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 3/3	N/A		1/1		N/A		1/1	N/A	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	0/1		1/1		0/1		0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses:	0% 0/3	0/1		0/1		0/1		N/A	N/A	N/A

	• 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.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	N/A		0/1		N/A		0/1	0/1	0/1

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

- According to Individual #595's IRRF, dated 7/17/18, he fell five times in the previous year. Despite these five falls, the IDT determined he was at low risk for falls, and they did not develop an IHCP. The IDT indicated that he had a skill acquisition program (SAP) to learn to tie his shoes, and this would help, because some of his falls related to him tripping on his shoe laces. Between 10/1/18 and 1/27/19, the individual fell 10 times. The IDT determined seven were "true" falls, with the remaining three having a behavioral cause. During this four-month period, Individual #595's falls showed a significant increase in comparison with the previous year. The PNMT should have at least conducted a review, but they did not, nor did the IDT hold ISPA meetings to discuss strategies to reduce the falls.
- On 6/5/18, the PCP saw Individual #291 in sick-call due to wheezing, and ordered chest x-rays. The x-rays revealed a left lower lobe infiltrate. The PCP ordered Levaquin, and changed the Mucinex to scheduled dosing. This was the second pneumonia the individual had during the calendar year. On 1/24/18, she had an exacerbation of asthma following Type A influenza. Upon her admission to the hospital, a chest x-ray showed a left lower lobe infiltrate. In response to the recurrent pneumonia, the PNMT made a timely self-referral, and on 7/5/18, completed a timely comprehensive assessment.

  However, although the individual was still on the caseload, the Monitoring Team found no evidence of the PNMT conducting a thorough review after the individual's subsequent hospitalization (i.e., from 8/14/18 to 8/21/18) with a diagnosis of aspiration pneumonia. On 10/25/18, the PNMT discharged the individual, but did not identify potential etiologies or recommend specific goals to address the suspected etiology(ies). From 11/2/18 to 11/13/18, Individual #291 was hospitalized again for aspiration pneumonitis, but beyond the PNMT RN review, the PNMT did not complete and/or document a review. A note indicated that further PNMT assessment was not indicated as supports were sufficient. Given that the individual continued with recurrent pneumonia, the supports were not effective.
- Individual #638's IDT placed him at medium risk for weight, due to his diagnosis of morbid obesity. The IDT set a goal/objective for weight loss of one to two pounds per month to move him towards his Estimated Desired Weight Range (EDWR), which was 175 to 215 pounds. In January 2018, he weighed 289 pounds, and on 1/27/19, he weighed 248 pounds. However, the rate of his weight loss increased from November 2018, when he weighed 270 pounds to 1/27/19, when he weighed 248 pounds. This represented an 8% loss in a three-month period, a 5% weight loss in one month (i.e., from 268 on 11/28/28, to 255 pounds on 1/10/19), and was not the one to two pounds per month that the IDT planned. As a result, in January 2019, he met criteria for referral to and review by PNMT.

- On 11/23/18, Individual #511 was discharged from the hospital with diagnoses of a UTI, pneumonia, and sepsis. On 1/13/19, she was discharged from another hospitalization with a diagnosis of aspiration pneumonia. After this diagnosis of aspiration pneumonia, the IDT did not make a referral to the PNMT, and the PNMT did not make a self-referral. It was after the third hospitalization discharge, on 2/19/19, that the PNMT initiated an assessment. On 3/5/19, prior to the completion of the PNMT assessment, Individual #511 died at the age of 55 with one of the causes of death listed as aspiration pneumonia.
- On 6/6/18, Individual #724's IDT referred him to the PNMT due to a fracture of the left lateral malleolus, and an increase in falls. On 7/4/18, the PNMT completed the assessment. The quality of the assessment is discussed below.
- On 12/2/18, Individual #528's IDT referred her to the PNMT, after her discharge from the hospital on 11/26/18, for aspiration pneumonia. On 12/3/18, the PNMT initiated a comprehensive evaluation, and on 1/15/19, they completed it. The quality of the assessment is discussed below.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible, at times, to determine which members of the PNMT participated in the PNMT assessments. Currently, PNMT documents include a list of "participants" within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of "participants" without those clinicians having any role in the process or even knowing that they are listed as "participants." Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

e. It was positive that as needed, a RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results.

h. As noted above, Individual #511 should have had a comprehensive assessment conducted after her first diagnosis of aspiration pneumonia. For each of the three assessments reviewed, it was positive that they all addressed the following:

- Presenting problem;
- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- 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; and
- Evidence of observation of the individual's supports at his/her program areas.

The following summarizes some of the concerns noted with the three assessments that the PNMT completed:

- For Individual #291, the PNMT did not conduct a head-of-bed elevation (HOBE) evaluation, but rather recommended that one be done. Similarly, the PNMT recommended a modified barium swallow study (MBSS), as opposed to completing one. The PNMT did not gather and/or analyze data related to the individual's asthma exacerbation, although they identified it as a

potential cause of the pneumonia. The PNMT indicated that on 10/4/17, the pulmonologist recommended a medication, but the PCP did not order it. The PNMT recommended the PCP consider it, as opposed to consulting with the PCP/Medical Department during the evaluation process to attempt to resolve the issue. The PNMT offered no recommendations beyond this to address the suspected underlying or "root" cause of the individual's pneumonias. The PNMT identified criteria for re-referral as overt signs and symptoms of reflux, including vomiting, yet this had not been an issue. Conversely, they did not include exacerbation of asthma as a re-referral criterion, even though this was identified as a potential "root" cause of the pneumonias. The recommended goal related to HOBE, even though the PNMT had not identified this as an issue impacting the risk for pneumonia.

- Many of the components of Individual #724's PNMT assessment met criteria. It was positive that the PNMT identified potential causes of his falls, which placed him at risk for falls. For example, the PNMT identified that he had difficulty with uneven surfaces, as well as cognitive-communication impairments that impacted his attention to the environment, necessitating staff prompts and cues to assist in keeping him safe. However, one of the goals the PNMT recommended was for the individual to identify three fall prevention strategies with one or fewer visual or verbal cues. It was unclear, though, if the PNMT conducted sufficient evaluation to determine if this was a realistic goal.
- For Individual #528, the PNMT did not provide sufficient data and analysis to support their conclusion that supports were effective. Inconsistencies were noted in the assessment report. For example, one section identified vomiting as a potential root cause, but another section indicated ineffective management of lung secretions was the cause; it was unclear what this meant. The recommendations the PNMT made (i.e., related to her wheelchair and position) did not address the identified potential etiology(ies).

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

Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. At times, action steps were not measurable. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	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 plan includes preventative interventions to minimize the condition 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 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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	meet the identified objectives listed in the measurable goal/objective.	0/18									
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	1/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	0/2	1/2	1/2	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: Individual #595 – choking, and falls; Individual #381 – choking, and falls; Individual #291 - falls, and aspiration; Individual #469 – choking, and falls; Individual #638 – choking, and weight; Individual #276 – constipation/bowel obstruction, and neurological (i.e., Parkinson's disease); Individual #511 – falls, and aspiration; Individual #724 – weight, and falls/fractures; and Individual #528 – fractures, and aspiration.

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. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "monitor as needed," "encourage daily exercise and healthy foods," etc.).

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

- It was positive that all of the PNMPs/Dining Plans, as applicable to the individuals' needs included:
  - Photographs;
  - Descriptions of assistive/adaptive equipment;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions; and
  - Oral hygiene instructions.
- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Were reviewed and/or updated within the last 12 months (i.e., Individual #724's PNMP was last reviewed/revised on 1/16/18);
  - Included a complete list of risk levels related to supports and individual triggers, if applicable; and
  - Included complete medication administration instructions.

- The component of the PNMPs on which the Center should focus on making improvements relates to the inclusion of:
  - Complete communication strategies. None of the PNMPs reviewed provided a complete description of strategies staff should utilize to communicate with the individuals, and often specifics were not included about the individuals' communication abilities (e.g., the only reference was "speaks English").

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 included necessary clinical indicators.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #276 - neurological.

g. Often, the IHCPs reviewed did not include action steps for Habilitation Therapy staff to complete PNMP monitoring, define PNMP monitoring at a frequency consistent with the individual's level of risk, and/or include other monitoring to assess progress (e.g., measurement of weight). Those that did were for: Individual #638 – weight, and Individual #276 - neurological.

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	595	381	291	469	638	276	511	724	528
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% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1
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% 0/2							0/1		0/1

Comments: a. and b. For Individual #511, the IDT included no discussion in the IRRF with regard to the continued medical necessity of her enteral nutrition.

For Individual #528, the IDT did not provide data to support the continued use of enteral nutrition, and their conclusion that she refused all nutrition by mouth.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs continued to be of concern. The quality of OT/PT assessments continues to be an area on which Center staff needed to place considerable focus, so it was good to see that some initiatives were underway to make improvements. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	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.	N/A									
	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.	50% 5/10	2/2	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	40% 4/10	1/2	0/1	0/1	0/1	1/1	1/1	0/1	1/1	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;	N/A									

	▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/10	0/2	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 and b. For the nine individuals reviewed, four received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- For three individuals (Individual #381, Individual #291 and Individual #511), the Center did not provide evidence that Habilitation Therapy had submitted a screening or an assessment for the ISP annual meeting. More specifically, for Individual #291, Center staff indicated no screening or assessment was needed, even though she had a PNMP and needed supports.
- Habilitation Therapy staff did not submit an assessment at least ten working days before the ISP annual meeting for Individual #276 (i.e., submitted on 10/4/18, for the meeting held on 10/17/18), or for Individual #528 (i.e., the OT portion of the assessment was submitted on 7/5/18, for the meeting held on 7/19/18.) OT/PT staff should focus on ensuring assessments are available to the rest of the IDT for the full ten days in order to facilitate team members' preparation in the ISP meeting.

b. Five individuals did not receive the type of assessment that was in accordance with their needs. The following concerns were noted:

- On 7/17/18, Individual #595 had an ISP meeting. At that point, the OT/PT only completed a screening, which was timely. However, according to documents submitted, he had no previous assessment, so this assessment should have been a comprehensive assessment due to the fact that he received indirect formal OT/PT supports. Then, according to the monthly QIDP review, dated 9/27/18, the IDT made a referral to Habilitation Therapies for a sensory assessment. On 10/15/18, the OT/PT completed a new comprehensive evaluation, which appeared to be a timely response to the IDT's request. This was the type of assessment required; however, as the findings below illustrate, this assessment did not meet his needs.
- The Center did not provide evidence of an assessment or a screening for Individual #381, but should have because he required a PNMP.
- The Center did not provide evidence of an assessment or a screening for Individual #291, but should have based on identified needs for direct OT services to increase strength and endurance for transfers that had not been fully addressed.
- The Center did not provide evidence of a comprehensive assessment for Individual #469, even though the 1/2/18 update referred to a comprehensive assessment as the basis for the updated findings.
- The Center did not provide evidence of an assessment or a screening for Individual #511, but should have because she had a PNMP with significant supports required.
- For Individual #528, the Center provided a screening dated 6/30/18, completed by the PT only, and an additional screening dated 7/5/18, completed by the OT only. OT/PT should have completed a comprehensive assessment due to her use of wheelchair, and because she had significant PNM-related risks and required a PNMP.

d. None of ten required comprehensive assessments met criteria for a quality assessment. As noted above, the Center did not submit needed comprehensive assessments for Individual #381, Individual #291, Individual #469, Individual #511, or Individual #528. Overall, across the comprehensive assessment reviewed, information was often incomplete and disorganized in content, and OTs/PTs offered weak clinical analyses. In some cases, the OT/PT completed a screening, when they should have completed an assessment. Very few of the assessment reviewed met more than a few, if any, of the following requirements:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; 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.

On a positive note, some steps reportedly are underway to improve assessments. There was a new assessment template in place statewide, which hopefully will assist therapists to improve assessment content and readability. In addition, the Center's Habilitation Therapy Director was auditing every assessment prior to submission to the IDTs. Based on discussions on site, the Habilitation Therapy Director appeared to have a good understanding of the audit tool criteria and was on point with his expectations for assessments.

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	595	381	291	469	638	276	511	724	528
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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	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% 0/9	0/1	0/1	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.	33% 1/3	0/1	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A

Comments: a. The ISPs reviewed did not include concise but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.

b. IDTs typically did not document discussion of any needed revisions to the PNMPs and/or Positioning Schedules, but simply indicated approval. Therapists should work with QIDPs to make improvements. It was positive, though, to see that the IDT for Individual #276 had discussed discontinuing his weighted spoon, because he did not have tremors with regular spoon.

c. IDTs did not address individuals' OT/PT needs by including recommended interventions in ISP action plans, and/or include goals/objectives for direct therapy that OT/PT's recommended or implemented.

d. IDTs also did not always hold ISPA meetings to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports. Examples of concerns included:

- On 10/11/18, Individual #595's IDT held an ISPA meeting to address recommendations from an OT/PT comprehensive assessment for direct therapy, with specific goals outlined. The ISPA stated the evaluation was completed on 10/1/18, while the assessment document indicated it was entered on 10/11/18. Per a review of the assessment document, however, some portions and at least one signature had entry dates after the ISPA meeting was held. The IDT needed to have the complete assessment to fully consider and approve the implementation of the services.
- In July 2018, Individual#638 started a cardiovascular program, although no goals had been identified. The Center provided no evidence the IDT had integrated it into his ISP or IHCP.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are	Individuals:

fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.											
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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 have moved to the category of 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.	44% 4/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/5	N/A	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A

d.	Individual receives quality Comprehensive Assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. and b. The following concerns were noted:

- For five individuals (Individual#381, Individual #291, Individual #638, Individual #276 and Individual #511), the Center did not provide evidence of any communication screening or an assessment.
- For Individual #469, the update referred to a comprehensive assessment, but Center staff did not submit the assessment referenced.

d. and e. None of the comprehensive assessments or the update met criteria for a quality assessment. As noted above, the Center did not submit an assessment for Individual#381, Individual #291, Individual #638, Individual #276, or Individual #511. Overall, across the comprehensive assessments and the update reviewed, information was often incomplete and disorganized in content, with weak clinical analyses. Very few of the assessments met more than a few, if any, of the following requirements:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- 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;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- 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;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; 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.

On a positive note, some steps reportedly are underway to improve assessments. There was a new assessment template in place statewide, which hopefully will assist therapists to improve assessment content and readability. In addition, the Center's Habilitation Therapy Director was auditing every assessment prior to submission to the IDTs. Based on discussions on site, the Habilitation Therapy Director appeared to have a good understanding of the audit tool criteria and was on point with his expectations for assessments.

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: To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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	1/1	0/1	0/1	0/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/8	N/A	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% 0/9	0/1	0/1	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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. IDTs often did not include in individuals' ISPs clear descriptions of how they communicate or how staff should communicate with them. The following exceptions and concerns were noted:

- Two individuals (i.e., Individual # 595 and Individual #469) had descriptions as required;
- Five individuals (i.e., Individual#381, Individual #291, Individual #638, Individual #276, and Individual #511) did not have a screening or assessment that identified their current communication strengths and needs upon which to base a relevant description; and
- The IDTs for Individual#724 and Individual #528 did not provide a clear description of communication needs in their respective ISPs, even though their assessments provided an ample resource for this purpose.

b. Individual # 595 communicated verbally and did not need a Communication Dictionary. For the remaining eight individuals, the IDTs did not provide evidence of what the IDT reviewed, revised, and/or approved, whether the individual needed a Communication Dictionary, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. As described with regard to Outcome 1 above, the IDTs did not ensure that strategies, interventions (e.g., therapy interventions), and

programs (e.g. skill acquisition programs) recommended in assessments were integrated in individuals' ISPs/ISPAs.

d. It was positive that the IDT for Individual #724 met to discuss the initiation of direct therapy in an ISPA meeting, held on 9/6/18. The ISPA indicated the goals were to be developed, although the IHCP had already been modified, on 8/31/18, to list the measurable goals. It was not clear why the IDT did not discuss and approve the specific goals at the time of the ISPA meeting.

In addition, his ISP meeting occurred after the initiation of therapy (i.e., the ISP meeting was on 12/20/18), but the IDT did not discuss these goals or his progress in achieving them. Therefore, it was not clear whether or not they were still active, if he had accomplished them, or they needed revision.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Summary: All individuals had SAPs, they were mostly measurable and based on assessments. Even so, many (one-third) were not practical, functional, and meaningful. Most did not have reliable data. Across this set of indicators, performance remained the same, that is, high for indicators 2 and 3 compared with the last review. There was improvement in indicator 4. Indicator 5 remained the same as at the last review, that is, low. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	797	816	381	595	80	157
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.	81% 22/27	3/3	3/3	3/3	3/3	2/3	2/3	3/3	3/3	0/3
3	The individual's SAPs were based on assessment results.	96% 26/27	3/3	3/3	3/3	3/3	2/3	3/3	3/3	3/3	3/3
4	SAPs are practical, functional, and meaningful.	70% 19/27	2/3	3/3	1/3	3/3	3/3	1/3	1/3	2/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	26% 7/27	3/3	0/3	0/3	0/3	1/3	0/3	0/3	3/3	0/3

Comments:
The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review, for a total of 27 SAPs.

2. Individual #816's measure ingredients SAP and Individual #381's identify personal information SAPs did not have a prompt level

identified, and all three of Individual #157's SAPs had unclear prompt levels and, therefore, were scored as not measurable.

3. Individual #816's measure ingredients SAP was scored as not based on assessment results, because the cooking section of his FSA was not completed.

4. Several SAPs were scored as not practical or functional because they were not clearly related to their ISP goals/vision statement (e.g., Individual #80's sanitize her hands SAP). Other SAPs were scored as not practical or functional because they represented describing behaviors rather than demonstrating them (e.g., Individual #431's safe bicycle rules 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 #381's make microwave popcorn SAP).

5. One-quarter 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, both indicators might be moved to the category of requiring less oversight after the next review. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	797	816	381	595	80	157
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
11. Individual #431's FSA and vocational assessments were not available to the IDT at least 10 days prior to his ISP.

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, 25 of these indicators were moved to the category of requiring less oversight. For this review, two other indicators were added to this category, in restraints and behavioral health services.

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

In psychiatry, as Mexia SSLC creates indicators and goals for reduction and for improvement of individuals' psychiatric disorders, data can be collected, and progress determined.

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

For frequent occurrences of crisis intervention restraint, teams met when needed. There was progress in the required content of these reviews. These are indicators 20-23.

In psychiatry, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action for all but one individual.

Given that State Office recently provided training and Center staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Based on this review, nurses only sometimes followed relevant guidelines with regard to documenting the time of the onset of symptoms and/or the completion of necessary initial assessments. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation and/or documentation of the completion of the interventions.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's

ability to identify the strengths, as well as some of the weaknesses in the acute care plans and the related nursing assessments. With some refinements to the process, and continued auditing with constructive feedback to the nurses responsible for writing and implementing acute care plans, the Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

As was the status at the time of the Monitoring Team's last review and report, for acute care issues addressed at the Center, overarching concerns included problems with medical assessments, including, but not limited to a lack of clinically necessary plans for further evaluation, treatment, and monitoring; and a lack of needed follow-up. Based on this review, Center staff sustained their progress in providing treatment prior to individuals' transfer to the ED or hospital. However, problems were noted with regard to PCPs' assessments of individuals prior to transfer, and thorough follow-up upon their return continued to be a significant problem.

Telemedicine

The Center continued to utilize a telemedicine program to provide primary and acute care to some of the individuals. In many instances, it has the ability to provide care consistent with current standards. However, based on record reviews and observation, there is cause for concern. There were several instances in which a PCP/telemedicine provider had not completed and/or documented an examination meeting applicable standards. For example:

- Injuries of extremities require documentation of the motor and neurovascular status of the injured extremity. For an individual who complains of pain in a lower extremity for three weeks, limps, and has edema of the extremity, a PCP should complete a thorough evaluation that meets standards of care. Documentation of a visual exam alone is not sufficient.
- Similarly, the use of telemedicine does not alter the requirement to conduct a complete examination for an individual with gastrointestinal (GI) complaints. Inspection, auscultation, and palpation remain important elements in the evaluation and diagnosis of an individual with abdominal pain. Based on observation, this did not occur for another individual.

These examples illustrated that without a presence in the room with the individual, the PCP's evaluations sometimes did not include the fundamental components of an exam. Although the nurse assigned to the telemedicine program was able to bridge this gap at times, in other instances, the individual needed a hands-on medical assessment, as opposed to a nursing assessment.

As the Monitoring Team discussed with State Office staff when they proposed using telemedicine, in order to comply with the Settlement Agreement, policies and procedures need to be in place to ensure that individuals supported through the telemedicine program are afforded medical care in accordance with current standards of care. Based on findings from this review, the telemedicine program was not meeting this standard, and it did not appear that Center and/or State Office staff had defined instances in which telemedicine was not appropriate and developed and implemented procedures to provide alternatives. This lack of planning and oversight left individuals at increased risk.

Implementation of Plans

Psychiatric coordination with behavioral health showed steady improvement. The Center administration was aware of this need and plans were being put in place. To this end, recently, psychiatry staff started to attend behavioral health's BTC meetings.

Regarding collaboration between psychiatry, for one individual prescribed medication for dual use, there was some indication of collaboration between psychiatry and neurology. For two other individuals in the review group, there was confusion about whether medications were or were not for dual usage. Either way, it would seem to make sense for there to be some collaboration between psychiatry and neurology on these cases.

Psychiatry clinic reviews were held quarterly for three-quarters of the individuals. Documentation of each of these encounters was missing a number of components.

There were improvements in the percentage of PBSPs implemented within 10 days of receiving necessary consents. One-third of individuals had a sufficient percentage of staff trained in their PBSPs.

The data system for several individual's PBSP data was not individualized and did not adequately measure their behavior (e.g., moderate to high frequency target behaviors, and data only collected once per shift). PBSP data were not demonstrated to be reliable because no individuals had data collection timeliness data. There were some very good examples of individualized data systems that met criteria for indicator 26, and there were examples that did not meet criteria for measuring target behaviors. Measures of data collection timeliness need to be set and implemented.

Attention needs to be paid to the programming/housing for the group of individuals who recently graduated from Longhorn unit and have been diagnosed with autism spectrum disorder (ASD). They lived in the same home on the Martin unit. Staff continued to appear to be confused about how to best provide engaging activities, skill instruction, and overall programming. There was not anyone on campus with extensive experience in developing and managing programming for individuals with ASD. This was recognized by the Center. A special work group for this was being led by the ADOP. One suggestion is to see if there might be any collaboration/consultation opportunities with Baylor University's applied behavior analysis department.

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 a lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

For most of the individuals' chronic or at-risk conditions that the Monitoring Team reviewed, PCPs working with IDTs had not conducted medical assessments, tests, and evaluations consistent with current standards of care, and/or had not identified the necessary treatment(s), interventions, and strategies, as appropriate.

Moreover, IHCPs did not include a full set of action steps to address individuals' medical needs. In fact, many IHCPs reviewed did not include any medical interventions for the PCP to implement.

It was good to see improvement overall with regard to PCPs' review and handling of non-Facility consultations. For the consultations reviewed for this report, PCPs generally reviewed consultations and indicated agreement or disagreement, and did so in a timely manner. Often, PCPs wrote orders for agreed-upon recommendations.

Two of the nine individuals reviewed received the preventative care they needed.

The Center should 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.

Efforts continue to be needed to ensure that individuals receive necessary dental treatment. On a positive note, individuals reviewed had received the dental x-rays they required.

Improvement is needed with regard to the quality of Quarterly Drug Regimen Reviews (QDRRs), particularly with regard to the review of laboratory results. In addition, problems continued to occur with regard to prescribers' implementation of the agreed-upon recommendations from QDRRs.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (45% of 42 observations) in which staff were not implementing individuals' PNMPs/Dining Plans or were implementing them incorrectly. In addition, some individuals who were observed engaging in mealtime practices that placed them at risk did not have Dining Plans. PNMPs/Dining Plans 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/Dining Plans correctly (e.g., competence, accountability, etc.), and address them. Center staff also should ensure that individuals who require mealtime supports have them.

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: Teams met when needed. This has been the case for this and the previous two reviews, too (with one exception). Therefore, indicator 18 will be moved to the category of requiring less oversight. There was progress in the required content of these reviews. These are indicators 20-23. To compare with the two previous reviews, the averages for this review and the past two reviews for these four indicators were 59%, 25%, and 0%, respectively. For indicators 28 and 29, with sustained high performance, they might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	431	816	595						
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.	100% 3/3	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	100% 3/3	1/1	1/1	1/1						
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.	67% 2/3	1/1	0/1	1/1						
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:	67%	1/1	0/1	1/1						

	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.	2/3									
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									
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:
The scoring of indicators 18-29 was based on a review of Individual #431's 11/12/18 ISPA, Individual #816's 11/12/18 ISPA, and Individual #595's 3/7/19 ISPA documenting a meeting for more than three restraints in 30 days.

18. Individual #431's fourth restraint occurred on 10/31/18, his IDT met to discuss more than three restraints in 30-days on 11/12/18. Individual #816's fourth restraint was on 11/5/18, his IDT met to discuss more than three restraints in 30-days on 11/12/18. Individual #595's fourth restraint occurred on 2/26/19 and his IDT met to discuss more than three restraints in 30-days on 3/7/19.

21. The minutes from Individual #431 and Individual #595's IDT meetings reflected a discussion of contributing environmental variables, and a plan to address them. The minutes of Individual #816's IDT did not reflect a discussion of contributing environmental variables.

22. A discussion of the role of antecedent events on the dangerous behaviors that provoked restraint was not reflected in Daren's ISPA. Individual #431 and Individual #595's ISPAs identified antecedent to their restraints, however, no action to address this contributing event was documented.

23. The minutes of Individual #816's IDT did not reflect a discussion of the role maintaining variables played in his restraints.

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 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 for all but one individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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.	N/A									
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. Given the absence of appropriate psychiatric indicators, goals, and data shown to be reliable (and perhaps valid) for psychiatric goals/indicators, progress could not be determined for goals for reduction or for increase. As there were no individuals with goals written or included in the IHCP goals could not be updated.

10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms,

changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

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

Summary: Psychiatric coordination with behavioral health showed steady improvement in documentation for indicator 23, scoring higher than at any previous review. Indicator 24 scored higher than at the last review, too. The plan for more frequent and more structured collaboration between psychiatry and behavioral health is a good one. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	797	816	381	595	80	157
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
24	The psychiatrist participated in the development of the PBSP.	33% 3/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavioral assessment reviewed the role of the psychiatric disorder upon the presentation of the target behaviors for eight of the individuals. Individual #157 did not have a current behavioral health assessment.

24. This was specifically documented for three individuals, Individual #80, Individual #797, and Individual #885. During the monitoring visit, behavioral health staff and psychiatry clinic staff made the determination that psychiatry would begin to attend behavioral therapy committee in order to review the behavioral support plans for individuals on their caseload. This will allow for psychiatric participation in the planning. In addition, as discussed during the monitoring visit with staff from both behavioral health and psychiatry, this will allow for a focused discussion regarding diagnoses, symptoms, and indicators and how these impact specific behaviors. One issue with regard to integration of behavioral health and psychiatry was the reliance on contract psychiatric physicians and psychiatric nurse practitioners. The facility should work towards reducing the reliance on contract providers who provide services for a limited period of time, transitioning to providers who are permanent members of an individual's treatment team.

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: For one individual prescribed medication for dual use, there was some indication of collaboration between psychiatry and neurology, but neurology documentation was not available or did not exist. For two other individuals in the review group, there was confusion about whether medications were or were not for dual usage. Either way, it would seem to make sense for there to be some	Individuals:

collaboration between psychiatry and neurology on these cases. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/1									0/1
26	Frequency was at least annual.	0% 0/1									0/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/1									0/1

Comments:
25 -27. These indicators applied to one individual, Individual #157. Although the pharmacy indicated that anti-epileptic medication, Trileptal, was indicated for both Bipolar Mood Disorder and seizure disorder, and the psychiatrist reviewed the consultation from neurology dated July 2018, there was no neurology consultation information available for review.

In the case of Individual #885, although he was prescribed medications for seizures, specifically Depakote and Trileptal, psychiatry clearly documented that these were prescribed for seizures and not for a psychiatric indication. This was somewhat confusing because this individual had a diagnosis of Bipolar Mood Disorder, which is frequently treated with Depakote.

In another example, regarding Individual #381, there was cause for confusion because there was documentation by psychiatry that the medication Depakote was prescribed for seizures, but documentation by neurology that this medication was prescribed for a dual indication, both seizures and a psychiatric diagnosis. Per communication received following the monitoring visit, the psychiatric nurse practitioner and the treating neurologist conferred and confirmed that the Depakote was prescribed for the sole indication of seizure. The Center wrote that the individual's PCP contacted the neurology specialist to let her know. It was not known at the time of this report as to whether the neurologist made any treatment changes based upon this new information.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: For three-quarters of the individuals, psychiatry clinic reviews were held quarterly. Documentation of each of these encounters was missing a number of components. Psychiatry clinics lacked the kind of data that the psychiatrists needed in order to make informed treatment decisions. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
33	Quarterly reviews were completed quarterly.	75% 6/8	0/1		1/1	1/1	1/1	1/1	1/1	1/1	0/1
34	Quarterly reviews contained required content.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/4								0/1	0/1

Comments:
33. Quarterly reviews were completed in a timely manner for six individuals requiring them. Individual #626 was a new admission as of August 2018 and, therefore, it was too soon to establish a pattern of quarterly reviews. The records of Individual #157 and Individual #431 did not indicate consistent quarterly clinical reviews. For example, regarding Individual #431, there was a quarterly review dated 3/21/18 with the next evaluation, an annual, dated 9/27/18. There was no quarterly clinical review in June 2018. For Individual #157, the last quarterly clinical review was 11/8/18 with the following quarterly review performed during the monitoring visit 4/16/19.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components, they were each missing four to five components.

35. During the monitoring visit, the psychiatric clinic was observed for two individuals in the review group. In addition, psychiatry clinic was observed for two individuals not included in the review group. Overall, there were issues with the receipt and review of behavioral health data during the psychiatry clinics. For example, regarding Individual #157, there was a discussion regarding the need for sleep data. Sleep data had been previously requested, but was not available for review. There was a discussion that sleep and behavioral data were important due to the diagnosis, but again, these were not presented. The psychiatrist indicated that the medication regimen was confusing, but indicated that he did not have sufficient information in order to make a determination regarding the regimen.

In another example, regarding Individual #80, sleep data were presented anecdotally. Data had been requested regarding crying, but these data were of questionable validity and utility as there was no definition of crying, and there was a need to ensure that staff were not including whining in the captured data. In an effort to address this, the psychiatrist and the team made the decision to add sadness as an indicator and planned to monitor this via an ADAMS rating scale which may be more objective. This was good to see. This will allow for the use of data to determine improvement, or lack thereof, with regard to psychiatric symptomatology.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Side effect assessments were not completed or reviewed as timely as they needed to be. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:
36. There were issues with both the timely completion and prescriber review of MOSES and AIMS assessments. For example, regarding Individual #157, the AIMS dated 7/12/18 was not reviewed until 9/17/18. The MOSES dated 11/12/18 was not reviewed until

12/11/18. The MOSES 1/14/19 was not reviewed. In another example, regarding Individual #80, the AIMS and MOSES dated 8/22/18 were not reviewed until 11/5/18. The next AIMS was not performed until 1/24/19 and was not reviewed until 3/7/19. The MOSES dated 1/24/19 was not reviewed until 3/7/19.

The positive exception was for Individual #816.

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:												

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	431	626	885	797	816	381	595	80	157	
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A										
Comments:												

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.	
Summary: Polypharmacy documentation, review, and discussion needed some	Individuals:

improvement. Scores on these indicators were about the same as at the last review. Note, however, that for one individual, all three indicators met criteria. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	17% 1/6	0/1	0/1	1/1		0/1		0/1		0/1
45	There is a tapering plan, or rationale for why not.	67% 4/6	0/1	0/1	1/1		1/1		1/1		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.	50% 3/6	0/1	0/1	1/1		0/1		1/1		1/1

Comments:
Comments:
44. These indicators applied to six individuals. Polypharmacy justification was appropriately documented in one example, for Individual #885.

For Individual #381, there was conflicting information in his documents as to whether his medication regimen met the criteria for polypharmacy. It turned out that Depakote was not being used by psychiatry, but neurology thought it was. In the weeks following the onsite review, the Center's PCP notified the consulting neurologist about this.

45. There was documentation for four individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation as to why this was not being considered in four examples.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for three of the individuals meeting polypharmacy criteria.

Individual #816 met criteria for polypharmacy as of 10/18, but had not yet been reviewed. Although Individual #626 was included in the list of individuals meeting criteria for polypharmacy, there was no documentation of a review. Individual #431 was last reviewed in April 2017. This was discussed with psychiatry clinic staff during the monitoring visit. The psychiatry clinic staff reported issues with the meeting minutes and acknowledged that they were not being kept appropriately.

The polypharmacy committee meeting was observed during the monitoring visit. During this meeting, the regimens of eight individuals were reviewed. The committee meeting was attended by multiple disciplines including primary care, nursing, pharmacy, and behavioral health. There was little challenge to the polypharmacy regimens by nursing and primary care staff. The meeting was essentially a review of the medications and indications. This meeting should be a review of the medication regimen prescribed to an individual and a brisk discussion of the regimen and the justification for the utilization of specific medications for an individual. Overall,

there was a need for improvement with regard to the documentation of the review and justification of the regimens.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: 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 (none had yet met their goals). When Center data showed no progress, actions were proposed for less than half, and taken for two-thirds of individuals. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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.	N/A									
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	43% 3/7		1/1	0/1	0/1	1/1	1/1		0/1	0/1
9	Activity and/or revisions to treatment were implemented.	67% 2/3		0/1			1/1	1/1			

Comments:

6. Individual #431 and Individual #381 were progressing, however, their data were not demonstrated to be reliable (see indicator #5), so they were scored as zero for this indicator. Individual #626, Individual #885, Individual #797, Individual #816, Individual #595, Individual #80 and Individual #157 were not making progress toward their targeted behavioral objectives.

8. Individual #595, Individual #816, and Individual #626 were not making progress, however, their progress notes indicated actions to address the lack of progress. For example, Individual #626's January 2019 progress note indicated that a modification to his PBSP would be made to address increases in SIB and inappropriate behavior. On the other hand, Individual #885, Individual #797, Individual #80 and Individual #157 were also not making progress, but there was no evidence in their progress notes of actions to address the absence of progress.

9. Individual #595 and Individual #816 had evidence that corrective actions were implemented. There was no evidence, however, that Individual #626's actions to address the absence of progress occurred.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: One-third of individuals had a sufficient percentage of staff trained in their PBSPs. PBSPs were written by staff with the proper credentials. With	Individuals:

sustained high performance, indicator 18 might be moved the category of requiring less oversight after the next review. Indicators 16 and 18 will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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	0/1	1/1	0/1	0/1	1/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 16. Individual #157, Individual #80, and Individual #816 had documentation that at least 80% of direct support professionals (DSPs) implementing their PBSPs were trained on its implementation. Assuring that all DSPs are trained in the implementation of PBSPs should be a priority for the facility.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: All progress notes commented on the individuals' progress for this and for all previous reviews, with exceptions in October 2017. Therefore, indicator 19 will be moved to the category of requiring less oversight. Indicator 20 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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.	

Comments:
20. Individual #80's graphs did not allow for the visual observation of recent frequency changes.

Outcome 8 – Data are collected correctly and reliably.

Summary: There were some very good examples of individualized data systems that met criteria for indicator 26, and there were examples that did not meet criteria for measuring target behaviors. Measures of data collection timeliness need to be set and implemented. This affected indicators 28 and 29, which, however, will remain in the category of requiring less oversight. Indicators 26 and 30 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 431	626	885	797	816	381	595	80	157
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	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.										
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 #80's data collection system was individualized to measure her very high rate behavior by using frequency counters and a hourly data recording system.

The target behavior data collection system for the remaining individuals specified that target behaviors should be recorded at least once a shift. For Individual #431, Individual #626, Individual #797, Individual #816, and Individual #381, whose targets occurred at a low frequency, this system represented an adequate measure of their target behaviors.

For Individual #885, Individual #595, and Individual #157, who had some target behaviors that were occurring at moderate to high rates, recording data once a shift may likely result in an underestimate of the target behavior. The data systems for these individuals, therefore, 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.

28-29. Mexia SSLC did not have an established measure of date collection timeliness. There were established goal frequencies and levels for IOA and treatment integrity for all individuals. There were established goal frequencies and levels for data collection timeliness for Individual #381 and Individual #80.

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.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/18	1/2	1/2	1/2	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 #595 – constipation/bowel obstruction, and diabetes; Individual #381 – cardiac disease, and diabetes; Individual #291 – diabetes, and other: Stage 3 chronic kidney disease; Individual #469 – other: iron deficiency anemia, and osteoporosis; Individual #638 – other: chronic deep vein thrombosis, and cardiac disease: hypertension; Individual #276 – GI problems, and other: hyperthyroidism; Individual #511 – other: hyperlipidemia, and seizures; Individual #724 – cardiac disease: hypertension, and other: hyponatremia; and Individual #528 – other: hypothyroidism, and infections).

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 #595 – constipation/bowel obstruction, Individual #381 – cardiac disease, and Individual #291 – diabetes.

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: Two of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until improvement is seen with compliance, and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	17% 1/6	N/A	1/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1
	iii. Breast cancer screening	50% 1/2	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	71% 5/7	N/A	1/1	1/1	1/1	N/A	0/1	1/1	0/1	1/1
	vii. Cervical cancer screening	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	0/1	1/1	0/1	1/1

Comments: a. A number or problems were noted with regard to the timely provision of preventive care. For example:

- For Individual #381, no documentation was found for a herpes zoster (shingles) vaccination.
- For Individual #291:
  - Documentation was not submitted to show she received the shingles vaccine.
  - Based on documents submitted, the individual had a colonoscopy in 2009, but the report/results were not found. This was concerning, because the cause of the individual's anemia had not been determined.
  - In November 2017, a one-year screening mammogram was recommended. The AMA did not provide an explanation for not obtaining a mammogram, and none was found.
- For Individual #381:
  - No documentation was found for a herpes zoster (shingles) vaccination.
  - On 10/12/17, a note from the gastroenterologist indicated that the individual could not do a proper preparation for a colonoscopy. The note also stated that even a non-invasive screening, such as fecal immunochemical test (FIT), was not recommended, because if it were positive, the individual could not do the preparation for a colonoscopy. There was no documentation that this decision was discussed with the IDT or the sister. They should have been involved in the decision to discontinue all colorectal cancer screening for this individual. It is possible that they would want to obtain a second opinion or they might elect to proceed with a simple stool test and make a decision later, if it were positive.
- For Individual #276:
  - In 2015, a screening colonoscopy was abnormal. A barium enema was recommended, but no evidence was found to show that it occurred, nor was explanation provided for why it was not done.
  - Although the DEXA was normal in 2013, due to the individual's continued risk, it should have been repeated in five years.
- A note from Individual #511's gynecologist, dated 9/5/17, stated that cervical cancer screening was discontinued. However, the justification for this decision was not found.
- For Individual #724, the Center's response to the document request indicated that a DEXA scan was not applicable. However, the individual had a long history of treatment with multiple psychotropic agents and anti-epileptic drugs. The PCP should document a risk assessment.
- The AMA stated Individual #528 had a colonoscopy in 2009, but Center staff did not submit a report.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. This occurred for four of the nine individuals.

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.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	N/A									
Comments: a. Based on the documentation provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed had DNR Orders that the Center would execute in place.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: As was the status at the time of the Monitoring Team's last review and report, for acute care issues addressed at the Center, overarching concerns included problems with assessments, including, but not limited to a lack of clinically necessary plans for further evaluation, treatment, and monitoring; and a lack of needed follow-up. Based on this review, Center staff sustained their progress in providing treatment prior to individuals' transfer to the ED or hospital. However, problems were noted with regard to PCPs' assessments of individuals prior to transfer, and follow-up upon their return continued to be a significant problem. The remaining indicators will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	17% 2/12	0/1	0/2	1/2	0/1	0/2	0/2	N/A	1/2	N/A
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.	8% 1/12	0/1	0/2	1/2	0/1	0/2	0/2		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	57% 4/7	N/A	N/A	2/2	N/A	1/1	N/A	0/2	N/A	1/2

	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.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4			2/2		N/A		0/1		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.	86% 6/7			2/2		1/1		1/2		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 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.	33% 1/3			N/A		N/A		1/1		0/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	29% 2/7			0/2		0/1		2/2		0/2

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses addressed at the Center, including: Individual #595 (pneumonia on 3/14/19), Individual #381 (ankle sprain on 11/8/18, and chest pain on 11/26/18), Individual #291 (asthma exacerbation on 11/30/18, and asthma on 1/17/19), Individual #469 (mass on his left lower extremity on 12/9/18), Individual #638 (recurrent epistaxis in November 2018, and abdominal pain on 1/28/19), Individual #276 (mandibular adenopathy on 12/27/18, and knee bursitis on 1/31/19), and Individual #724 (headache on 10/25/18, and right hand contusion on 9/18/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #291 (asthma on 1/17/19), and Individual #724 (right hand contusion on 9/18/18).

b. For Individual #291 (asthma on 1/17/19), the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 3/14/19, at around 10:00 a.m., a nursing IPN entry indicated that Individual #595 was moving slow, and had slurred speech and increased drooling. On 3/14/19, the PCP documented that the individual was seen for reports of a cough without fever or shortness of breath. He was also drowsy after chemical restraints. The PCP documented an assessment of the individual's heart and lungs, but did not document other physical findings. The plan was to check a chest x-ray to rule out aspiration pneumonia. The chest x-ray showed a probable pneumonia. On 3/15/19, the chest x-ray was repeated, and it showed a

worsening left pneumonia and a moderate pleural effusion. The PCP prescribed antibiotics and indicated follow-up would occur in three days. However, based on the documentation submitted, the PCP did not complete a physical assessment for an individual with significant and worsening pneumonia.

On 3/19/19, the PCP documented that the individual was improving. On 3/25/19, the PCP noted that the pneumonia was resolved and follow-up would occur as needed. The PCP provided no further discussion regarding to the possibility of aspiration in an individual who received multiple chemical restraints, and then, was lethargic and drooling. It was unclear when a chest x-ray would be obtained to document resolution of the infiltrate and effusion.

- On 11/8/18, nursing staff documented that Individual #381 complained of pain in the left ankle which had 2+ pitting edema. The nurse administered Tylenol. On 11/9/18, nursing staff documented that the individual had pain and swelling in the left ankle and was limping. His blood pressure was 160/92. The nurse notified the PCP, who ordered hydrochlorothiazide 25 milligrams (mg) to start the next day. The follow-up blood pressure was 160/100.

  On 11/12/18, nursing staff continued to document complaints of ankle pain and observed the individual limping. On 11/12/18, the PCP conducted a telemedicine evaluation. The PCP documented that the left ankle had lateral swelling and the individual was limping. The diagnosis was left ankle sprain. The PCP's evaluation did not include the fundamental components of an exam, such as inspection and palpation. There was no documentation of tenderness or presence/absence of joint effusion. The Ottawa ankle rules could not be applied, since the exam was not complete. The PCP did not document the motor and neurovascular status. The plan was ice packs for two days and follow-up in one week.

  On 11/19/18, the PCP noted that the individual's left ankle was still swollen. The plan was to use an ace wrap for a week. On 11/20/18, and 11/23/18, nursing staff documented that the individual's limp and swelling persisted. On 12/3/18, the PCP documented that the ankle sprain was resolved.
- On 2/26/19, at around 6:00 a.m., nursing staff documented that Individual #381 complained of left side chest pain. His blood pressure was 184/104. The nurse notified the PCP, and the nurse administered sublingual nitroglycerine (NG) along with blood pressure medication. Documentation indicated his pain was greatly diminished with the NG. At 11:49 a.m., the PCP assessed the individual. The assessment was chest pain and hypertension. The PCP did not document the type of pain, quality of pain, or that the individual was given sublingual NG, which relieved the pain. The plan was to give him Mucinex, perform daily blood pressure checks, and follow up in one week. On 3/5/19, the PCP documented no further chest pain and noted that the individual had a history of angina. Follow-up was as-needed.

  According to the AMA, the individual had a diagnosis of coronary artery disease/angina. He also was diagnosed with hypertension, prediabetes, hyperlipidemia, and obesity. The AMA provided no further information related to the diagnosis of coronary artery disease. The extent of disease, diagnostic evaluation, and symptomology were not documented. Given this history, it would appear that the PCP's evaluation of chest pain in this instance was not appropriate. It should be noted that the cardiology consult, completed on 6/26/18, did not include any discussion of coronary artery disease.
- On 11/30/18, the PCP evaluated Individual #291 due to complaints of wheezing. The PCP's assessment was asthma with exacerbation. The plan was to continue nebulizer treatments, and start prednisone and Flonase. Follow-up was to occur as needed, or on 12/3/18, if symptoms worsened. According to relevant SSLC guidelines, the PCP should have conducted follow-

up the following day for this acute exacerbation of asthma. However, based on documentation submitted, the PCP did not conduct any follow-up.

- On 12/9/18, nursing staff reported that Individual #469 had a 2 centimeter (cm) by 1 cm hard mass on the left shin. The etiology was unclear. Nursing staff documented the presence of this mass over a series of days, but did not appear to notify the physician until 12/14/18. On 12/14/18, the PCP evaluated the individual and documented a 1.8 by 2.5 cm mass over the left tibia. The plan was for nursing staff to monitor and the PCP would re-consult, if it appeared to get larger. Based on documentation submitted, neither the medical nor the nursing staff conducted necessary follow-up with regard to this mass.
- On 11/13/18, nursing staff documented that Individual #638 had a nosebleed while at work. The nurse assessed him and found a large clot in his left nostril. Based on the documentation submitted, the nurse did not notify the PCP that this individual, who was fully anticoagulated, experienced epistaxis. On 11/17/18, nursing staff documented that the individual again had epistaxis and required pressure to stop the bleeding. On 11/18/18, blood was noted on his pillow. Again on 11/20/18 and 11/28/18, bleeding was documented. In the notes reviewed, nursing staff did not document a rationale for failing to notify the PCP of recurrent bleeding for an individual who received a direct oral anticoagulant (DOAC).

  On 11/30/18, the PCP documented that the individual "presents this morning for episodes of urinary incontinence and an episode of nosebleed." No acute bleeding was noted. The plan was to obtain a urinalysis (UA), a complete blood count (CBC), and a partial thromboplastin time (PTT); start Macrobid, and continue Xarelto. The plan was to follow up in one week. However, the PCP should have planned to follow up with the individual and the labs as soon as possible.

  On 12/1/18, the individual's labs showed a critical value of a white blood cell (WBC) count of 1.8 with an ANC of .4. He was sent to the ED for evaluation, which is discussed in further detail below.
- On 1/28/19, at approximately 5:00 a.m., nursing staff documented that Individual #638 complained of abdominal discomfort after going to the toilet: "Small grimace at epigastric area." At around 1:00 p.m., nursing documented that the individual stated: "I don't feel good," and pointed to his head and stomach. The nurse notified the PCP, who ordered labs and x-rays. No medical provider assessed the individual. The individual's mother contacted Center staff concerned about his behavior while at home over the weekend. Per nursing documentation: "She is insistent on the client seeing a doctor 'before he's dead'." On 1/29/19, a PCP ordered milk of magnesia (MOM) as treatment for abdominal pain. Again, no medical provider completed a medical assessment, even though the individual had complained of abdominal pain for two days. On 1/29/19, the telemedicine nurse documented that the individual complained of a headache, but denied abdominal pain. Home staff indicated he was not himself. The PCP evaluated the individual via telemedicine, and documented that the abdomen was "ND [not distended], NT [not tender], BS [bowel sounds] x4." The PCP's assessment was "change in behavior and weight loss." The plan was to check labs and follow-up in two weeks.

  The PCP did not provide a comprehensive assessment of the individual to address the weight loss (25 to 30 pounds). On 2/11/19, the PCP documented a five-line note stating fatigue was resolved, and follow-up would occur as needed.

  In March 2019, nursing staff continued to document intermittent abdominal pain/epigastric discomfort. The individual continued to report abdominal pain, experienced a significant weight loss, and was treated with multiple medications known to have GI effects. Of note, high-dose Valproic acid is associated with the development of pancreatitis, but it did not appear that

the PCP had ruled this out as a possibility.

- On 12/27/18, at approximately 2:00 a.m., a nurse documented that Individual #276 complained of a toothache in the bottom left last tooth (#19). The nurse gave him Tylenol and placed him on sick call. At around 3:00 p.m., nursing staff documented that the individual had swelling at the lower left jaw and gingival redness was present. The individual did not go to work due to pain. There was no documentation of a medical or dental assessment.

  On 12/28/18, the PCP documented seeing the individual to evaluate him for tooth pain that started two days earlier. The PCP documented that there was 5-cm tender mandibular lymph node. There was no obvious abscess. However, the PCP did not perform percussion on the suspected tooth. The assessment was lymphadenopathy and the emergency referral to the dental clinic was cancelled. The PCP prescribed amoxicillin. On 1/2/19, the PCP noted that the swelling was greatly improved. On 1/9/19, the dentist evaluated the individual in dental clinic, and determined that tooth #19 had periodontal disease and was non-restorable requiring extraction.
- On 1/31/19, nursing staff documented that Individual #276 complained of left knee pain. The left knee was visibly swollen. The PCP evaluated the individual and documented that the left knee had "fluid filled swelling," and was non-tender. The assessment was bursitis/possible injury. The plan was to obtain x-rays.

  The PCP did not re-evaluate the individual. On 2/6/19, the PCP documented that the x-rays showed tri-compartmental degenerative changes. The PCP also documented that since 2/5/19, the individual had no pain. Physical therapy was ordered and Tylenol was to be used as-needed
- On 10/25/18, the PCP documented that Individual #724's "BP [blood pressure] up with headache across forehead." The blood pressure yesterday was "up 160/102 improved with rest, today 160/92." The headache responded to ibuprofen and the plan was to "evaluate TID [three times a day] BPs and at 2 weeks adjust therapy if needed." The PCP did not document a physical examination. For an individual with a significant elevation in blood pressure who complained of a headache, the PCP should have completed and documented a physical examination.

  Nursing staff completed blood pressure readings twice a day. On 10/30/18, the PCP added hydrochlorothiazide to the individual's medication regimen. The first PCP note related to the blood pressure readings was on 11/19/18. The blood pressures were noted to have responded to treatment; however, the PCP noted blood pressures of 156/80s. Current guidelines recommend a blood pressure <130/80 for this individual.
- On 9/18/18, the PCP documented that Individual #724 sustained a hand injury. The physical exam showed bruising and tenderness over the thenar eminence. X-rays were negative. The PCP's assessment was a contusion. The plan was to administer Tylenol, use icepacks, and recheck in three days. The PCP did not complete and/or document follow-up.

c. For four of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #291 (bronchitis on 2/14/19, and asthma on 2/19/19), Individual #638 (leukopenia on 12/1/18), Individual #511 (apnea and dehydration on 12/19/18, and aspiration pneumonia on 1/9/19), and Individual #528 (pneumonia on 11/18/18, and aspiration pneumonia on 11/26/18).

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

- On 2/14/19, the PCP documented that Individual #291 was evaluated for fever and respiratory distress. The individual was transferred to the ED for evaluation. On 2/15/19, upon the individual's return to the Center, the PCP saw her. The PCP did not document a specific diagnosis. The assessment/plan stated respiratory distress - resolved. Nursing documentation indicated the diagnosis was bronchitis. The PCP did not document a plan of care or any additional follow-up.
- On 2/19/19, nursing staff documented that Individual #291 had wheezing, but no respiratory distress. At around 3:20 p.m., the PCP evaluated the individual and noted that wheezing and respiratory distress were present. The PCP sent the individual to the ED via Center van for evaluation. The PCP documented respiratory distress with a respiration rate of 34, heart rate of 110, oxygen (O2) saturation of 94%, and temperature of 101 degrees. Emergent transfer might have been indicated. She returned to the Center later that day.

  On 2/20/19, the PCP evaluated the individual. The diagnosis was exacerbation of asthma. The exam was remarkable for mild expiratory wheezing. The plan was to continue steroids and nebulizer treatments with follow-up on 2/25/19. Nursing staff continued to document a cough and expiratory wheezes. On 2/22/19, the PCP documented lab results, but did not document an assessment of the individual. On 2/26/19, the PCP documented that the individual was improved. The exam revealed a wet cough, some rhonchi, and mild crackles in the bases. The assessment was resolution of asthma exacerbation, and the plan was to continue regular medications.
- As noted above, on 12/1/18, Individual #638's labs showed a critical WBC value of 1.8 with an ANC of .4. He went to the ED for evaluation. This was an after-hours transfer, and on 12/2/18, the PCP wrote a note, and conducted follow-up. The assessment was leukopenia and fatigue. The plan was to obtain a CBC and follow up the following day. The PCP did not discuss the possible etiology of a significant decrease in the white blood cell count.

  On 12/3/18, the PCP did not conduct follow-up. On 12/4/18, the PCP documented that the low white cell count was discussed with psychiatry. The psychiatrist lowered the Depakote dose, and discontinued the Macrobid. The plan was to follow up as needed, and await the CBC results.

  On 12/4/18, the PCP documented a WBC count of 2.2. The PCP did not document the clinical status of the individual, such as signs or symptoms of infection or the presence of a fever. The Monitoring Team member could not review the assessment and diagnostics done in the ED, because Center staff did not submit the ED records as requested.
- On 12/13/18, nursing staff documented that Individual 511's color was off, and she was puffy in the face. The individual was also not closing her right eye. Nursing staff relayed this information to two primary care providers, but there was no documentation to show that a PCP conducted an assessment.

  On 12/19/18, nursing staff documented that the individual appeared to "feel unwell." Nursing staff heard expiratory wheezes throughout the lungs, and the individual's O2 saturations were 94 to 96%, when awake. The individual was placed on sick call for 12/20/18. Additional nursing documentation noted six-second delays in breathing and the inability to clear secretions. At approximately 4:00 p.m., the individual was transferred to the ED for evaluation. There was no physician assessment documented during normal business hours.

  On 12/20/18, the PCP wrote a note stating that the individual was referred to the ED due to episodes of apnea, fever, and thick

oral secretions. The diagnosis was dehydration and "overdosage" of carbamazepine and Valproic acid. The plan was to obtain a sleep study and monitor. Again, on 12/21/18, the PCP conducted follow-up.

- On 1/9/19, at around 4:00 a.m., Individual 511's gastric tube became dislodged. Attempts to replace it were not successful. The individual was transported to the hospital for replacement. On 1/12/19, the individual experienced two episodes of emesis. At around 6:00 a.m., the individual was lethargic with an increase in her respiratory rate and decreasing oxygen saturation. She was transferred to the ED for evaluation and admitted to the hospital with aspiration pneumonitis. This was an after-hours transfer, but the PCP did not write a note within one business day.

  On 1/13/19, she returned to the Center, and at approximately 7:00 p.m., the PCP saw her. The plan was to continue antibiotics. On 1/14/19, the PCP conducted additional follow-up, and on 1/15/19, documented lab and x-ray results.
- On 11/17/18, at 2:47 p.m., nursing staff documented that Individual #528 had a cough. The nurse gave the individual Robitussin. At around 5:20 p.m., nursing staff documented the individual was coughing and wheezing. Robitussin was administered again. On 11/18/18, at 2:37 a.m., nursing staff documented that the individual had a temperature of 101.6. The nurse administered Tylenol, loratadine, and guaifenesin. At around 11:00 a.m., the LVN requested that the Campus RN evaluate the individual due to a croupy cough, temperature of 100.5, and lungs with coarse crackles. At 1:55 p.m., the RN documented that the individual was spitting up "red/frank blood." At 12:45 p.m., the PCP requested transfer to the hospital via Center vehicle. At approximately 2:00 p.m., the RN noted that staff had not notified the PCP that the individual had a fever overnight. The individual was admitted to the hospital, and returned on 11/23/18, at 4:30 p.m. This was a weekend transfer, but the PCP did not write a note within one business day.

  On 11/26/18, the PCP signed an IPN entry documenting a post-hospital assessment for the diagnosis of pneumonia. This was reported as a late entry for 11/24/18. Nursing staff indicated that on 11/24/18, the individual attended sick call with the PCP with no new orders. Nursing staff also documented that on 11/24/18, the individual had emesis.

  On 11/25/18 (signed on 11/26/18), the PCP wrote a note indicating the individual's diagnosis was pneumonia and pulmonary edema. The plan was to continue antibiotics and diuresis. On 11/25/18, nursing staff documented an increased temperature of 100.4, blood pressure 100/60, and a respiration rate of 24.

  On 11/26/18, at 1:47 a.m., the PCP documented CBC results and noted that staff reported a fever. At around 10:00 a.m., nursing staff noted the individual had emesis, a cough, and congestion. At 12:17 p.m., the PCP documented an assessment noting that the individual was declining and would be transferred back to the hospital. She was admitted to the hospital, and on 12/2/18, she was discharged back to the Center.

  On 12/2/18, the PCP conducted a post-hospital assessment. The discharge diagnoses were recurrent aspiration pneumonia, congestive heart failure, acute kidney injury, and hypernatremia. The PCP did not provide a cogent plan of care, but copied all medication orders into the note. On 12/3/18, the PCP conducted additional follow-up. The next PCP note was dated 12/4/18, and it was a summary of lab results. Another PCP summary of lab results was dated 12/7/18, but there were no additional assessments of the individual's physical status. Again, on 12/13/18, the individual was admitted for pneumonitis, recurrent aspiration, and a urinary tract infection (UTI).

On 12/10/18, the IDT held a post-hospital ISPA meeting. However, the PCP did not participate, but should have.

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

Summary: It was good to see improvement overall with regard to PCPs' review and handling of non-Facility consultations. For the consultations reviewed for this report, PCPs generally reviewed consultations and indicated agreement or disagreement, and did so in a timely manner. Often, PCPs wrote orders for agreed-upon recommendations. Currently, these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	93% 14/15	2/2	2/2	2/2	N/A	2/2	2/2	2/2	1/1	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 15/15	2/2	2/2	2/2		2/2	2/2	2/2	1/1	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.	93% 14/15	2/2	2/2	2/2		2/2	2/2	2/2	1/1	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	87% 13/15	2/2	2/2	2/2		1/2	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.	N/A									

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #595 for podiatry on 2/13/19, and podiatry on 11/14/18; Individual #381 for neurology on 9/17/18, and optometry on 11/8/18; Individual #291 for cardiology on 2/25/19, and pulmonology on 2/4/19; Individual #638 for hematology/oncology on 12/18/18, and podiatry on 2/28/19; Individual #276 for endocrinology on 1/25/19, and endocrinology on 10/22/18; Individual #511 for ophthalmology on 1/8/19, and neurology on 11/18/18; Individual #724 for neurology on 11/26/18; and Individual #528 for endocrinology on 12/10/18, and neurology on 9/5/18.

a. through c. For the consultation reports reviewed, PCPs completed timely reviews, and generally wrote IPNs that included the necessary components, including an indication of agreement or disagreement with the recommendations, and provided rationales for disagreements. The exception was for Individual #528's neurology consultation on 9/5/18, for which the PCP did not comment in the IPN with regard to agreement or disagreement with the recommendations, and/or whether or not IDT involvement was needed.

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 exceptions of the following: for Individual #638's hematology/oncology consultation, follow-up on neutropenia was needed in two weeks, but no follow-up consultation was submitted; and for Individual #528's neurology consultation on 9/5/18, it was unclear if the PCP agreed with the recommendations.

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

Summary: For most of the individuals' chronic or at-risk conditions the Monitoring Team reviewed, PCPs had not completed medical assessments, tests, and evaluations consistent with current standards of care, 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: 595	381	291	469	638	276	511	724	528
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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #595 – constipation/bowel obstruction, and diabetes; Individual #381 – cardiac disease, and diabetes; Individual #291 – diabetes, and other: Stage 3 chronic kidney disease; Individual #469 – other: iron deficiency anemia, and osteoporosis; Individual #638 – other: chronic deep vein thrombosis, and cardiac disease: hypertension; Individual #276 – GI problems, and other: hyperthyroidism; Individual #511 – other: hyperlipidemia, and seizures; Individual #724 – cardiac disease: hypertension, and other: hyponatremia; and Individual #528 – other: hypothyroidism, and infections).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #511 – seizures, and Individual #528 – other: hypothyroidism. The following provide examples of concerns noted:

- According to the AMA, Individual #595 had a diagnosis of constipation, but had regular bowel movements. The only medication mentioned in the plan was docusate. At the time the PCP completed the AMA, the individual was also receiving polyethylene glycol (PEG). Per the PCP, "he does appear to drink adequate fluids." Since fluid and fiber are important to the management of constipation, the PCP should have included related interventions in the plan. The PCP in conjunction with dietary should determine the proper amount of fiber and fluids. Then, the IDT should clearly define responsibility for ensuring fluid intake is adequate, as well as for maintaining a bowel log in order to determine efficacy.
- Individual #595 was treated with lurisadone and Seroquel, which increased the risk for hyperglycemia. However, the PCP did not discuss the potential for endocrine side effects in the AMA.
- Individual #381's AMA listed coronary artery disease/angina as an active diagnosis. The PCP's comments were limited to: "Being followed by Medical and Specialists." The AMA provided no additional information related to this diagnosis. There was no information on how the diagnosis was made, interventions performed, or if the individual experienced angina symptoms. The PCP provided no medical plan of care outlining the management for this condition.

The cardiology consult, performed on 6/26/18, documented: "Chart review does not list cardiac problems however, he is taking beta blocker and long acting nitro." The cardiology provider was unable to substantiate the diagnosis of coronary artery disease. The PCP should review the available records to determine the accuracy of this diagnosis. Based on the diagnoses of hypertension, metabolic syndrome, and obesity, the individual was at risk for coronary artery disease.

- The assessment component of Individual #381's AMA stated: "hypertension/metabolic syndrome. Being followed by medical." The PCP provided no medical plan of care to address any of these diagnoses. Each required discussion and a plan of care.

In addition, this individual met the criteria for the diagnosis of prediabetes based on the 11/9/18 A1c of 6.1. On 5/7/18, the A1c was 5.8. However, the AMA did not discuss the management of prediabetes. Eventually, in December 2018, the PCP started the individual on metformin.

- Per Individual #291's AMA, dated 7/31/18, Type 2 diabetes mellitus (T2DM) was "controlled with diet." The PCP documented no other comments, assessments, or plans of care. The individual met the criteria for the diagnosis of T2DM based on A1cs greater than 6.4. The PCP did not document any of the monitoring that the American Diabetes Association (ADA) guidelines require. On 1/24/19, the PCP documented that the A1c was 6.7%, but due to the individual's age and co-morbid conditions no oral agents would be started.
- On 12/21/18, a renal consult was done for Individual #291. Per the nephrologist, the individual had chronic kidney disease Stage G3 with an estimated glomerular filtration rate (EGFR) of 36, based on a creatinine level of 1.38 (8/28/18). She also had essential hypertension, and the goal was to achieve a blood pressure of 130/80. Stage 3 chronic kidney disease was listed on Individual #291's active problem list. However, the PCP did not provide a plan of care for chronic kidney disease in the AMA. The IMR, completed on 1/25/19, listed the date of the renal consult, but provided no summary of the recommendations.
- Individual #469's AMA documented iron-deficiency anemia as an active problem. In the assessment/plan section of the AMA, the PCP stated iron deficiency anemia was chronic, but had "good control." The PCP's plan was to "Monitor CBCs [complete blood counts]. Medication if needed." The PCP provided no explanation or etiology for the diagnosis of iron-deficiency anemia in a 53-year-old male, who had never had colorectal cancer screening.
- According to the AMA assessment/plan section, Individual #638 had a chronic deep vein thrombosis, and was clinically stable. The PCP did not include a medical plan of care in the AMA to address the diagnosis. Therefore, it was not clear how the deep vein thrombosis was treated. The IRRF indicated that the individual received Lasix for treatment of chronic edema. However, it did not specify the site of the edema. It was not clear if the individual suffered from post-phlebitic syndrome, or had chronic edema secondary to some other cause.
- In the AMA, Individual #638's PCP did not provide an assessment and status for the diagnosis of hypertension. Hypertension, high-density lipoprotein (HDL), and hypothyroidism were grouped together with one plan: "stable; need labs updated next month." The treatment goals, current status, and plan of care were not included in the AMA. The PCP was treating this individual with two diuretics, but the rationale for this was not documented.
- According to Individual #276's PCP, in 2012, a colon polyp was found that could not be retrieved. In March 2015, a tubulovillous adenoma was removed. A subsequent colonoscopy was normal, but the preparation was poor. There was no discussion of the follow-up interval. Under the preventive care section, the next date for a colonoscopy was listed as 2020. This should have been included in the plan for the active medical problem. However, the gastroenterologist made a recommendation that a barium enema be completed, and Center staff did not submit documentation to show that this occurred.

- For Individual #276, the assessment/plan section of the AMA did not include Graves Disease as a diagnosis. In the medication section, the PCP listed methimazole as a daily medication for hyperthyroidism. The PCP should outline the plan of care guided by the endocrinologist's recommendations. In the AMA, the PCP also should indicate clearly the potential side effects related to the use of methimazole.
- Individual #511 was prescribed a statin to address hyperlipidemia, and appeared to have some periodic monitoring of lipid levels. However, in the AMA, the PCP provided no discussion of the individual's low-density lipoprotein (LDL) level or atherosclerotic cardiovascular disease (ASCVD) risk score. The PCP documented no plan for further treatment or monitoring.
- The assessment/plan section of Individual #724's AMA stated: "Chronic/stable. Continue to follow with medication listed below." The PCP had not documented the status of the individual's hypertension. That is, the PCP did not indicate if the hypertension was controlled or the blood pressure target was met. The IPNs documented that the individual frequently complained of headaches that prompted measurement of blood pressure. The blood pressure readings often were high, including systolic blood pressures sometimes over 160 and diastolic blood pressures between 90 and 102. The PCP added hydrochlorothiazide to the metoprolol, but the individual's blood pressures remained high. In the AMA, the PCP provided no documentation of the assessment of target organ damage, and there was no specific plan of care.
- Individual #724 had a significant hyponatremia, with the last sodium level being 129, on 12/19/18. The AMA and interval medical review provided no documentation of the etiology of the hyponatremia or the plan to address it. In the assessment/plan section of the AMA, the PCP merely stated: "Continue to follow medically with periodic lab tests."
- According to the AMA, since 1974, Individual #528 had a positive purified protein derivative (PPD) status. The plan was: "TB [tuberculosis] questionnaire unremarkable. CXR [chest x-ray] yearly if cooperative. T spot assay is an option." In the AMA, the PCP did not provide any information on previous treatment for latent tuberculosis infection (LTBI). Moreover, the Centers for Disease Control (CDC) no longer recommends annual CXRs for asymptomatic individuals.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In fact, many IHCPs reviewed did not include any medical interventions for the PCP to implement. In some cases, medical interventions were not assigned to specific staff/positions, or they were assigned to more than one position (e.g., medical/nursing). This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

Individuals:

#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	25% 1/4	N/A	N/A	N/A	1/1	0/1	N/A	N/A	0/1	0/1

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. In some cases, medical interventions were not assigned to specific staff/positions, or they were assigned to more than one position (e.g.,

medical/nursing).

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	595	381	291	469	638	276	511	724	528
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: a. and b. 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 QDRRs, particularly with regard to the review of laboratory results. In addition, problems continued to occur with regard to prescribers' implementation of the agreed-upon recommendations from QDRRs. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it 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;	61% 11/18	0/2	0/2	1/2	2/2	2/2	2/2	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	100% 10/10	2/2	2/2	N/A	N/A	2/2	2/2	N/A	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.	57% 4/7	2/2	0/2	N/A `	N/A	1/1	1/1	N/A	0/1	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 some individuals reviewed, the Clinical Pharmacist had not included, commented on, or made recommendations related to relevant lab data. Some examples include:

- Individual#595 was prescribed lithium, and a urinalysis was required for monitoring per the Center's lab matrix, but the Clinical Pharmacist did not provide comments on these lab results. In addition, on 12/7/18, this 28-year-old's creatinine was 1.29 (high), but the QDRR included no discussion of renal function, and the slow increase in creatinine. The impact of lithium on renal function is well documented, and the PCP and IDT should be made aware of the change in renal function.
- For Individual #381, the Clinical Pharmacist commented on the June 2018 cardiology consult that noted that the individual had no history (in the records reviewed) of coronary artery disease. However, the pharmacist made no comments on the individual's use of long-acting daily nitroglycerin. Also, the pharmacist documented the individual's hyponatremia, but made no further comments related to chronic hyponatremia and the possible association with medication use.
- For Individual #291, overall, the Clinical Pharmacist offered relatively good discussions of the disease processes treated with daily medications and the corresponding lab monitoring. However, the Clinical Pharmacist documented that the individual met the criteria for metabolic syndrome. She actually had an A1c consistently above 6.4, which met the criteria for T2DM. This should have led to a discussion of the management of T2DM, but the only comment was no medications. Until 1/25/19, the PCP provided no explanation for not prescribing medications.
- For Individual #724, the Clinical Pharmacist noted that the individual's blood pressure was stable on metoprolol and

hydrochlorothiazide (HCTZ). However, the IPNs documented multiple instances in which the individual's blood pressure readings were elevated. Moreover, the Clinical Pharmacist noted that the chronic hyponatremia was most likely due to Trileptal. However, there was no documentation of the appropriate work-up to rule out other causes of hyponatremia.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation often was not presented to show they implemented them. For example:

- For Individual #381, the Clinical Pharmacist made recommendations in the two QDRRs reviewed regarding the valproic acid, and the PCP agreed. However, based on review of the orders and IPNs, it was unclear what if any action the PCP took.
- The November 2018 QDRR indicated that Individual #724 needed an updated EKG, because the last one was over a year old. The most recent one the Center submitted to the Monitoring Team was dated, 10/17/17.

  In its comments on the draft report, the State disputed this finding, and stated: "EKG performed 11/15/2018 and uploaded to IRIS 11/19/2018." As the State is aware, in providing comments, it needs to cite the relevant documentation. It did not do so in this case. The Monitor reviewed documentation Center staff submitted in response to document request #69, which requests: "The most recent EKG." As indicated in the draft report, the EKG included was dated 10/17/17. If a more recent EKG was available, Center staff should have provided a copy in response to the Monitor's request.

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.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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	N/A	0/1
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 #291 was edentulous, and was part of the outcome group, so a limited review was conducted. Individual #724 was at low risk for dental, but was part of the core group, so a full review was conducted. 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. For most individuals, the stated goal/objective was: "individual will have a decrease or absence in decay over the next 12 months." Given that these were goals in individuals' ISPs, they needed revision to address actions that the individuals could reasonably take to improve their dental health.

A good way to think about it 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 for two minutes 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. It also is essential that the goal/objective reflect the individual's baseline.

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/A			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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									

Comments: Individual #291 was 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 implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: Efforts continue to be needed to ensure that individuals receive	Individuals:

necessary dental treatment. On a positive note, if the Center sustains its progress with regard to the completion of dental x-rays, after the next review, Indicator c might move to the category requiring less oversight.											
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	63% 5/8	1/1	1/1	N/A	1/1	0/1	0/1	0/1	1/1	1/1
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 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.	88% 7/8	1/1	1/1		1/1	0/1	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.	75% 3/4	1/1	1/1		N/A	0/1	1/1	N/A	N/A	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 3/3	1/1	1/1		N/A	N/A	1/1	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	50% 1/2	N/A	N/A		0/1	N/A	1/1	N/A	N/A	N/A
Comments: a. through f. Individual #291 was edentulous. f. On 1/23/19, the dentist extracted Individual #469's tooth #18. Although the consent signed allowed for extractions, the IPN did not include an explanation from the dentist for the extraction.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced a dental emergency in the six months prior to the review.											

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	595	381	291	469	638	276	511	724	528
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% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2							0/1		0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2							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% 0/2							0/1		0/1

Comments: a. For the two applicable individuals, IDTs did not include measurable suction tooth brushing strategies/plans in their ISPs/IHCPs. For both individuals, IHCPs included action steps for suction tooth brushing twice a day. To make them measurable, IDTs need to add the duration of suction tooth brushing that reflects the individual's needs and current tolerance (e.g., for 30 seconds, two minutes).

b. Based on documentation submitted, for the two individuals, staff completed suction tooth brushing twice a day. However, because the IDTs had not included the expectations for duration in the IHCPs, it was not possible to measure success.

c. Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." The IHCPs for these two individuals did not include any action steps related to monitoring. Moving forward, IDTs should ensure that individuals needing suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. QIDP reports did not include specific data, but rather statements, such as "no issues or concerns." Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. None.											

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: For the couple acute events reviewed, nurses only sometimes followed relevant guidelines with regard to documenting the time of the onset of symptoms and/or the completion of necessary initial assessments. Improvements are needed with regard to the quality of acute care plans, as well as nurses' implementation or documentation of the completion of the interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 1/2	N/R	0/1	N/R	N/R	N/R	N/R	1/1	N/R	N/R
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.	50% 1/2		0/1					1/1		
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	100% 1/1		1/1					N/A		
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and	0% 0/1		N/A					0/1		

	post-hospitalization assessments.										
e.	The individual has an acute care plan that meets his/her needs.	0% 0/2		0/1					0/1		
f.	The individual's acute care plan is implemented.	0% 0/2		0/1					0/1		

Comments: Given that State Office recently provided training and Center staff are at the beginning stages of developing and implementing acute care plans that reflect the training, the Monitoring Team reviewed a small number of acute care plans. Specifically, the Monitoring Team reviewed two acute illnesses and/or acute occurrences for two individuals, including those for Individual #381 – on 11/21/18, choking on pecans; and Individual #511 – on 1/12/19, aspiration pneumonia.

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

The following provide some examples of findings related to this outcome:

- For Individual #381, based on review of a nursing IPN, dated 11/21/18, at 11:49 p.m., and an addendum, dated 11/22/18, at 5:16 a.m., as well as IView entries, dated 11/21/18, 11:35 p.m., the nurse did not follow the guidelines for recording the time staff notified the nurse of the choking event. In addition, the nurse did not follow the respiratory distress/aspiration guidelines for conducting an abdominal assessment. The nurse also did not document the time of PCP notification.

  However, following the initial assessment, the nurse did follow the respiratory distress/aspiration guidelines when conducting additional assessments, including conducting abdominal assessments.

  The acute care plan included the frequency for vital sign assessments (i.e., every four hours). However, it did not incorporate other necessary assessments from the respiratory/aspiration guidelines, such as assessments of lung sounds. A number of the action steps that the nurse included in the acute care plan were not measurable (e.g., encourage fluids). As a result, staff's implementation of the plan could not be assessed.
- For Individual #511's aspiration pneumonia diagnosis, based on review of a nursing IPN, dated 1/12/19, at 8:03 a.m., and IView entries, dated 1/12/19, at 6:08 a.m., nursing staff followed standards of care for completing SOAP documentation, which included the time staff reported the initial concerns (i.e., 6:03 a.m.). Based on this documentation, nursing staff followed the respiratory distress/aspiration guidelines in conducting assessments. The nurse also notified the PCP in accordance with the applicable standards of care.

  Upon the individual's return to the Center from the hospital, the nurse wrote an IPN, dated 1/13/19, at 7:08 p.m. The assessments the nurse documented did not follow the guidelines for respiratory compromise and for skin (turgor) assessments. Vital sign assessments showed abnormalities, but the nurse did not reassess the individual to ensure that the initial readings were not false readings, or if not, to make physician notification.

Examples of problems with the acute care plan included: the intervention for assessing drug reaction, did not specify the frequency; the intervention for vital signs and respiratory status required nurses to complete them each shift for 10 days, but it did not provide criteria for assessing the individual's "respiratory status." For example, the intervention should have defined the parameters for performing clinical observations, listening to the individual's lungs sounds, assessing whether or not the individual had a cough, conducting abdominal assessments, reviewing residuals (as she had PEG tube), etc.

Of note, as part of the onsite review week, the Monitoring Team appreciated the Chief Nurse Executive and the Program Compliance Nurse's willingness to conduct an objective review of one acute care plan for one of the individuals reviewed, and discuss their findings openly with the members of the Monitoring Team and State Office staff. This effort showed Center staff's ability to identify the strengths, as well as some of the weaknesses in the acute care plans and the related nursing assessments. With some refinements to the process, and continued auditing with constructive feedback to the nurses responsible for writing and implementing acute care plans, the Monitoring Team is hopeful that at the time of the next review improvements will have occurred.

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.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
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.	11% 2/18	1/2	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 specific risk areas, and the IHCPs, if available, to address them (i.e., Individual #595 – respiratory compromise, and GI problems; Individual #381 – choking, and diabetes; Individual #291 – respiratory compromise, and infections; Individual #469 – dental, and constipation/bowel obstruction; Individual #638 – circulatory, and choking; Individual #276 – respiratory compromise, and GI problems; Individual #511 – aspiration, and seizures; Individual #724 – weight, and falls; and Individual #528 – aspiration, and GI problems).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used

to measure the individual's progress or lack thereof: Individual #595 – GI problems, and Individual #469 – constipation/bowel obstruction.

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 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 nursing supports and services to these nine individuals.

Outcome 6 – 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.

#	Indicator	Overall Score	Individuals: 595	381	291	469	638	276	511	724	528
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% 0/9	0/1	0/2	0/2	N/A	0/1	N/A	0/1	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	11% 2/18	0/2	1/2	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 also 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 exceptions were for Individual #381 – diabetes, and Individual #291 – infections.

b. As illustrated below, a pervasive problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of

conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- On 3/14/19, at around 10:00 a.m., a nursing IPN entry indicated that Individual #595 was moving slow, and had slurred speech and increased drooling. On 3/14/19, the PCP documented that the individual was seen for reports of a cough without fever or shortness of breath. He was also drowsy after chemical restraints. The plan was to check a chest x-ray to rule out aspiration pneumonia. The chest x-ray showed a probable pneumonia. On 3/15/19, the chest x-ray was repeated, and it showed a worsening left pneumonia and a moderate pleural effusion. However, the IDT did not hold an ISPA meeting to develop an IHCP to address his new risk related to respiratory compromise/aspiration pneumonia.
- Based on documentation submitted, on 11/21/18, a supervisor contacted the Campus RN, and reported that Individual #381 "was in his bedroom eating pecans that he'd picked up on campus. Began violently coughing." The individual did not have an IHCP for choking, and the IDT did not meet after this event to develop one.
- On 11/9/18, Individual #381 started Metformin to address an elevated A1c of 6.1, and the individual's dosage of Fenofibrate increased to 48 mg for dyslipidemia (i.e., his triglycerides were 529). In the interval medical review, dated 3/19/19, the PCP documented a new diagnosis of pre-diabetes. After these changes of status, the IDT did not meet to discuss his increased risk, and review, and if necessary, modify his IHCP.
- On 11/2/18, Individual #291 was hospitalized for bronchitis, aspiration pneumonitis, and pleural effusion. On 11/13/18, the IDT held an ISPA meeting to discuss the hospitalization. Based on the documentation, the IDT did not discuss her risks in any depth, and/or review and modify, as needed, the IHCP. Previous ISPAs showed issues related to the individual's use of suction tooth brushing, as well as reports of coughing before and after meals, but the IDT had not addressed these issues.
- On 9/12/18, Individual #638 choked requiring two abdominal thrusts to dislodge what was described as sausage. The SLP's assessment, dated 9/12/18, stated that the individual did not have a previous history of choking, and indicated that: "the lack of following the supports listed on the dining plan led to him choking on a large piece of food." The individual did not have an IHCP to address choking, and his IDT did not develop one. More specifically, on 9/12/18, the IDT met to discuss an Emergency restriction related to his choking event, and recommended: 1) dining plan revisions to add verbal and physical cues, along with adding a cue to use his tongue to clear his cheeks when eating; 2) level of supervision changes; and 3) a change-of-status (COS) risk change from low to a medium, with an addendum to the IRRF and a new IHCP. However, a choking IRRF and/or IHCP were not submitted. At minimum, the IDT should have outlined action steps, including preventive measures.
- On 11/23/18, 1/12/19, and 2/2/19, Individual #511 had changes of status related to respiratory distress/respiratory compromise. More specifically, on 11/16/18, she was hospitalized for pneumonia, a urinary tract infection (UTI), and sepsis; on 1/12/19, she was hospitalized for aspiration pneumonitis; and on 2/2/19, she was hospitalized for food/vomit pneumonitis. For each of these hospitalizations, the IDT held post-hospitalization ISPA meetings. However, the IDT never reviewed the IRRF or the IHCP related to respiratory compromise to evaluate whether or not the interventions were meeting the individual's needs. In addition, follow-up ISPAs were not found. On 2/17/19, Individual #511 was hospitalized for respiratory failure, and remained hospitalized until her death with a cause of death listed as aspiration pneumonia.
- On 6/5/18, 9/28/18, 12/27/18, 1/4/19, 1/7/19, and 2/5/19, Individual #724 fell. On 3/4/19, his IDT held an ISPA meeting to review action plans and the active record. However, based on the discussion record, the IDT did not discuss the updated data on falls that had occurred since his ISP meeting, on 12/20/18. However, the record did mention the Mobility and Orientation Evaluation, conducted on 1/9/19, which identified "demonstrated difficulties with depth perception and detecting ground level obstacles all of which may have contributed to falls." The therapist recommended a mobility cane. However, the IDT did not

take the opportunity to review the therapist's findings and recommendations to determine if they might assist in ameliorating his risk.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: For the at least the two previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. However, given the importance of this indicator to individuals' health and safety, these indicators will continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/4	0/1	N/A	0/1	N/A	N/A	N/A	0/1	N/A	0/1
	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 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	29% 2/7	0/2	N/A	1/2	N/A	N/A	N/A	0/1	N/A	1/2

	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.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #595, Individual #381, Individual #291, Individual #469, Individual #638, Individual #276, Individual #724, and Individual #528.

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

d. The following concerns were noted:

- On 3/14/19, Individual #595 was diagnosed with left lower lobe pneumonia, but his IHCP did not include respiratory assessments, and the nurse did not complete them during the medication pass that the Monitoring Team member observed.
- It was positive that the medication nurse for Individual #291 performed lung sound assessments before and after the medication pass observed, even though her IHCP did not specify that the assessments occur in conjunction with medication pass (i.e., the IHCP included an intervention for lung sound assessments every shift). Based on a review of a sample of IView entries, nursing staff were not completing daily respiratory assessments. In fact, they only completed them monthly.

- For Individual #511, the IHCP required lung sounds each shift, but the intervention was not measurable, because it did not define "shifts" (e.g., eight-hour, 12-hour, times, etc.). In addition, given her significant risk for aspiration pneumonia and the use of a gastrostomy tube, the IHCP should have required lung sound assessments before and after medication administration and feedings. On 3/5/19, Individual #511 died at the age of 55 with one of the causes of death listed as aspiration pneumonia.
- It was positive that the medication nurse for Individual #528 performed lung sound assessments before and after the medication pass observed. Although the medication nurse indicated that the IHCP required these assessments before and after each medication pass, the IHCP the Center provided to the Monitoring Team did not include a corresponding intervention. Rather, it required monthly and PRN respiratory assessments, which were not of sufficient intensity for this individual at high risk for respiratory compromise.

f. Often, medication nurses implemented the portions of individuals' PNMPs related to medication administration, including checking the position of the individuals prior to medication administration. The exception was for Individual #469 for whom the nurse did not ensure his wheelchair was correctly positioned (i.e., it was tipped with two wheels on the mat, and two wheels off the mat).

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was that the nurse fist-bumped Individual #381, but then did not use hand sanitization procedures prior to continuing with the medication pass.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see some improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, 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	595	381	291	469	638	276	511	724	528
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/1	0/2	0/1	0/2	0/1	0/2	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	8% 1/12	0/1	0/2	0/1	0/2	0/1	0/2	0/1	1/1	0/1
	iii. Integrated ISP progress reports include specific data	0%	0/1	0/2	0/1	0/2	0/1	0/2	0/1	0/1	0/1

	reflective of the measurable goal/objective;	0/12									
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/1	0/2	0/1	0/2	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/2	0/1	0/2	0/1	0/2	0/1	0/1	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;	67% 4/6	0/1	N/A	1/1	N/A	0/1	N/A	1/1	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1		0/1		0/1		0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6	0/1		0/1		0/1		0/1	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1		0/1		0/1		0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/1		0/1		0/1		0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1		0/1		0/1	0/1	0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #595 – choking; Individual #381 – choking, and falls; Individual #291 - falls; Individual #469 – choking, and falls; Individual #638 – choking; Individual #276 – constipation/bowel obstruction, and neurological (i.e., Parkinson's disease); Individual #511 – falls; Individual #724 – weight; and Individual #528 - fractures.

a.i. and a.ii. 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 #724 – weight.

b.i. The Monitoring Team reviewed six areas of need for six 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 those for: Individual #595 – falls, Individual #291 – aspiration, Individual #638 – weight, Individual #511 – aspiration, Individual #724 – fractures, and Individual #528 - aspiration.

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

- According to Individual #595's IRRF, dated 7/17/18, he fell five times in the previous year. Despite these five falls, the IDT determined he was at low risk for falls, and they did not develop an IHCP. The IDT indicated that he had a skill acquisition

program (SAP) to learn to tie his shoes, and this would help, because some of his falls related to him tripping on his shoe laces. Between 10/1/18 and 1/27/19, the individual fell 10 times. The IDT determined seven were "true" falls, with the remaining three having a behavioral cause. During this four-month period, Individual #595's falls showed a significant increase in comparison with the previous year. The PNMT should have at least conducted a review, but they did not, nor did the IDT hold ISPA meetings to discuss strategies to reduce the falls.

- Individual #638's IDT placed him at medium risk for weight, due to his diagnosis of morbid obesity. The IDT set a goal/objective of weight loss of one to two pounds per month to move him towards his Estimated Desired Weight Range (EDWR), which was 175 to 215 pounds. In January 2018, he weighed 289 pounds, and on 1/27/19, he weighed 248 pounds. However, the rate of weight loss had increased from November 2018, when he weighed 270 pounds to 1/27/19, when he weighed 248 pounds. This represented an 8% loss in a three-month period, a 5% weight loss in one month (i.e., from 268 on 11/28/28, to 255 pounds on 1/10/19), and was not the one to two pounds per month that the IDT planned. As a result, in January 2019, he met criteria for referral to and review by PNMT.

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.

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: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. A number of the PNM action steps that were included were not measurable, making it difficult to collect specific data, and for others, data were not found to confirm that staff implemented them. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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.	10% 1/10	0/2	0/2	0/1	N/A	0/2	N/A	0/1	1/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A

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

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

- Between 10/1/18 and 1/27/19, Individual #595 fell 10 times. During this four-month period, the individual's falls showed a significant increase in comparison with the previous ISP year, when he fell a total of five times. The IDT did not hold ISPA meetings to discuss strategies to reduce the falls.
- Based on documentation submitted, on 11/21/18, a supervisor contacted the Campus RN, and reported that Individual #381 "was in his bedroom eating pecans that he'd picked up on campus. Began violently coughing." No evidence was found that Habilitation Therapy staff reviewed this incident or assessed the individual. The individual did not have an IHCP for choking, and the IDT did not meet after this event to discuss the need for one or to develop one.
- Individual #381 had no PNMP supports related to falls, and no OT/PT assessment. However, he fell on 11/28/18, 12/6/18, 12/14/18, 12/16/18, 1/9/19, 1/11/19, 1/24/19, 1/27/19, 3/14/19, and 3/27/19.
- On 1/24/18, Individual #291 had an exacerbation of asthma following Type A influenza. Upon her admission to the hospital, a chest x-ray showed a left lower lobe infiltrate. On 6/5/18, the PCP saw Individual #291 in sick-call due to wheezing, and ordered chest x-rays. The x-rays revealed a left lower lobe infiltrate. From 8/14/18 to 8/21/18, the individual was hospitalized with a diagnosis of aspiration pneumonia. From 11/2/18 to 11/13/18, Individual #291 was hospitalized again for aspiration pneumonitis. On 2/19/19, she had possible pneumonia with her lungs filling with fluid and a fever. The Monitoring Team found no evidence to show that the IDT analyzed data to determine the causes for the individual's multiple episodes of pneumonia/respiratory compromise, and/or that they developed an action plan to address the underlying or "root" causes of these issues. As discussed in further detail elsewhere in this report, the PNMT made a self-referral and conducted an assessment, and on 10/25/18, discharged the individual. Even at this point, the IDT did not incorporate the few recommendations the PNMT offered, or discuss alternatives to address the suspected underlying cause(s) of the repeated pneumonias.
- On 9/12/18, Individual #638 choked requiring two abdominal thrusts to dislodge what was described as sausage. The SLP's assessment, dated 9/12/18, stated that the individual did not have a previous history of choking, and indicated that: "the lack of following the supports listed on the dining plan led to him choking on a large piece of food." The individual did not have an IHCP to address choking, and his IDT did not develop one. More specifically, on 9/12/18, the IDT met to discuss an Emergency restriction related to his choking event, and recommended: 1) dining plan revisions to add verbal and physical cues, along with adding a cue to use his tongue to clear his cheeks when eating; 2) level of supervision changes; and 3) a change-of-status (COS) risk rating from low to a medium, with an addendum to the IRRF and a new IHCP. However, a choking IRRF and/or IHCP were not submitted. At minimum, the IDT should have outlined action steps, including preventive measures.
- On a positive note, on 6/6/18, Individual #724's IDT made a timely referral to the PNMT after he fractured his ankle, and they

took some immediate steps to protect and support him as he recovered. Subsequently, based on a July 2018 ISPA, the IDT outlined specific strategies to address the PNMT's recommendations related to the acute change of status. As discussed below, though, the IDT did not appear to follow through in response to the final PNMT assessment.

c. On 10/25/18, the PNMT discharged Individual #291, and the IDT held an ISPA meeting. However, the PNMT did not provide clinical justification for discharging her at that time. Moreover, it did not appear that the IDT incorporated into the IHCP any of the recommendations the PNMT made in the over four months they followed her. The ISPA did not reflect the status of the recommendations or discuss actions to be taken moving forward to prevent further asthma exacerbations or episodes of pneumonia. The PNMT identified criteria for re-referral as overt signs and symptoms of reflux, including vomiting, yet this had not been an issue. Conversely, they did not include exacerbation of asthma as a re-referral criterion, even though this was identified as a potential "root" cause of the pneumonias.

According to the PNMT minutes, on 10/25/18, the PNMT discharged Individual #724. An ISPA, dated 10/25/18, indicated that the IDT agreed to the PNMT discharge, but it provided no evidence that the IDT discussed the goals, strategies, and /or revisions to the falls/fractures IHCP moving forward. For example, the PNMT recommended that the individual participate in direct therapy for balance and ambulation twice a week for four weeks, use of gait belt and a long-handled sponge, and that the IDT install rails in back of his home due to the occurrence of falls there as well as around campus. The IDT did not address any of these recommendations in an updated IHCP.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Efforts are needed to continue to improve Dining Plan implementation, as well as staff's adherence to PNMP instructions for positioning and transfers. Often, the errors that occurred (e.g., individuals taking large bites, and/or eating at an unsafe rate without staff intervention) placed individuals at significant risk of harm. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health 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.	55% 23/42	
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.	13% 1/8	

Comments: a. The Monitoring Team conducted 42 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during six out of 12 observations (50%). Staff followed individuals' dining plans during 16 out of 27 mealtime observations (59%). Staff completed transfers correctly during zero out of one observations (0%). For one of two medication administration observations (50%), the medication nurses implemented PNMPs correctly.

In addition, the Monitoring Team member observed two individuals (i.e., Individual #933, and Individual #15), who did not have Dining Plans, engage in unsafe behavior during mealtimes. Staff did not intervene or were not observing the individuals. Both individuals were taking large bites, which placed them at significant risk of choking. In fact, Individual #15 bit off three-quarters of a hot dog, and then placed the remaining piece in his mouth at the same time, and chewed and swallowed the entire hot dog.

Individual #966, who also did not have a Dining Plan, was seated in his wheelchair, which due to his size, placed him too far from the table. After the Monitoring Team asked about it and the individual said someone else was in the chair he usually used, staff transferred him to another chair.

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, or ate at too fast a rate. Correct positioning of individuals during mealtimes also was sometimes an issue.
    - In Martin, high numbers of staff were present during one of the lunch times observed. Often, more staff were present than individuals, and at times, the staffing ratio was two staff for every one individual with additional staff observing, as well as kitchen staff assisting. The Monitoring Team requested documentation regarding the seating and staffing plans during mealtimes for Martin, as well as Barnett. Although the Center's response included some information about staffing in the Barnett dining room, it did not include information about assigned staffing for Martin, except to provide a list of mealtime coordinators. It was not clear to the Monitoring Team that this high level of staffing was typical for all meals.
- With regard to positioning, problems varied, but the most common problem was that individuals were not positioned correctly. Often, this was due to staff's failure to follow the positioning plan. In addition, in about 25% of the observations, adaptive equipment/supports were not used correctly.
- For the one transfer observed, staff did not position the individual correctly after the transfer.

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	595	381	291	469	638	276	511	724	528
a.	There is evidence that the measurable strategies and action plans	N/A							N/A		N/A

	included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.										
Comments: a. N/A											

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: Individuals reviewed did not have clinically relevant and measurable goals/objectives included in their ISPs/ISPAs to address their needs for formal OT/PT services. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/13	0/4	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/13	0/4	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/13	0/4	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/13	0/4	0/1	0/1	0/2	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% 0/13	0/4	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
Comments: a. through c. Overall, individuals did not have clinically relevant and measurable goals/objectives that were included in their ISPs/ISPAs to ensure they were implemented and monitored for progress. As a result, it was difficult to determine whether or not individuals were receiving services as needed or making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Although Individual #469's goal/objective for identifying sensory motor-based activities was clinically relevant, it was not included in the ISP or incorporated through an ISPA. Individual #595 had a goal/objective to complete heavy work tasks, which was measurable, but it also was not included in the ISP or incorporated through an ISPA. 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 in ISP integrated reviews to show that OT/PT supports were implemented, nor did IDTs meet to discuss termination of existing OT/PT services and supports. These indicators will	Individuals:

continue in active oversight.											
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
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	0/1	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews.

b. IDTs did not always hold ISPA meetings to review and approve OT/PT's recommendations for termination of therapy services and supports. The following concerns were noted:

- For Individual #595, an OT note, dated 3/14/18, stated that direct OT would continue as progress was expected, but another note on the following day indicated direct OT would be discontinued as it would not be beneficial. The Center provided no evidence the IDT met to consider and approve the rationale for termination.
- On 9/5/18, the PT completed a discharge summary for Individual #638's cardiovascular program, indicating he had met all the goals, but did not provide relevant data to support this conclusion. The discharge note further stated that he would be considered for participation in another such program after all other individuals who were at high or medium risk for cardiovascular, diabetes, and metabolic syndrome had been addressed. The IDT did not meet to review and approve this termination, whether that was permanent or temporary. The PT did not make any additional notes about the individual's participation in the program until 3/20/19, so there was a lengthy period during which services were not provided.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: 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 each of 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	494	557	160	297	154	185	140	469	456
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category of requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is										

	in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	67% 10/15	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		528	302	35	175	966	567			
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	1/1	1/1	0/1	1/1			
Comments: c. The Monitoring Team conducted observations of 15 pieces of adaptive equipment. Based on observations of Individual #154, Individual #140, Individual #528, Individual #302 and Individual #966 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #154, Individual #140, and Individual #302 appeared to have insufficient supports to maintain their positioning in their wheelchairs. The wheelchair for Individual #528 did not provide adequate support and alignment for safe tube feeding. Individual #966 wheelchair appeared to be too small for his large size and his legs were not adequately supported. 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, two indicators were in or were moved to the category of requiring less oversight. At this review, one other indicator will be moved to this category, in engagement.

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 goals did not have reliable data, progress could not be determined.

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, with the exception of for one individual.

There were overall improvements in the quality of SAPs. The majority of SAPs contained most of the necessary components for effective skill training.

All SAPs did not, but should, have integrity/IOA assessments that demonstrate that they are implemented as written and scored accurately.

There were clear improvements in individual engagement (except in the Martin unit), and in the overall quality of individual/staff interactions.

There were many very positive interactions among individuals and staff. In particular, in Longhorn after dinner, the individuals were all engaged in homework and/or SAPs. Although the individuals were doing work, the atmosphere was very positive. Everyone, the individuals and staff, appeared to be happy to be there and to be engaged in those activities.

Mexia SSLC should establish monthly community outing and community SAP training goals for each individual.

For the individual reviewed with dental refusals, the IDT did not have a way to measure a clinically relevant outcome(s) related to dental refusals.

It was concerning that individuals' AAC devices were not consistently present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not consistently prompt individuals to use them. The Center should focus on improvements in these areas.

In addition, based on the list provided, SLPs had implemented only seven alternative and augmentative communication (AAC) devices/low tech communication supports for individuals who live at Mexia SSLC.

- Most of these AAC systems have been in place since 2014 and 2016. Only one new communication wallet has been added to this list. When this person was asked about his wallet, he indicated that it was at his home and not on his person for ready access and use.
- The Monitoring Team observed/interacted with many individuals who presented with communication deficits and might benefit from additional communication supports via direct therapy and/or AAC systems.
- For the nine individuals reviewed, SLPs had not conducted thorough AAC assessments.

On a positive note, there were approximately 11 individuals listed as receiving direct therapy related to receptive/expressive language, articulation, voice and fluency, and/or pragmatics.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without regular implementation and without reliable data, progress could not be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	381	595	626	885	724	638			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
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. A personal goal that meets criteria for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For this review period, no goals met these prerequisite criteria (though many met criteria with indicator 1.											

Overall, data were not reliable and monthly reviews did not summarize progress made towards goals, so it was not possible to determine if individuals were making progress and achieving goals.

Per QIDP interviews and observations, none of the goals reviewed had been met.

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:

Individuals:

#	Indicator	Overall Score	381	595	626	885	724	638			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1			
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. For the most part, direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs.

The exception was staff working with Individual #885. During numerous observations, Individual #885's ISP was not being implemented, so the Monitoring Team was unable to determine whether or not action plans were implemented as written.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. ISPs rarely included detailed instructions to guide staff when implementing the ISP. As noted throughout this section of the report, ISPs often included service objectives that did not have specific implementation methodologies and this contributed to the lack of implementation.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then 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 decreased

Individuals:

since the last review. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
6	The individual is progressing on his/her SAPs.	7% 2/27	1/3	0/3	0/3	0/3	0/3	0/3	0/3	1/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	0/1								
8	If the individual was not making progress, actions were taken.	0% 0/13	0/1	0/2		0/2	0/2	0/2	0/2	0/2	
9	(No longer scored)										

Comments:
6. Individual #431's interviewing SAP and Individual #80's choose her leisure activity SAP were scored as progressing.

Several SAPs were not progressing (e.g., Individual #626's managing a bank account SAP).

Some SAPs (e.g., Individual #157's budgeting SAP) had sufficient data to determine progress, but were scored as 0 (rather than N/A) because their data were not demonstrated to be reliable (indicator #5). Other SAPs (Individual #381's make microwave popcorn SAP) were progressing, but scored as 0 because their data were not demonstrated to be reliable.

Some SAPs (e.g., Individual #885's tie his shoes SAP) were progressing, but were scored as 0 because they were not practical or functional (indicator #4).

7. Individual #431's state bicycle safety rules SAP achieved the training step objective in January 2019, but he was not moved to the next step.

8. Thirteen SAPs were not progressing, however, there was no action to address their lack of progress (e.g., Individual #595's appropriate greetings SAP).

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Performance was about the same as at the last few reviews, though there were more SAPs that contained more components. Components needing improvement were, more or less, the same as during previous reviews. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
13	The individual's SAPs are complete.	19% 5/27	0/3 24/28	0/3 25/30	0/3 26/30	3/3 30/30	1/3 27/30	0/3 26/30	0/3 26/29	1/3 28/30	0/3 27/30

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.

Five of the SAPs were judged to be complete (i.e., all three of Individual #797's SAPs, Individual #816's traffic safety SAP, and Individual #80's choose a leisure activity 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,
- teaching schedule
- specific consequences for correct responses
- specific consequences for incorrect responses
- a plan for generalization and maintenance of skills
- documentation methodology

There were clear improvements in the individualization of reinforcers for correctly completing SAPs, and on focusing SAPs that require individuals to directly demonstrate skills, rather than just describe them.

Regarding common missing components:

- One common missing component involved multiple step SAPs. Many multiple step SAPs indicated that once an individual achieves the objective on one step, they move to the next step. Most of these SAPs, however, did not clearly indicate if the individual should complete the remaining steps. Additionally, the instructions did not indicate if the individual should complete the prior steps, or instructions as to how staff should record situations when the individual needs additional training on a previously trained step (e.g., Individual #381's microwave popcorn SAP)
- Another common missing component was the absence of the identification of the training step on the SAP training sheets (e.g., Individual #885's work safety SAP).
- A multiple step SAP that did address these issues was Individual #816's identify traffic signs.

Regarding other missing components:

- In some SAPs (e.g., Individual #431's interview SAP) it was not clear if training should occur on one step or multiple steps at a time. The SAP was described as a single step, however, multiple steps were presented and the data sheet indicated that Individual #431 was currently on step 2.
- Some SAPs did not have clear objectives, either because no prompt level was provided (e.g., Individual #816's measure ingredients SAP), or the objective was not clearly stated (Individual #595's greet people SAP).

Outcome 5- SAPs are implemented with integrity.											
Summary: Some SAPs were implemented as written. Few had regular integrity checks conducted. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
14	SAPs are implemented as written.	60% 3/5			0/1	0/1		1/1		1/1	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	33% 9/27	3/3	0/3	2/3	0/3	1/3	0/3	0/3	3/3	0/3

Comments:

14. The Monitoring Team observed the implementation of five SAPs. Individual #157's budgeting SAP, Individual #80's play music SAP, and Individual #381's make microwave popcorn SAP were judged to be implemented and recorded as written. Individual #797's complete two-digit math problems SAP was implemented as written, however, it was not recorded correctly. Individual #885's tie his shoes SAP was not implemented as written.

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%. One-third of the SAPs had integrity checks. Ensuring the integrity of SAP implementation should be a priority at Mexia SSLC.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: About two-thirds of SAPs were reviewed monthly; but most had graphic summaries of individual performance. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
16	There is evidence that SAPs are reviewed monthly.	70% 19/27	3/3	2/3	2/3	3/3	2/3	3/3	1/3	3/3	0/3
17	SAP outcomes are graphed.	92% 22/24	2/3	3/3	3/3	3/3	3/3	2/3	3/3	3/3	

Comments:

16. The monthly reviews of most SAPs (in QIDP monthly reports) included a data-based review (e.g., Individual #381's identify personal information SAP). Some SAPS, however, were not reviewed in the QIDP monthly review (e.g., Individual #157's budgeting SAP).

17. All SAP data were graphed (e.g., Individual #797's identify tools SAP). Individual #381's make microwave popcorn, and Individual #431's state bicycle safety rules graphs did not, however, indicate when steps were achieved, making the identification of improvement difficult to visually assess. 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: Engagement observed by the Monitoring Team was higher than at any previous review at Mexia SSLC (though it was 56%). The Center was regularly measuring engagement. Given sustained high performance, indicator 21 will be moved to the category of requiring less oversight. Indicator 18 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	431	626	885	797	816	381	595	80	157
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	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	1/1	1/1	0/1	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 #431, Individual #626, Individual #595, Individual #381, and Individual #797 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). This represents a dramatic improvement from the last review when one individual was found to be engaged.

Attention needs to be paid to the programming/housing for the group of individuals who recently graduated from Longhorn unit and have been diagnosed with autism spectrum disorder (ASD). They lived in the same home on the Martin unit. Staff continued to appear to be confused about how to best provide engaging activities, skill instruction, and overall programming. There was not anyone on campus with extensive experience in developing and managing programming for individuals with ASD. This was recognized by the Center. A special work group for this was being led by the ADOP. One suggestion is to see if there might be any collaboration/consultation opportunities with Baylor University's applied behavior analysis department.

21. Individual #595's residence did not have engagement measures in each of the last six months. Mexia SSLC established an individualized engagement goal for each residence and day program site. The facility's engagement data indicated that all individuals achieved their goal level of engagement in the month of January 2019.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	431	626	885	797	816	381	595	80	157

		Score									
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 #381's ISP indicated that he had a goal of at least two community outing per month which he achieved for five of the last six months. The remaining 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 continued its good working relationship with Mexia ISD. Twenty-seven individuals were attending school (20 were under 18 years old). All were attending at the public school buildings, with one exception (Individual #620). The Center incorporated IEP activities into activities at the SSLC, such as homework periods. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	797								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								

Comments:
25. Individual #797 was under 22 years of age and attended public school at the time of the onsite review. His ISP indicated that his educational services were integrated into his ISP, and were shared with the IDT.

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 the individual reviewed with dental refusals, the IDT did not have a	Individuals:

way to measure a clinically relevant outcome(s) related to dental refusals. These indicators will remain in active oversight.											
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1	0/1								
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1	0/1								
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1	0/1								
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1	0/1								
Comments: a. through d. On 10/31/18, and 1/6/19, Individual #595 refused dental services. However, his IDT had not addressed the refusals through goals/objectives or action plans. This was concerning, given that the individual's visits to the dentist showed that he often had not brushed his teeth for a lengthy period of time, resulting in fair or poor oral hygiene, which increased his risk for dental problems. For example, on 11/9/18, dental notes indicated that he had not brushed his teeth in three days, and he had heavy plaque, calculus, and bleeding. On 11/29/18, he again had poor oral hygiene, and x-rays showed multiple caries, and the need for nine restorations. On 12/7/18, the dental IPN indicated it looked as if he had not brushed his teeth in days as his teeth had a lot of plaque and food on them. Although during one visit on 12/21/18, his teeth "looked really good," he subsequently refused an appointment (i.e., on 1/6/19), and an appointment was cancelled due to behaviors at home (i.e., on 2/27/19). At an appointment on 3/19/19, the hygienist documented fair oral hygiene with pathology present. According to the note, the dentist was to meet with the IDT.										

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: Work is still needed to improve the clinical relevance of goals/objectives, but it was good to see some progress toward development of communication goals/objectives that could be integrated with other needed supports. It will be important for SLPs to work with QIDPs to ensure these are included and effectively integrated in the ISPs, and that data on communication goals/objectives, and analysis of data, are incorporated in the QIDP monthly integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall	595	381	291	469	638	276	511	724	528

		Score									
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	27% 4/15	0/3	0/1	0/1	0/1	0/1	0/1	0/1	4/5	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	27% 4/15	0/3	0/1	0/1	0/1	0/1	0/1	0/1	4/5	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/15	0/3	0/1	0/1	0/1	0/1	0/1	0/1	0/5	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/15	0/3	0/1	0/1	0/1	0/1	0/1	0/1	0/5	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/15	0/3	0/1	0/1	0/1	0/1	0/1	0/1	0/5	0/1

Comments: a. and b. The goals/objectives that were clinically relevant, as well as measurable, were for Individual #595 (i.e., three goals/objectives to improve socially appropriate communication) and for Individual #724 (i.e., five goals for the use of safety strategies related to falls). While it was good to see this progress toward thinking about how communication strategies could be integrated with other support needs, some of these goals/objectives had not been specifically included in the individuals' ISP/IHCP or incorporated through an ISPA. The following concerns were noted:

- Per Individual #595's ISP, the integrated risk discussion referenced a summary of SLP assessment recommendations, including three specific goals, but did not document IDT discussion or approval of these recommendations. The ISP only included a broad action step/plan for speech therapy for pragmatics, but did not include the specific goals/objectives on which the IDT had agreed.
- For Individual #724, the Monitoring Team found evidence that on 8/31/18, the IDT included the four initial goals/objectives in his IHCP under the heading SLP/IHCP. This was positive, but the IDT more appropriately should have integrated these goals/objectives into the IHCP for falls. It was also unclear why the IDT did not document reviewing the specific goals/objectives at the ISPA meeting, dated 9/14/18, during which it agreed to initiate direct therapy. The IDT did not integrate a fifth related goal/objective (i.e., to demonstrate carryover of learned safety strategies) that was initiated at a later date (11/30/18), either through an ISPA, in the ISP, dated 12/20/18, or in the IHCP.

c. through e. The QIDP integrated monthly progress notes did not reflect specific data or analysis related to the measurable goals/objectives, as identified above for Individual #595 or Individual #724. As a result, it was difficult to determine whether or not individuals were receiving services as needed or making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

The Monitoring Team completed full reviews for all nine individuals due to 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: To move forward, QIDPs and SLPs should work together to make sure	Individuals:

IDTs discuss and include information related to individuals' needs communication supports in ISPs. These indicators will remain in active oversight.											
#	Indicator	Overall Score	595	381	291	469	638	276	511	724	528
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	50% 1/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
Comments: a. It remained concerning that most individuals reviewed did not have measurable strategies and action plans related to communication included in their assessments. It was also concerning that for two individuals (i.e., Individual #595 and Individuals #724) who had recommendations for measurable strategies and action plans, the IDTs did not always integrate them into the ISP/ISPAs. 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. Although it appeared from SLP notes that the measurable communication goals/objectives for these two individuals had been implemented to varying degrees, the QIDP monthly reviews did not include any information, data, or analysis.										

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: The Center should continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	494	15	40	567					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	50% 2/4	1/1	0/1	0/1	1/1					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 2/4	1/1	0/1	0/1	1/1					
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: b. It was concerning that for two of four individuals observed, their AAC devices were not present or readily accessible, including for Individual #15 (i.e., communication cards), and Individual #40 (i.e., communication wallet). For the other two											

individuals, it was positive to see that they were using their devices in a functional manner when opportunities presented themselves.

Based on the list provided, SLPs had implemented only seven alternative and augmentative communication (AAC) devices/low tech communication supports for individuals who live at Mexia SSLC.

- Most of these AAC systems have been in place since 2014 and 2016. Only one new communication wallet has been added to this list. When this person was asked about his wallet, he indicated that it was at his home and not on his person for ready access and use.
- The Monitoring Team observed/interacted with many individuals who presented with communication deficits and might benefit from additional communication supports via direct therapy and/or AAC systems. For the individuals reviewed, SLPs had not conducted thorough AAC assessments.

On a positive note, there were approximately 11 individuals listed as receiving direct therapy related to receptive/expressive language, articulation, voice and fluency, and/or pragmatics.

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 the last review, two of these indicators were moved to the category of requiring less oversight. For this review, one additional indicator was added to this category.

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.

As always, the transition staff were very receptive to the Monitoring Team's comments. A new APC was appointed; her first day in this new job was the first day of the onsite review. A new post move monitor began working about six months ago. Mexia SSLC continued to make progress on the outcomes and indicators of this domain.

A primary area for improvement is to add the additional content of 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. Pre-move competency testing did not yet 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.

There continued to be some important aspects of the individuals' lives that were not included in the list of post move supports.

Many aspects of post move monitoring were done correctly, however, there were instances where some supports were not examined thoroughly enough, recorded correctly, or issues followed to resolution. With continued attention to detail, it is likely that performance and resultant scoring will improve.

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. A primary area for improvement is to add the additional content of 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 indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	885	510							

		Score									
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: Twelve individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #885, Individual #510). 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. 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 14 pre-move supports for Individual #885 and 16 pre-move supports for Individual #510.
    - Some pre-move supports addressed actions the Center or provider would need to take to ensure environmental issues were addressed (e.g., the installation of a door chime for Individual #885's bedroom) or that needed items were delivered to the provider (e.g., Individual #510's birth certificate, Social Security card, ID, and change of address packet). These were typically measurable.
    - The majority of pre-move supports, however, addressed training for provider staff and other information-sharing with the provider. These often did not meet criterion for measurability. In order to be measurable, pre-move training supports need clearly define who will provide the training, which provider staff need to be trained, what topics will be covered, and what training methodologies will be used. The supports must also define the provider staff competencies to be achieved and how those will be reliably measured. To continue to move toward compliance, the Center should focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough and appropriate to the needs.
    - For these two CLDPs, pre-move training supports typically described who would be trained and who would do the training, and most stated, also broadly, the topics of training. Few, however, provided the specific competencies that should be achieved and tested. The pre-move competency testing did not yet clearly document provider staff had knowledge of all essential supports based on each individual's needs. That is, the Center relied solely on written quizzes that did not cover many of the individuals' important needs. Transition staff reported they had begun requiring disciplines to submit their proposed quizzes prior to the CLDP, which could be a valuable step, but the IDT will need to critically review the quizzes they receive for thoroughness. Findings included:
        - For Individual #885, the CLDP did not include any specific requirements for competency demonstration for his behavior support plan (BSP.) This was a significant oversight. The CLDP included a pre-move support with very detailed criteria regarding what staff needed to know for behavioral supports, but did not require Center staff to verify that provider staff could demonstrate competency. Instead, the evidence only required signed

training sheets for an inservice to be completed by the provider, but attendance at a training is insufficient evidence that staff have attained competency. Neither can the Center rely solely on attestation of staff competency by the provider. It must have a reliable mechanism for directly ensuring provider staff have the required knowledge and competencies to meet individuals' needs before relinquishing responsibility.

- For Individual #510, the Monitoring Team found some improvement in the comprehensiveness of competency testing, but the written quizzes still often did not address important information. For example, the social assessment provided a good written summary, including his history of having been the victim of sexual and physical abuse as well as having committed sexual assault on a child and that he had regular contact with a brother and the brother's caregiver and sister. The competency quiz included four questions, none of which addressed any of those important aspects.
- Individual #510's nursing inservice materials also provided a succinct summary of some of his daily health care needs, including signs and symptoms related cardiac, constipation, and GERD risks, as well as what to report to the nurse. This was positive. The corresponding competency quiz included 14 questions that addressed some, but not all, of these needs. The quiz included multiple choice, true/false and fill in the blank items, but the construction of the questions tended to lead test takers to the obvious correct answer. This limited the validity of the instruments for the purpose of verifying staff had needed knowledge. For example:
    - The true/false questions also were worded in such a way as to make clear to anyone what the right answer should be rather than clearly demonstrating provider staff had independent knowledge. For example, one question was posed as "You should NOT bother the nurse if Individual #510 has tightness in chest, chest pain, shortness of breath or dizziness, sudden change in behavior or shakiness/ tremors." It also did not test that staff specifically knew they needed to report immediately.
    - Fill-in-the-blank questions also led staff to enter what was considered to be the correct answer. For example, one such question was posed as "Encourage Individual #510 to select (blank) food selections and portion sizes at all meals." All provider staff who took the quiz filled in the blank with "appropriate" and or "good." This was clearly not a specific and measurable response. For instance, it did not test staff knowledge of his individual needs in this area, such as that staff needed to be aware of foods that could cause increased indigestion for him, such as spicy foods, or to encourage non-carbonated and decaffeinated fluid intake throughout the day.

- Post-Move: The respective IDTs developed 40 post-move supports for Individual #885 and 29 post-move supports for Individual #510. Many post-move supports were measurable, but this was not the case for all supports. Examples included, but were not limited to:
    - 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.
    - Post-move supports for Individual #885 did not consistently specify frequency expectations for certain activities. For example, his only leisure activity support indicated he would participate in one such activity within 30 days, but did not indicate any expectation about how often those should be offered after that. Another two post-move supports called for him to begin cognitive behavioral therapy and one-to-one counseling by 1/20/19, but neither provided any

expectation about how often those should occur.
    - Individual #510's post-move behavioral support called for his interim BSP to be in place for the first 90 days, but did not describe the staff competency criteria the PMM needed to verify. The pre-move support for the development of the interim BSP also did not specify provider staff competency criteria the PMM could have referenced.

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 yet 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 sometimes not clear and/or comprehensive.
    - For both individuals, the CLDP narratives identified specific and thoughtful strategies to be undertaken by the Center prior to transition that were intended to proactively address potential post-move behavioral concerns. In both instances, it would have been important for the IDT to track the implementation of these pre-move strategies, but the Center provide no evidence of their completion. It would have also been appropriate for the respective IDTs to include these strategies as pre-move supports, with clear timeframes and responsibilities for completion, but they did not.
        - Per the CLDP narrative for Individual #885, the IDT agreed that his pre-move counseling should emphasize that he should not walk off from the community program sites and that the QIDP would communicate this to the counselor. The IDT should have developed a pre-move support to ensure this was implemented before transition took place, including when the counselor would be notified and what evidence would be needed to confirm this had happened as required. The CLDP did not include such a support.
        - Per the CLDP narrative for Individual #510, the IDT agreed that he might need appropriate Center staff to be available to speak with him by telephone if he had concerns/issues before his post-move counseling began. They further agreed to identify those staff and make their names and phone numbers available to the provider. The IDT should have developed a pre-move support to ensure this information was obtained and made available to the provider staff and to Individual #510, as appropriate, including who would be responsible for obtaining the information and the date by which it need to be accomplished. The CLDP did not include such a support.
    - Neither IDT developed pre-or post-move supports that ensured provider staff had specific knowledge of the individuals' significant behavioral and psychiatric histories and/or strategies. For example:
        - For Individual #885:
            - Per his assessments, he had a history of headbanging and hallucinations. During the CLDP, transition staff probed this history and whether it should be included in a pre-move support for provider staff knowledge, but the IDT denied knowledge of these concerns. Some of his assessments also indicated

he had diagnoses of both alcohol and cannabis abuse, but the IDT indicated they had no knowledge of his having a substance abuse problem because he had not exhibited it while at Center. Because it was possible that a lack of access to these substances in the very controlled institutional setting was the primary reason he had abstained, the IDT had a responsibility to ensure the community provider knew of this possibility. Overall, it was concerning that the IDT did not have familiarity with Individual #885's significant history in these areas, particularly since their own assessments included relevant information.

  - Also during the CLDP discussion of his significant behavioral needs, the LIDDA representative stated Individual #885 would be assigned a START (Systemic, Therapeutic, Assessment, Resources, & Treatment) coordinator for crisis management. The CLDP did not include a post-move support, but should have. The IDTs should consider supports to be provided by the LIDDA, or any other third party, to be integral parts of the CLDP and develop supports that can be tracked for implementation.

- At the time of the last monitoring visit, 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. For Individual #510, the process had not resulted in desired outcome. His IDT had developed a support for Center behavioral health staff to provide information for the new community behavioral health specialist who would, in turn, develop an interim behavior support plan (BSP). While this support indicated a lengthy set of topics (e.g., behavioral history, current target behaviors, current replacement behaviors, prevention of challenging behaviors, training for generalization and maintenance, and replacement behaviors and response strategies for challenging behaviors), it provided no specific criteria for those. Several supports for pre-move inservice of the interim BSP were not in place because the community behavioral health provider had not completed the BSP as required. In addition, at the time of the at seven-day PMM visit, the PMM identified concerns that the interim BSP was very restrictive and needed to be modified. The Monitoring Team appreciated the intent of this approach to create a behavior support plan that considered the different models for behavioral interventions in the community, but there will likely be a need for much closer and perhaps intensive collaboration between the Center and community clinicians for this to be effective. This should include the identification by Center behavioral health staff of specific provider staff competencies that must be achieved. In addition, as the Center has realized, many community clinicians are reluctant to develop a behavior support plan for an individual they have not met. At the time of the last monitoring visit, the Monitoring Team suggested that 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. In interview, transition staff acknowledged they continued to face challenges in the implementation of this model.

- 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 criterion, 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 both Individual #885 and Individual #510, the Quarterly Drug Regimen Reviews (QDRRs) indicated they had three risk factors for Metabolic Syndrome and required ongoing monitoring, but CLDP supports did not address the need for provider staff knowledge or action in this area. Both required routine side effects monitoring (i.e., AIMS and MOSES) at the Center, but the CLDP did not include supports for this level of monitoring.
- For Individual #885, the CLDP did not include a clear support for staff knowledge regarding his diagnosis of Behcet's syndrome, an autoimmune disease that causes blood vessel inflammation throughout the body. The disease can lead to mouth sores, eye inflammation, skin lesions, and genital sores. The IDT did not develop any staff knowledge support for monitoring and reporting any related signs and symptoms, nor did it include a specific expectation he would be seen by a rheumatologist. Instead, the IDT deferred any follow-up to the community PCP, but without a without a clear transfer of knowledge about why rheumatology follow-up was needed.
- Per his medical assessment update, Individual #510 had a neurology consult on 7/17/18 for tremors "most likely due to antipsychotic medications" and a follow-up visit in 12 months was recommended. The medical update indicated he should have a neurology appointment by 2019 to monitor for the medication-induced tremors. The only related support included in the CLDP was to establish care with a new PCP within 30 days to refill medications, review and order lab work, and make any referrals that were needed, such as dietary and neurology. The support did not require any specific staff knowledge of the need to monitor for the medication-induced tremors or that a follow-up visit had been recommended to occur in 2019. Rather than just deferring to the community primary care practitioner (PCP), IDTs need to ensure the provider and PCP have needed information to make appropriate decisions with regard to individual's health needs.
- Per the IRRF, Individual #510 was rated low for respiratory compromise, but he was a smoker and had recent diagnoses of pneumonia and bronchitis. The IDT also needed to accurately inform the provider about his risk, for the purpose of ensuring needed monitoring takes 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 #885's CLDP indicated his important outcomes were to live more independently and eventually have his own apartment. Except for addressing his behavioral needs, the CLDP supports did not address skills for increased independent living and did not lay out any path toward having his own apartment.
  - For Individual #510, the IDT described that one of his important outcomes was that he wanted "to be free" and to have his own bedroom. It was not possible to quantify what the former outcome would require, but the IDT should have taken some time to explore with him what might allow him to feel more "free" that would also be permissible within his legal restrictions. The IDT could also have expanded upon these two outcomes by reviewing his ISP personal goals. For example, one of the most important factors in choosing the location for his new home was driven by the desire to stay near his brother and family friend, but the CLDP did not address what the provider would need to do to support

this relationship. In addition, per his ISP, he had a goal to have his driver's license re-instated, but the CLDP did not include any related supports.

- CLDPs should also include supports that formalize 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 #885's CLDP included only one support in this area, to participate in leisure activity of choice, such as going to a movie or out to eat, within 30 days of transition.
  - Individual #510's CLDP included a support to participate in a leisure activity of choice within 30 days and then monthly thereafter, to go to church of his choice on a monthly basis, beginning within the first 30 days and to go fishing three times a year. While Individual #510's supports had slightly more in the way of expectation for community participation, they could still have been considered met with only very infrequent activity.
- The ISPs for both individuals indicated employment was a very important outcome, but the CLDPs did not develop assertive outcome expectations for either of them, as described further below.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP included assertive outcomes that included an expectation they would be employed.
  - For Individual #885, the CLDP included a support for referral to the Texas Workforce Commission (TWC) within the initial 90 days. Another support indicated he would attend a day program until employment was obtained, but CLDP supports did not include any outcome for obtaining employment or for progress toward that goal to be tracked.
  - Individual #510's CLDP also included a support for TWC referral, within 45 days of transition, but did not include supports that defined any employment outcome or for tracking progress after the TWC referral had been completed. Per interview with transition staff, Individual #510 had decided after the move that he no longer wanted to work and was very satisfied with his daily activities. It was good to hear that he was doing so well. Still, the best information available to the IDT at the time of the CLDP indicated employment was important, so assertive, outcome-based supports should have been developed.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined few supports that included elements of positive reinforcement and other motivating components, even when the IDT had access to valuable assessment data that could have been used to craft appropriate supports. For example, Individual #510's BSP included a summary of a formal reinforcement inventory that had been completed for him, which was positive. It identified a good list of potentially reinforcing components, including the following: sitting outside smoking, going fishing, talking to family and friends on the phone, going to visit family and friends, making money, helping others, being looked up to or admired by someone, and arts and crafts, especially crocheting, and using his circular loom to make hats. Of these, the CLDP only included a post-move support for going fishing three times a year.

- Teaching, maintenance, participation, and acquisition of specific skills: Neither individual had supports for specific teaching, maintenance, participation, and acquisition of specific skills. The functional skills assessments (FSAs) for both individuals included specific areas of need that would have been appropriate for increased independent living, such as checking and

savings account use and making needed appointments, but the IDTs largely deferred skills acquisition to the provider. Other findings included:

- Individual #885's CLDP included a support to receive training in the area of job interview skills, but the CLDP provided no information about his current abilities in this area. Otherwise, the CLDP supports in this area only called for him to be re-assessed for functional/vocational training needs within the first 45 days and for a training needs plan developed within the first 60 days.
- Individual #510's assessments made recommendations similar to Individual #885's, but the CLDP did not include even minimal supports. Per the CLDP narrative, he said he didn't want to work on skill acquisition plans. It was explained to him he would be required to have a goal for both the day program and the home, but that these did not need to be formal training programs. The IDT, therefore, concluded he would not need to be formally evaluated for community-based training. This was not an assertive approach to supporting his needs and desires for maintenance, participation, and acquisition of specific skills that could prove valuable for his goal of living more independently. For example, he indicated he believed getting a driver's license would help him in community and this could have been addressed with a support.

- 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 and was also impressed that transition staff often engaged IDTs to further clarify individuals' needs. Still for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification as described above. For example:
  - The dental assessments for both individuals included recommendations that the IDTs did not address and/or did not provide an adequate justification for not doing so:
    - Individual #885's dental assessment made recommendations for staff reminders to brush his teeth, including his partial; staff reminders to wear and appropriately store his night guard; and monitoring for bone loss. The IDT did not address any of these with supports.
    - Individual #510's dental assessment recommended staff prompting for toothbrushing. Per the CLDP narrative, the IDT discussed that he may need prompting sometimes, but didn't mind brushing his teeth. They chose not to develop a support because the provider indicated this was done routinely in the group home for all individuals. IDTs should not defer needed supports because the provider reports it has a practice in place. The CLDP should include all needed supports.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Post move monitoring occurred at required intervals, at all locations, and recorded in the proper format for this and previous two reviews, too, with one exception. Due to this sustained high performance, indicator 3 will be moved to the category of requiring less oversight. Overall, many aspects of post move monitoring were done correctly, however, there were instances where some supports were not	Individuals:

examined thoroughly enough, recorded correctly, or issues followed to resolution. With continued attention to detail, it is likely that performance and resultant scoring will improve. A new post move monitor was appointed during the period since the last review. As noted below, he was, for the most part, thorough in his reviews, and pleasant in his style of interaction with providers. More thorough probing when asking questions and reviewing/asking for documentation was needed. These other indicators will remain in active monitoring.											
#	Indicator	Overall Score	885	510							
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									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1									

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 reliable and valid data.

- The PMM often provided comments that were succinct and 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. Examples included:
    - For Individual #885, a CLDP support called for line of sight supervision and for provider staff to be cautious in areas where children frequent. Both the 45 and 90-day PMM Checklist comments noted provider staff ensured line of sight supervision, which was positive, but provided no evidence that the PMM had probed staff knowledge about being cautious in areas that children frequent. This provided an example of why it is critical for supports to be clear and measurable about what provider staff need to know. In this case, it would have been important for staff to be able to articulate what line of sight supervision entailed, why it was necessary and what additional precautions might be needed in areas children frequented. Of note, provider staff might easily interpret that any additional caution needed to be enacted when children were present, but the need for extra vigilance likely needed to be applied in any area children might be expected to be present.
    - Individual #510's CLDP called for the provider nurse to have a full nursing assessment within seven days of transition. The PMM documented she reviewed the assessment completed on 10/11/18. This documentation demonstrated the assessment was completed within seven days, but did not address its content. In any event, the CLDP support did not describe how the PMM could evaluate whether it constituted a "full" assessment.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP. It was also good to see the PMM often made a practice of reminding providers of upcoming supports that were not yet due. As described above, however, the Monitoring Team sometimes could not evaluate or confirm whether either individual 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. Examples of supports not in place included:

- As described further below, at the time of the 45-day PMM visit, Individual #885 had not yet begun receiving CBT nor had the provider puts a skills training plan in place.
- Individual #510's CLDP included a TWC referral within 45 days. The referral had occurred at the time of the 45-day PMM visit, with an appointment pending. At the time of the 90-day PMM visit, he had gone to the appointment but did not have the needed Social Security documentation. The provider indicated they would proceed once it was obtained. The PMM marked this support as in place, but this failed to take into account that it was not completed in terms of achieving the outcome of employment. This was a good example of why it is important for the IDTs to develop employment supports that have an actual outcome expectation.

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. Other findings included:

- For Individual #885, the PMM failed to provide any comment that would have documented the presence of two supports (i.e., for the nurse-to-nurse consultation and for a modification to the language of the interim BSP) at the time of the pre-move site review, and provided no scoring.
- Individual #510 was to begin counseling services within 30 days to address specific high-risk issues. The PMM marked the

support as in place, but the evidence only indicated that the available notes did not document what had been addressed.

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.

- For Individual #885, the PMM did not consistently document timely verification that needed follow-up had occurred. Individual #885 had two supports that were not in place at the time of the 45-day PMM visit, including to have begun CBT and to have a skills training plan in place. In both cases, the PMM scored the supports correctly as not in place, but did not document follow-up until six weeks later.
- For Individual #510, at the time of the seven-day PMM visit, the PMM identified concerns with the interim BSP being very restrictive and appropriately addressed this with provider and brought the concern to the IDT. The IDT determined the interim BSP needed to be modified and that the provider should follow the Center BSP until modifications had been made. At the time of the 45-day PMM visit, the PMM noted a new BSP had been implemented, but did not document whether the restrictive issues previously identified had been addressed or whether the IDT had reviewed the new version.

9. Post move monitoring was observed for a 270-day (nine-month) review at the individual's home. It was for Individual #621. He was at home and he participated in some of the post move monitoring activities, such as sitting in for part of the staff interview, showing the PMM and Monitoring Team his home and room, calling his father to talk with the PMM, and being interviewed by the PMM. Overall, he (and his father) were happy with his life, supports, and care. Individual #621 had not had any serious issues since moving to this home and attending his day program.

The PMM gathered documentation earlier in the day at the community provider agency's office. At the home, he interviewed the direct care staff member who was working that afternoon. She had worked at the home for about eight months. The PMM sat with her at the dining room table. He asked her about Individual #621's history, social history, and medications and their purpose (especially regarding foods that were contraindicated based on the medication). He also went through each support, one by one, asking her about what she did to provide the support. He did not provide leading questions. He talked about every support, even those not directly related to what she was responsible for, which was fine because it did not take up too much time and perhaps made the staff member more aware of the range and breadth of supports that he was monitoring.

The PMM interviewed Individual #621 both at the table and then later when they were alone. This was a good practice, that is, it allowed the individual the opportunity to talk with the PMM without the staff member immediately present. Individual #621 was very happy with his home and day program. He called his father from his cell phone and put him on speaker. The PMM was then able to ask the father his opinion of his son's support, life, and care. The father said he was happy, too.

The PMM was newly appointed in the interim period since the last onsite review. He had a pleasant style, was very organized, and took his time when looking at documents, asking questions, and making notes. Some comments for improvement:

- The PMM should not be hesitant to probe, ask questions, and so forth as needed to obtain the information that he needs. As

discussed after the post move monitoring visit, the PMM is the "eyes and ears" of the IDT, SSLC, and state system and plays a key role in ensuring individuals are receiving the supports they should be receiving.

- If supports are not provided, or changed, that information should be brought back to the SSLC IDT. For instance, post move support 16 was about the development and implementation of the provider's PBSP. Individual #621 had a PBSP at the SSLC and it likely played some role in his progress, such that he was able to successfully transition to the community. The provider was required to do so by the 90-day post move monitoring review, with a specific date of 11/10/18. Post move monitoring occurred a few days prior to that (11/6/18). When the PMM came back for the six-month review on 1/24/19, the community provider said that they determined Individual #621 was doing well and didn't need a PBSP anymore. This was not what the IDT likely had in mind and should have been contacted regarding this. Further, given the target date was only a few days after the onsite post move monitoring review, the PMM should have followed-up on this rather than waiting another three months for the six-month review.
- Indicator 18 was about line of sight supervision when in the community. The staff member knew what this meant, and that was accepted by the PMM. However, when the Monitoring Team asked about how line of sight is handled regarding use of public bathrooms, clothing store fitting rooms (they were going clothes shopping later that evening), she was not sure. The PMM should probe staff knowledge and implementation for these types of supports.
- The PMM was aware of the three prongs of post move monitoring and sought to include all three (observation, interview, documentation). The use of simple checklists for provider staff to document the occurrence/nonoccurrence of provision of some supports can be helpful in this regard. For his post move monitoring, the PMM was reading every narrative note (i.e., the typical community provider service delivery notes), but those notes did not address many of the supports in the CLDP.
- For Individual #621's post move monitoring, it was easy to conduct the staff interview given Individual #621's ability to participate and his housemate and his ability to be independent with other activities at home during the interview. When that is not the case (e.g., the staff member cannot be distracted from providing direct supervision and interaction with the individual), the PMM should be sure to make arrangements to interview direct care staff if staff.
- The PMM should comment (and ask for follow-up) if there are safety, cleanliness, and/or cosmetic problems at the home or day program. For example, this home needed repairs (or replacement) of the flooring, walls needed to be painted, the vents cleaned, etc. One of the smoke detectors was chirping, indicating a need for a new battery (or some other repair).

10. The report described what was observed by the Monitoring Team. The report listed a number of items for follow-up.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: Neither individual had a negative event occurrence as per the definition of a PDCT. This indicator remains in active monitoring.			Individuals:									
#	Indicator	Overall Score	885	510								
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	100% 2/2	1/1	1/1								

	the provision of supports that would have reduced the likelihood of the negative event occurring.										
Comments: 11. The Center reported that neither individual had experienced a PDCT event.											

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:			Individuals:								
#	Indicator	Overall Score	885	510							
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 trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

	transition and following the transition.										
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, the Admissions and Placements Coordinator (APC) had taken the initiative to work with Quality Assurance staff to begin the development of a corrective action plan (CAP) to ensure assessments were comprehensive and resulted in adequate and measurable recommendations. Per interview, the Center had not implemented this CAP after all, having chosen to await the completion of the CLDP assessment template from State Office, but even so, transition staff continued to work with disciplines regarding the content of their assessments. While this remained an area of need of improvement, it was good to see some assessments providing more comprehensive information and more relevant recommendations for transition and community living. 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 a nutritional assessment for Individual #510 that was updated within 45 days of transition. He transitioned on 10/11/18 and the nutritional assessment provided was dated 8/6/18.
  - The Center provided the most recent QDRR for both Individual #885 and Individual #510 and documented in the CLDP narrative that the respective IDT had reviewed it, but the documentation did not discuss any of the needs described in those assessments. This was of some concern due to discrepancies regarding both individuals' status for risk of metabolic syndrome, as described above in Indicator 1.
  - The Center did not provide a copy of an updated Integrated Risk Rating Form (IRRF) for either individual, 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.
- 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, but some continued to provide incomplete or conflicting information. For example, the medical assessment for Individual #510 indicated he had two risk factors for metabolic syndrome, while the QDRR stated that he met criterion for metabolic syndrome with three of five factors present. His nursing assessment stated he was at low risk for metabolic syndrome.
- 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. Findings included:
  - On a positive note, some assessments, such as the social assessment for Individual #885, included some specific recommendations for needed content of provider pre-move training.
  - Assessments generally did not provide recommendations that could be used to promote community participation and integration for either individual.
  - For both individuals, the FSA listed many areas of need, but included few specific recommendations that the community provider could have used to assist the individuals to learn independent living skills. For example, Individual #885's FSA identified discrete areas of need, including the following: cues for computer skills, checking and

savings account use; verifying change, toileting hygiene, measuring; use of small appliances, knowledge of consequences for not obeying the law, knowing his physical address, and making appointments for himself. The assessment recommended only to continue to provide training on job interview skills and meal preparation skills and for the provider to re-assess training needs within the first 45 days for further implementation. At least, it would have been helpful to inform the provider about his current skills and needs in these two areas.

- Also for Individual #885, the nutrition assessment narrative included individualized mealtime instructions, such as for allowing him extra time during meals, but did not include these in the recommendations.

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. Per review of these documents and other materials (e.g., PSI and ISP) the Monitoring Team identified two concerns for this indicator:

- As documented above with regard to Indicator 2, the IDTs for both individuals identified certain needed pre-move supports within the CLDP narrative, but did not develop these as supports that clearly specified the SSLC staff responsible for implementation and/or the timeframes in which such actions are to be completed. The narrative for Individual #885 indicated the QIDP would be responsible for his pre-move support (i.e., informing the Center counselor to address possible elopement), but did not formalize this responsibility in the CLDP supports. Individual #510's IDT did not state who would be responsible for his (i.e., identifying Center staff who could be available to help fill the gap if he had concerns before his post-move counseling began.) Neither CLDP indicated whether the PMM or other staff would confirm completion and neither indicated a time frame by which the supports should be implemented.
- As it related to whether the CLDP was reviewed with the individuals to facilitate their decision-making about supports and services, documentation did not evidence that the IDTs provided either of the individuals with a clear understanding of how, or if, their CLDPs actually laid out a path toward their stated goals 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. 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. Concerns included:

- 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. 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.

- In addition to ensuring the quizzes were more thorough, the IDTs needed to consider other competency testing methodologies, such as return demonstration, when appropriate.
- 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.

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:

- As described at the time of the last monitoring visit, the Center had initiated a standard practice of requiring a support for nurse-to-nurse collaboration for all transitions, which was another positive practice. Both of the CLDPs reviewed for this monitoring visit included these supports. The IDT should describe the needed content of the collaboration and how the Center can verify all needed information has been received, particularly when this continued to be the basis for all further training for provider staff. For both individuals, the documentation of the nurse-to-nurse included a list of broad topics to be covered, such as medications, side effects, medical diagnoses, any pertinent medical history, etc., but did not provide any individual-specific information and/or competency criteria. The Monitoring Team reviewed the documentation (i.e., progress notes in IRIS) for the nurse-to-nurse consultations, but these did not provide specific detail to ensure important individualized was covered. For example:
    - The IRIS note for Individual #885 did not provide any indication the Center registered nurse case manager (RNCM) informed the provider nurse about his diagnosis of Behcet's syndrome. In addition, per the CLDP discussion of his need for a neuro-ophthalmology supports, the Center RNCM was supposed to give the provider nurse the related consults and labs from the last year. The IRIS note did not reference this and the CLDP provided no other evidence the information had been provided.
    - The IRIS note for Individual #510 did not address provider knowledge of his recent diagnoses of pneumonia and bronchitis and potential impact on his respiratory risk, nor did it address the recommended neurological follow-up for evaluation of medication-induced tremors.
- At the time of the last monitoring visit, 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. Per the documentation reviewed for this current monitoring visit, this collaborative process had not resulted in desired outcomes. For Individual #510, several supports for pre-move inservice of the interim behavior support plan were not in place because the community behavioral health provider did not complete the BSP as required. Then, at the time of the at seven-day PMM visit, the PMM identified concerns that the interim BSP was very restrictive and needed to be modified. The Center needed to continue to improve this effort at collaboration, as discussed further with regard to Indicator 2 above.

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. Both CLDPs documented that the IDTs assessed the homes and neighborhoods to ensure they were not in areas close to where children would congregate, which was positive. The IDT for Individual #885 also should have made that same assessment for the day program he would be attending.

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 preselection visits and pre-move site reviews, which was a very positive practice that the Monitoring Team commends. The IDTs provided some broad and generic statements about the nature and intent of this participation (e.g., being available to answer any questions and assist with in-servicing and helping to facilitate information-sharing). Rather than simply using stock statements, such as these, the CLDPs should, as indicated above, include a specific statement that is based on each individual's needs and preferences, and should also include a description of any such activities that occurred and their results. In other words, the Center should build upon this valuable practice by making it more specifically intentional to each individual's needs.

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 provided insufficient evidence that provider staff were competent.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary:			Individuals:									
#	Indicator	Overall Score										
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

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
SUR	Safe Use of Restraint
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus