United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Remote Virtual Review: October 18-21, 2021

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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 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.

In addition, the parties set forth 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.

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have 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 Center'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 review, the Monitoring Teams requested various types of information about the individuals who lived at the Center 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 Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Teams attended various meetings via telephone, such as Center-wide meetings [e.g., morning medical, unit morning, Incident Management Review Team (IMRT), Physical and Nutritional Management Team (PNMT)], and individual-related meetings [e.g., Individual Support Plan meetings (ISPs), Core teams, Individual Support Plan addenda meetings (ISPAs), psychiatry clinics]. In addition, the Monitoring Teams conducted interviews of various staff members via telephone (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator). Also, the Monitoring Teams met with some groups of staff via telephone (e.g., Psychiatry Department, Behavioral Health Services Department). This process is referred to as a remote review.
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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
d. **Observations** – Due to the nature of the remote review, the Monitoring Team could not complete some observations (i.e., as discussed above, some observations of meetings were possible). As a result, some indicators could not be monitored or scored. This is noted in the report below.
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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be monitored, but may be monitored at future reviews if the Monitor has concerns about the Center'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 Center'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 Center'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. 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.
g. **Quality improvement/quality assurance:** The Monitors' report regarding the monitoring of the Center's quality improvement and quality assurance program is provided in a separate document.

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 remote review. The Center 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, and their time and efforts are much appreciated.

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 contains seven outcomes and 23 underlying indicators in the areas of restraint management, pretreatment sedation/chemical restraint, mortality review, and quality assurance.

- The Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.
    - As a result, the Center exited from these parts of Section C of the Settlement Agreement. This resulted in the removal of 10 outcomes, and 20 underlying indicators.
    - Three indicators were added to the nursing restraint audit tool.
- The Center achieved substantial compliance with the requirements of Section D of the Settlement Agreement related to abuse, neglect and incident management.
    - As a result, the Center exited from Section D of the Settlement Agreement. This resulted in the removal of 10 outcomes, and 23 underlying indicators.
- At the start of this review, two indicators were in the category of requiring less oversight. Presently, two additional indicators will move to the category of less oversight.

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

<u>Restraint</u>

It was very positive that for all but one of the six restraints reviewed, nurses performed physical assessments, documented whether individuals sustained any restraint-related injuries or other negative health effects, and took action, as applicable, to meet the needs of the individuals. For the final restraint, the vital sign assessment was incomplete.

In the last report, the Monitoring Team identified some of the areas in which nursing staff needed to focus with regard to restraint monitoring including following the nursing guidelines for assessing individuals after the administration of chemical restraints, and expanding the descriptions of individuals' mental status beyond "alert" to describe their behaviors. Based on this review, it appeared that nurses made good

improvements in these areas, and sustained progress in some other areas related to restraint monitoring. To continue to move towards substantial compliance, nurses should maintain this progress.

Other
IDTs were not meeting the pretreatment sedation discussion, review, and planning requirements.

Although one of the three drug utilization evaluations (DUEs) completed did not appear to be clinically relevant, in the six months prior to the review, Center staff had completed two other clinically relevant DUEs. When follow-up was needed, staff developed and implemented action plans.

Restraint

At a previous review, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement.

The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects (immediately below).

With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.

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 very positive that for all but one of the six restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as applicable, to meet the needs of the individuals. For the final restraint, the vital sign assessment was incomplete.	Individuals:

In the last report, the Monitoring Team identified some of the areas in which nursing staff needed to focus with regard to restraint monitoring including: following the nursing guidelines for assessing individuals after the administration of chemical restraints, and expanding the descriptions of individuals' mental status beyond "alert" to describe their behaviors. Based on this review, it appeared that nurses had made good improvements in these areas, and sustained progress in some other areas.											
#	Indicator	Overall Score	15	609	595	685	884				
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	83% 5/6	1/1	1/1	2/2	1/1	0/1				
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	N/A									
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	N/A									
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A									
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 6/6	1/1	1/1	2/2	1/1	1/1				

d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	100% 4/4	1/1	1/1	1/1	1/1	N/A				

Comments: The restraints reviewed included those for: Individual #15 on 4/21/21 at 2:01 p.m. (cross-arm stabilization for one minute); Individual #609 on 3/13/21 at 3:57 p.m. (chemical); Individual #595 on 3/24/21 at 2:21 p.m. (multi-person cross-arm stabilization for one minutes), and 3/24/21 at 2:58 p.m. (State-approved side-lying horizontal for five minutes); Individual #685 on 4/14/21 at 12:00 a.m. (chemical, and side-lying horizontal for one minute); and Individual #885 on 3/4/21 at 2:20 a.m. (cross-arm stabilization, and horizontal for 10 minutes).

a., and c. and d. It was very positive that for all but one of the six restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as applicable, to meet the needs of the individuals. The exception was for Individual #885's restraint on 3/4/21. The only concern for this restraint was that the nurse did not document a pulse rate.

In the last report, the Monitoring Team identified some of the areas in which nursing staff needed to focus with regard to restraint monitoring including: following the nursing guidelines for assessing individuals after the administration of chemical restraints, and expanding the descriptions of individuals' mental status beyond "alert" to describe their behaviors. Based on this review, it appeared that nurses had made good improvements in these areas, and sustained progress in some other areas.

Of note, the circumstances around the chemical restraint selected for review for Individual #685 were particularly challenging. He had received multiple chemical restraints in the hours preceding this one, and he continued to exhibit aggressive behavior as well as property destruction. After this chemical restraint, he fell while trying to climb over furniture and sustained a laceration. Upon his return from the ED, he also experienced projectile vomiting. Later, in the day, he was transported to the local hospital, and then admitted to Austin State Hospital for an extended stay. Throughout this process, nursing staff conducted assessments in accordance with the applicable nursing guidelines, when he would allow them, and monitored his respirations when he refused other vital sign assessments. They also attended to his emergent needs as they arose. The nurses involved are commended for their efforts to meet this individual's needs.

Abuse, Neglect, and Incident Management

At a previous review, the Monitor found the Center to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement).

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/2								0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/3	0/2								0/1

Comments: a. and b. The Monitoring Team reviewed the uses of TIVA for the following individuals who met criteria for its use, as well as the concurrent use of oral pre-treatment sedation, as applicable: Individual 436 on 4/7/21, and 6/16/21; and Individual #635 on 4/28/21.

For each of the uses of TIVA and, as applicable, the concurrent administration of oral pre-treatment sedation, Center staff obtained informed consent, ensured the individuals had nothing-by-mouth prior to the procedures, and wrote operative notes describing the assessment and procedures completed. In addition, nursing staff completed post-operative vital signs according to the required schedule.

However, as discussed in previous reports, the Center's policy related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure; however, an 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 should also address perioperative management, which includes, for example, information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on the completion of perioperative evaluations for non-cardiac surgery. Given the risks involved with TIVA, it is essential that such guidelines be revised/developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

In addition, for oral pre-treatment sedation, Center staff did not always ensure the IDT provided input to the dentist/primary care practitioner (PCP) for determination of the medication and dosage range. The following describes concerns noted:

- For Individual #635, the Center did not provide documentation the IDT provided input for the use of the oral pre-treatment sedation (i.e., .25 mg Halcion) concurrent with the administration of TIVA.
- For Individual 436, the Center did not provide documentation the IDT provided input for the use of the oral pre-treatment sedation (i.e., .5 mg. Halcion) on 4/7/21. Per nursing documentation on 4/8/21, the IDT met to discuss TIVA. It was reported that the individual did well during the procedure, but was excessively drowsy and sleepy for several hours post-operatively. Upon return to his home, he was placed in bed, rolled over and fell out of the bed. It was noted that the medication dose would

need to be reduced or discontinued. On 4/8/21, additional nursing documentation commented that the individual was very drowsy during recovery after receiving Halcion .25 mg for TIVA in September 2020.

On 4/8/21, the PCP saw the individual and noted a history of excessive sedation. Per PCP documentation: "There were no issues during the procedure or complications after." The PCP was aware of the excessive sedation, but did not mention the fall. Given that the individual did not have a history of refusals, and had documentation of excessive drowsiness in September 2020, the IDT should have met to discuss the need for the Halcion prior to its administration. On 6/16/21, Halcion was not administered concurrent with the TIVA.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the physical health review group 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 were not meeting the pretreatment sedation discussion, review, and planning requirements of this outcome. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 1/2					0/1				1/1
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	0% 0/1					0/1				

4	Action plans were implemented.	0% 0/1					0/1				
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 #436's TIVA on 4/7/21 and Individual #620's TIVA on 11/9/20.

1. Available documentation did not reflect a discussion of Individual #436's TIVA usage and effectiveness during the past 12 months, other supports or interventions that could be provided for future appointments, the risk and benefit of the procedure with and without TIVA, or informed consent.

2. There was no evidence that the IDT for either Individual #436 or Individual #620 either (a) developed an action plan to reduce the usage of TIVA, or (b) determined that any actions to reduce the use of TIVA would be counter-therapeutic for the individual.

3. The IDT determined that Individual #436 should brush his teeth twice a day to prevent the need for TIVA in the future. This plan was not, however, written as a SAP or action plan in the ISP.

4. There was no evidence that the treatment plan was implemented

5-6. There was no evidence that strategies to decrease the use of TIVA were implemented.

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	469	724	618	1					
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% 4/4	1/1	1/1	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% 0/4	0/1	0/1	0/1	0/1					

c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/1	N/A	N/A	0/1	N/A					

Comments: a. Since the last document submission, seven individuals died. The Monitoring Team reviewed four deaths. Causes of death were listed as:

- On 12/4/20, Individual #272 died at the age of 56 with causes of death listed as aspiration pneumonia, neurogenic dysphagia, and mental retardation.
- On 1/13/21, Individual #469 died at the age of 55 with causes of death listed as shock, ischemic left leg, arterial occlusion, and COVID-19 infection.
- On 1/18/21, Individual #60 died at the age of 84 with cause of death listed as myocardial infarction.
- On 1/24/21, Individual #278 died at the age of 76 with causes of death listed as metabolic encephalopathy, hypernatremia, acute kidney injury, and COVID-19 infection.
- On 2/16/21, Individual #724 died at the age of 48 with cause of death listed as COVID-19.
- On 9/14/21, Individual #618 died at the age of 29 with cause of death listed as severe sepsis with septic shock.
- On 9/17/21, Individual #1 died at the age of 66 with cause of death listed as choking.

b. through d. The Center completed death reviews for each of the four individuals. These reviews identified some concerns, and resulted in some recommendations. However, evidence was not submitted to show the Center staff conducted thorough reviews of the care and treatment provided to individuals, or an analysis of the mortality reviews to determine additional steps that should be incorporated into the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

- For Individual #469:
  - According to the medical review the individual was stable during the six months prior to his death, and had no acute medical issues. On 1/7/21, the individual tested positive for COVID-19 and was quarantined. He was asymptomatic, until 1/10/21, when around 1:05 p.m., staff reported that he had a firm knot on his left lower extremity (LLE) with no swelling. According to the medical review, there was normal color and skin temperature. The individual's vital signs "were normal." There was no documentation that a provider examined the neurovascular status of the limb; specifically, there was no documentation of the distal pulses and the capillary refill. Presumably, the PCP asked nursing staff to place the individual on the list for sick-call, because the next statement was that: "On 1/11/21 prior to sick call, he was noted to be unresponsive and was transferred to the ED."

    In the ED, he was hypotensive and started on pressors for blood pressure support. An ultrasound revealed no detectable blood flow below the level of the knee, as well as extensive clots and thrombi in the deep venous system of

the LLE. He also was in acute renal failure and required transfer to a higher level of care. He deteriorated to the point that he was considered a poor surgical candidate and supportive and palliative care was implemented. This individual, who was reported as stable with no acute issues prior to this acute illness, expired two days after admission to the hospital.

According to the medical services review, the COVID-19 vaccine was not available at the Center prior to the onset of his illness in mid-January. The medical review did not provide any explanation for why the use of monoclonal antibodies (MAB) did not occur. In January 2021, the relationship between COVID-19 infections and hypercoagulability was well established, and treatment protocols to address this were available. There was also no discussion related to why the PCP did not evaluate the individual immediately when nursing staff reported the abnormal finding on 1/10/21.

Mortality reviews are completed to identify areas of immediate concern, contributing factors surrounding the death, and trends. This information is critical to determining what actions or recommendations need to occur to prevent similar events for other individuals. For this review, the medical reviewer ended the review by stating that the use of MAB may have been helpful along with providing anticoagulation. However, the reviewer provided no further details on why this was not considered, and what actions would be taken to ensure that appropriate evaluations and treatment of COVID-19 positive individuals would occur. Unfortunately the Clinical Death Review committee did not address these issues, and determined that no recommendations were necessary.

- The review of medical services did not thoroughly address all of the items in the State Office template. For example, in response to the management of chronic medical conditions, the reviewer only addressed cerebral palsy. The reviewer indicated that preventive care was appropriately provided. A structured death review should outline all of the elements of preventive care and address each one, along with reviewing the care provided for chronic and acute medical conditions. This is necessary to review the care of the deceased individual.
- The Administrative Death Review committee discussed the need to ensure proper hydration status for individuals with COVID-19 infections to assist nurses at the community clinic in obtaining intravenous (IV) access. However, this individual was never evaluated after determining he had a change of status (CoS) with his COVID-19 infection.
- Similarly, the nursing review did not include whether or not, on 1/10/21, the nurse performed an initial circulatory check. It was positive that the nurse auditor identified that the nurse did not document a specific blood pressure, and that describing the individual's vital signs as "within normal limits" did not provide sufficient detail. Despite the identification of some problems, the Nursing Clinical Death Review included no recommendations.
- The nursing review also did not include a review of the individual's immunization status, other than to state "up-to-date." In general, a comprehensive nursing death review should include information regarding preventive health, and the individual's current active problems.
- As part of the death review, the Quality Assurance (QA) Registered Nurse (RN indicated that she wanted to discuss discrepancies noted on 1/10/21. The QA RN suggested that discussion was needed on ways to improve communication when nurses are reporting to the on-call providers, related assessments, and potentially the use of live video at least for after hours, holiday, and weekends on the quarantine COVID-19 home. She indicated that the use of video might be beneficial to the providers, facilitate the providers seeing what the nurses were seeing, and potentially

prompt some questions. It might result in direction from the providers for further nursing assessment. The Clinical Death Review committee did not make recommendations to address these concerns.

- The death reviews for this individual resulted in no recommendations.

- For Individual #724:
  - According to the medical review, on 1/22/21, the individual tested positive for COVID-19. The individual remained asymptomatic, but was considered at-risk for progression to severe disease. Therefore, on 1/25/21, was sent to the infusion center for MAB treatment. Staff at the infusion center were unable to establish intravenous access. The plan was for the individual return to the infusion center in a few days after sufficient hydration. The individual deteriorated before he could return to the infusion center. On 1/27/21, he became febrile and hypoxic, and "EMS [Emergency Medical Services] was called a couple of hours later at the recommendation of the on-call doctor." The medical death review did not specify the length of time between the onset of symptoms and transfer.

    Upon arrival to the Emergency Department (ED), the individual was unresponsive with an arterial blood gas that showed an oxygen saturation of <50. The initial chest x-ray was "whited out." The individual was admitted to the intensive care unit (ICU), and required intubation and mechanical ventilation. He was diagnosed with acute respiratory failure, COVID-19 pneumonia, bacterial pneumonia, acute respiratory distress syndrome (ARDS), ileus, hypocalcemia, hyponatremia, and malnutrition. On 2/16/21, the individual died.

    The medical services review appeared incomplete. It did not follow the State Office template. For example, the list of active problems was not included in the review. Additionally, it did not address if the annual medical assessment (AMA), interval medical reviews (IMRs), etc. were completed timely and thoroughly. Preventive care was not documented. Rather, there was a statement from the reviewer: "It is my medical opinion preventive was appropriately provided." Objective data should have been documented to support that opinion. The template provides a list of specific preventive care services that the Center's reviewer should address.

    There was no discussion related to the individual being dehydrated, how hydration status could have been improved, or a specific plan to provide the MAB after the initial failure to administer it. If dehydration was considered the cause of the inability to obtain intravenous access, there should have been a specific plan for hydration. There also should have been discussion about whether alternative resources could have been used to gain IV access. For example, there was no documentation that any of the Center's providers attempted to obtain IV access. The use of MAB should occur very early during the course of illness. Moreover, given that this was the second COVID-19-related death in which dehydration was identified as an issue, further systemic review and action was needed.

    The PCP who conducted the review and clinical death review appeared to be the physician who provided medical care for the individual. This presented a potential conflict of interest.
  - In the nursing review, the Center's reviewer concluded that two acute care plans, dated 9/17/20, and 8/20/20, were "adequate to provide care." However, the reviewer did not identify what audit tool or review process they used to come to this conclusion. In addition, based on this finding, it did not appear that nursing staff developed and implemented an acute care plan when the individual returned from the infusion clinic after nurses were unable to start

an IV with a plan was to send him back "after a few days of hydration." The Center's nursing review did not identify/review actions that nursing staff took to monitor his intake and output, such as an acute care plan.
    - In addition, the Nursing Clinical Death Review did not include a comprehensive review of his active problems, and/or preventive health, including his immunization status.
    - The death reviews for this individual resulted in no recommendations.
- For Individual #618:
    - According to the medical services review, the individual was in stable health with no acute problems. The review of medical services provided an incomplete review. For example, it was reported that his compliance with continuous positive airway pressure (CPAP) improved. That statement did not address the issue of whether his obstructive sleep apnea (OSA) was adequately treated. It also stated his sodium had normalized with sodium supplementation, but that statement did not provide information on the cause of the hyponatremia or if sodium supplementation was prescribed appropriately based on the proper evaluation of hyponatremia. Moreover, sodium supplementation would not be a first line treatment in a 29-year-old obese male with hypertension. The individual had a glucose-6-phosphate dehydrogenase (G6PD) deficiency, but the Integrated Risk Rating Form (IRRF) did not discuss the practical implications of this diagnosis, or that the individual received any sort of instruction on what medications he needed to avoid. These items may not be related to the cause of death, but the State Office template requires a review of chronic medical issues to determine if appropriate care was provided.
    - With regard to the terminal events, on 9/12/21, at around 3:35 p.m., the PCP was made aware that the individual manipulated his urethra with a foreign object significant enough to cause bleeding, and the RN reported a small defect in the urethral meatus. However, the PCP did not evaluate the individual. That evaluation should have occurred regardless of the assessment by the RN. The individual had a previous history of septic shock due to a foreign body in the urethra, as well as another incident with foreign bodies in the bladder. The medical review also did not provide information on what the PCP did to address the urinalysis that showed a significant number of white blood cells indicative of infection. Thus, the individual was manipulating his urethra in the presence of a probable infection based on the documented pyuria. On the morning of 9/14/21, the individual decompensated quickly and died that night with septic shock being the likely cause of death.
    - The nursing review identified a problem with the risk ratings and the Integrated Health Care Plan (IHCP), but the exact nature of the problem was unclear. In addition, the nursing review identified that after they were developed on 5/7/21, nursing staff did not implement his IHCPs (i.e., with the exception of the weight IHCP for which the nutritionist was responsible). The resulting recommendation was that the RN Case Manager will initiate/implement the IHCP at the individual's annual ISP per guidelines.
    - The nursing review only addressed one acute care plan (i.e., dated 4/23/21). However, on 9/12/21, at 2:25 p.m., direct support professional staff (DSP) reported that the individual had blood dripping from the urethra area of his penis and also around his mouth area. He admitted to the LVN that he had "rammed a straw in his penis several times, while in the toilet area." Based on the self-induced trauma, with bleeding, as part of the Nursing Clinical Death Review, the reviewer did not consider that nursing staff should have implemented an acute care plan.
- For Individual #1:
    - Again, the medical review did not provide thorough and complete information. The State Office template provides some specific guidance, but that guidance was not reflected in the document. For example, for one critical question

"was acute care appropriately provided in the past 6 months?" the template states: "Provide supporting details for your conclusion." The reviewer responded with one word "yes." Most of the other critical questions consisted of similarly deficient responses.

- With regard to the nursing review:
  - The nursing reviewer again identified a problem with nursing staff's implementation of IHCPs, and made a corresponding recommendation.
  - The reviewer also identified a concern that the last documented complete dysphagia assessment was in January 2019. There was a dysphagia assessment in IRIS documented on 12/3/20, but it was still "in progress," and not completed. The reviewer indicated that: "This is being addressed with a recommendation in a previous death dated 12/4/20…"
- With regard to the habilitation therapy review:
  - According to the review, the individual was prescribed a pureed diet with nectar-thick liquids. The individual's IRRF indicated that staff should watch him closely so that he did not take others' food. They cited that enhanced supervision would have been appropriate given his impulse control with food and an oropharyngeal dysphagia diagnosis.
  - The Center's reviewer described that the individual had moved to the quarantine home due to COVID-19. Then, he moved back home, but later that evening, he returned to quarantine home due to another potential exposure. During the night, two staff were in the home, but one staff left at around 6:00 a.m., before coverage arrived for the next shift. The reviewer indicated that there should have been additional staffing assigned to the quarantine home, and noted that the staff breakroom door was not locked, which was where the individual obtained the food on which he choked.

    One staff member had not been trained specifically on his Physical and Nutritional Management Plan (PNMP). This may or may not have changed the staff member's decision to leave early. That staff member was not actually present during the incident. The Center's procedures indicated that staff were to read the PMMP before each shift for unfamiliar individuals.
  - The Center's reviewer also reported that the individual had not received the last two dysphagia assessments. Although it was thought that the dining plan was appropriate and the individual had been on a pureed diet for many years, this could not be confirmed given the incomplete dysphagia assessment. The action recommended was to ensure that dysphagia assessments are completed when the IDT requests them at the ISP meeting.

e. For Individual ##469, and Individual #724, the Center's death reviews resulted in no recommendations. As discussed above, recommendations were warranted. Individual #1's death occurred shortly before the Monitoring Team's review, so documentation of closure of the recommendations was not yet available.

Some improvement was noted with regard to the mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation that read: "Primary Care Providers should personally evaluate within 24 hours any individual with visually witnessed or reported trauma to the lower urinary tract or rectum/anus in a wound or bleeding [sic]" resulted

in an in-service training, but the committee also appropriately required audits of any individuals' records who met this criterion. That said, the timeframe for the audits was within 72 hours of the events, which might not result in the timely identification of problems.

Other recommendations did not identify methods that assessed whether the underlying problem was fixed. For example, another recommendation was for Registered Nurse Case Managers (RNCMs) to "initiate implement [sic] the IHCPs at the individual's annual ISP per guidelines." The committee agreed on a monitoring plan for the RNCM Supervisor to check to make sure that the IHCPs were initiated in IRIS. This did not ensure that nurses actually began to implement the IHCPs, which would require a review of IView entries, and IPNs.

For some of the recommendations, Center staff provided raw data as evidence of implementation. For example, staff training rosters were included, but Center staff did not include information about how many staff required training. As a result, this documentation could not be used to determine whether or not staff fully implemented the recommendation. Staff should summarize data, including, for example, the number of staff trained (n), and the number of staff who required training (N).

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									

Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.

As discussed in the Monitoring Team's previous reports on the Center's QA/QI system, it is essential Center implement reliability probes/checks to determine whether or not data are reliable. These would include mechanisms to ensure that potential ADRs are reported (e.g., comparing lists of medications prescribed for allergic reactions to the list of ADRs reported, etc.). In addition, guidelines such as those that the American Society of Hospital Pharmacists (ASHP) publishes provide direction in terms of ensuring full reporting.

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: Although one of the three DUEs completed did not appear to be clinically relevant, in the six months prior to the review, Center staff had completed two other	

clinically relevant DUEs. Given the Center's scores during over the last three reviews (Round 15 – 100%, Round 16 – 100%, and Round 17 – 67%), Indicator a will move to the category requiring less oversight. Center staff also consistently conducted follow-up on the DUEs completed (Round 15 – 100%, Round 16 – 100%, and Round 17 – 100%). As a result, Indicator b, will move to the category requiring less oversight.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	67% 2/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1

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

- A DUE on Benztropine that was presented to the Pharmacy and Therapeutics (P&T) Committee on 3/17/21.
  - The DUE documented objectives to:
    - Evaluate the justification of the choice of medication;
    - Evaluate the appropriateness of the ordered dose;
    - Determine if there were adverse reactions associated with the medication;
    - Provide recommendations related to benztropine use.
  - Nineteen individuals prescribed benztropine were identified.
  - It resulted in three recommendations:
    - Use clinical judgment and consider limiting the use of medication to the initial phase of high-potency antipsychotic use;
    - Consider the use of an alternative antipsychotic for the individual with an extrapyramidal symptoms (EPS) score of 63; and
    - Consider using specific indication terms, such as acute dystonia/parkinsonism instead of the term "to prevent EPS."
  - Staff implemented person-specific action plans for the second and third recommendations. The minutes of the June P&T Committee meeting noted that no change was necessary for the second recommendation and a new provider was reviewing the third recommendation. The minutes from the 9/8/21 P&T Committee meeting documented that this recommendation was completed.
- A DUE on central nervous system (CNS) stimulants that was presented to the P&T Committee on 6/16/21.
  - The stated objectives for the DUE were:
    - Evaluating the indication for use;
    - Determining adverse reactions associated with the medication use; and
    - Determining if scheduled monitoring was completed.
  - Three individuals were identified who were prescribed CNS stimulants. Clinically relevant DUEs should be prioritized and should address medications with high volume use, low therapeutic index, high incidence of ADRs, expensive

medications, and/or medications for high-risk patients. Conducting a full DUE on a medication prescribed to only three individuals would appear to be a low-value project. The Texas Health and Human Services provides the Medication Audit Criteria and Guidelines for the CNS stimulants reviewed. The data related to the rationale for completing the DUE should have been reviewed for the three individuals as part of the routine QDRR process.
    - The only recommendation was to consider the use of non-CNS stimulants in the adult population when warranted by concerns of substance use disorder (SUD).
    - The action plan was that this recommendation would be considered on a case-by-case basis following discussion with individuals and guardians. No follow-up was needed.
- A DUE on Geodon that was presented to the P&T Committee on 9/8/21.
    - The DUE documented objectives to:
        - Evaluate the justification of choice of medication;
        - Evaluate the appropriateness of ordered dose;
        - Determine if there were adverse reactions associated with the medication; and
        - Provide recommendations relating to ziprasidone use.
    - Nine individuals prescribed ziprasidone were identified.
    - This DUE resulted in three recommendations, which the P&T Committee discussed and developed action plans to address. At the time of the Monitoring Team's review, follow-up was not yet due.

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, 38 of these indicators were in or were moved to the category of requiring less oversight. For this review, nine other indicators were moved to this category, in ISPs, psychiatry, medical, nursing, OTPT, and skill acquisition. One indicator, in psychiatry, will be returned from this category back to active monitoring.

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

Assessments

ISP-related assessments were identified and obtained.

The behavioral health functional assessments were complete.

In order to assign accurate risk ratings, IDTs need to continue 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 and update the Integrated Risk Rating Forms (IRRFs) within no more than five days.

On a positive note, for this review and the previous two reviews, Medical Department staff completed the new-admission, and annual medical assessments (AMAs) in a timely manner. As a result, the related indicators will move to the category requiring less oversight.

Center staff should continue to improve the quality of the medical assessments, and interval medical reviews (IMRs). For the AMAs, staff should focus on addressing, as applicable, family history, childhood illnesses, pertinent laboratory information, and thorough plans of care for each active medical problem, when appropriate.

The Center should continue its focus on improving the quality of dental exams and summaries. When reviewing the dental exams, the Monitoring Team noted that for three of nine applicable individuals reviewed, the annual dental exams provided for review were not within 365 days of the previous (i.e., the previous exams were dated in 2019). Unless the Center improves its performance, at the time of the next review, the related indicator will return to active oversight.

For the six individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. For four out of five applicable individuals, nurses also completed timely quarterly nursing record reviews and physical assessments.

Nursing Department staff continued to improve the quality of the annual and quarterly record reviews and physical assessments. It was positive that for five of the six individuals in the review group, nurses completed annual physical assessments that addressed the necessary components, and that all five quarterly physical assessments met criteria. It also was positive that for about half of the risk areas reviewed, nurses included status updates in annual record reviews, and for two of the 10 risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for Registered Nurse Case Managers (RNCMs) to analyze this information, and offer relevant recommendations.

For over half of the instances in which individuals experienced exacerbations of their chronic conditions, nurses completed assessments in accordance with current standards of practice.

Work is needed to ensure that individuals meeting criteria are timely referred to the Physical and Nutritional Management Team (PNMT). It was positive that the PNMT completed timely comprehensive assessments for the two individuals requiring them. The Center should focus on continued improvements to the quality of the PNMT comprehensive assessments.

Some individuals in the review group did not have timely Occupational and Physical Therapy (OT/PT) assessments and/or the type of assessment they needed. Overall, the Center needs to focus significant attention on ensuring that OT/PT assessments thoroughly address all the required criteria.

It was positive that almost all individuals reviewed received the type of communication assessment that was in accordance with their needs, but timeliness of the assessments was a concern. In addition, significant work was still needed to improve the quality of communication assessments 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 are objectively evaluated.

SAP-related assessments included recommendations for skill acquisition.

<u>Individualized Support Plans</u>

In the ISPs, one individual's goals met criteria for indicator 1 for all five personal goal areas. Across the six individuals, personal goals met criteria in from three to five areas for a total of 22 goals that met criteria. Overall, this was about the same as at the last

review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

In the ISPs, about half of the personal goals were written in measurable terminology. Most of those goals that met criteria with indicators 1 and 2 had documentation. About one-third of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal.

ISP overall implementation timeliness improved from the last review. Of the five ISP goals that had data to determine progress, one was met or progressing. IDTs did not take action on those that were not progressing.

The psychiatry department was identifying indicators for reduction and in some cases for increase. The psychiatry clinicians need to define the indicators, ensure that the relationship of the indicator to the individual's diagnosis is clearly designated, and that indicators are consistently identified.

Psychiatrists attended ISP meetings for all individuals. Psychiatry-related ISP documentation continued to need some improvement.

Three psychiatric PSPs were reviewed in the review group. One met criteria for content.

In behavioral health, the Center was regularly collecting IOA and DCT information and meeting monitoring criteria.

Overall, the Integrated Health Care Plans (IHCPs) of the individuals in the physical health review group 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.

Five of the Physical and Nutritional Management Plans (PNMPs) included the necessary components to meet the individuals' needs. The remaining PNMPs/Dining Plans included most of the necessary components.

All individuals had a number of SAPs. About two-thirds had implementation data that were regularly collected and shown to be reliable.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, one individual's goals met criteria for all five personal goal	Individuals:

areas. Moreover, across the six individuals, personal goals met criteria in from three to five areas for a total of 22 goals that met criteria. Overall, this was about the same as at the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. Overall, about half of the goals were written in measurable terminology. Indicator 3 shows that about one-third of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring.

#	Indicator		Overall Score	844	640	436	620	143	689			
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.	Personal goals	17% 1/6 73% 22/30	3/5	4/5	4/5	5/5	3/5	3/5			
		Health goals	0% 0/6 0% 0/15	0/2	0/2	0/3	0/3	0/3	0/2			
2	The personal goals are measurable.	Personal goals	0% 0/6 55% 12/22 52% 14/27	1/3 2/5	3/4 3/5	2/4 2/4	3/5 3/5	1/3 1/3	2/3 3/5			

		Health goals	0% 0/6 --% -/- 0% 0/15	-/- 0/2	-/- 0/2	-/- 0/3	-/- 0/3	-/- 0/3	-/- 0/2			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 32% 7/22	2/3	2/4	1/4	0/5	1/3	1/3			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Mexia State Supported Living Center: Individual #143, Individual #689, Individual #436, Individual #844, Individual #640, and Individual #620. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs, Home Managers and QIDPs, and directly observed individuals on the Mexia SSLC campus.

Individual #844's most recent ISP meeting was held less than one month prior to the start of the monitoring review. His action plans had not been fully developed, and there were no data to determine if he was making progress towards goal-achievement. For Individual #844, the previous year's ISP was used to evaluate indicators 5, 6, 7, 8, and 17. For the remaining indicators, Individual #844's new ISP was rated.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 22 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review, 22 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #143, Individual #689, Individual #436, Individual #844, Individual #640, and Individual #620.
- the relationship goal for Individual #436, Individual #844, and Individual #620
- the work/day/school goal for Individual #844, Individual #640, and Individual #620
- the independence goal for Individual #143, Individual #689, Individual #436, Individual #640, and Individual #620.
- the living options goal for Individual #143, Individual #689, Individual #436, Individual #640, and Individual #620.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs or they did not provide opportunities to try new activities and learn new skills. For instance:

- Individual #689 had a relationships goal to join a swim team. As written, the goal did not indicate who he would like to spend time with, and it was not evident how he would be supported to develop relationships with others.
- Individual #640 had a relationships goal to plan and attend a gaming convention. Although the action plan included a step to invite a peer, it was not evident how Individual #640 would be supported to develop a relationship with the peer by attending the convention.

- Individual #689 had a work goal to maintain continuous employment through the Mexia SSLC Vocational Education department. As written, the goal was not aspirational and did not identify the kind of job Individual #689 would like to have.
- Individual #844 had a living options goal to reside in an ICF SSLC in the Houston, Texas area. The goal was based on Individual #844's preference to remain at the Mexia SSLC due to his fear of transitioning to the community. Individual #844 had reported that he felt safer at the Mexia SSLC, and that there were more restrictions in the community. It was not evident that the IDT worked with Individual #844 to understand his living options, address his trepidation, or to show how a transition to the community could be positive. As written, it was not evident how transferring from one SSLC another would enhance his life. He did not express his preference to move to the Houston area, and he did not have any contact with family or friends in that area.

None of the individuals had individualized healthcare goals based on their preferences. Goals to address the following risk areas were reviewed:

- Individual #143: dental, skin integrity, and choking.
- Individual #689: osteoporosis, falls and fractures, and weight.
- Individual #436: dental, skin integrity, and weight.
- Individual #844: respiratory and diabetes. The goal to train and complete a 5K in the community was not based on Individual #844's preferences. It was also not clear what Individual #844 was expected to do to train for a 5K race.
- Individual #640: dental and medication
- Individual #620: dental, osteoporosis, falls and fractures, and gastrointestinal

2. There were 14 measurable goals. Twelve of the measurable goals met criterion for indicator 1. Individual #689's relationships goal, and Individual #844's living options goal were measurable, but did not meet criterion for indicator 1. The goals that were measurable were:

- Recreation/Leisure: Individual #689 and Individual #620.
- Relationship: Individual #689 and Individual #620.
- Job/School/Day: Individual #844 and Individual #640.
- Greater Independence: Individual #640
- Living Option: Individual #143, Individual #689, Individual #436, Individual #844, Individual #640, and Individual #620.
- Health and Safety: none

Goals that were not measurable were not written in observable, measurable terms, and they did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Goals that did not meet criterion for measurability were:

- Recreation/leisure: Individual #143, Individual #844, and Individual #640.
- Relationship: Individual #143, Individual #436, Individual #844, and Individual #640.
- Job/School/Day: Individual #143, Individual #689, Individual #436, and Individual #620.
- Greater Independence: Individual #143, Individual #689, Individual #436, Individual #844 and Individual #620.

    - For Individual #436, as written, the goal to make a burrito did not describe what Individual #436 was expected to do. Another individual's goal, to make an Oreo cheesecake, involved a no-bake boxed kit that was complete with ingredients and directions. It was unclear how Individual #436 would make a burrito when the corresponding SAP was to teach him to heat a frozen burrito using the microwave.
    - For Individual #689, as written, the goal to do laundry without assistance was not measurable. It was not clear what aspects of the laundry task he was to perform or how staff would determine that the tasks had been completed.
    - For Individual #620, as written, the goal to wash his clothes was not measurable. It was not clear what aspects of the laundry task he was to perform or how staff would determine that the tasks had been completed.
- Health and Safety: Individual #143, Individual #689, Individual #436, Individual #844, Individual #640, and Individual #620.

3. For the 22 goals that met criterion for being personal and individualized, seven had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk; incorporate needs included in ancillary plans; offer opportunities to make choices and decisions; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #143's independence goal.
- Individual #689's independence goal.
- Individual #436's independence goal.
- Individual #844's recreation/leisure and relationships goals.
- Individual #640's recreation/leisure and independence goals.

Goals that did not have supportive action plans that might lead to goal-achievement included:

- Individual #143's recreation/leisure goal to blow bubbles with an adaptive bubble wand. The action plan did not include steps to teach Individual #143 use the bubble-blowing device. It also did not include steps to mitigate the identified risk that she might drink the solution. Action plans included:
    - will shop for different bubbles once monthly.
    - will manipulate a maraca and/or different fidget toys once weekly.
    - will pop bubbles when staff blows with her peers on the home weekly.
    - will use the bubble machine to blow with peers on the home weekly.
    - will exhibit six or less instances of aggression per month for six consecutive months.

- Individual #620's recreation/leisure goal was to ride with the Mexia SSLC fire brigade in an on-campus parade. The goal was to increase Individual #620's tolerance of large groups, and to support him to feel comfortable enough to ride his bike or walk in a parade alongside others. Individual #620 preferred to follow the on-campus parades while riding his bike from a distance. The action plan did not include steps to address Individual #620's uneasiness around groups of people or to teach him coping skills or strategies to minimize his discomfort. The action plan set is supposed to map out a clear path to goal-achievement. The action plans did not support Individual #620's goal to ride with the fire brigade. It also did not describe supports to help him to overcome his fear of large crowds, which was reported to be a barrier to achievement of the goal. Action steps included:
    - will take a trip to the Groesbeck fire station.

- will work with staff on getting on the van.
- will work with his staff on being around large crowds of people.
- will display zero incidents of SIB per month.
- will display zero aggression per month.
- will display zero property destruction per month.
- will sit outside to watch a parade.

- Individual #436's relationship goal was to invite a peer to participate in karaoke once per month. As written, the action plan did not include training or supports needed to teach Individual #436 how to invite a peer to join him. The action plan also did not incorporate strategies to mitigate Individual #436's risk of engaging in peer-to-peer aggression while sharing the karaoke machine. The action steps included:
  - will pick a music list
  - will ask a peer to join him.
  - will get the karaoke machine out.
  - will put the karaoke machine up.
  - will alternate his song choice with his peer's song.

- Individual #689's living options goal was to live with his family in Houston, TX. His behavioral challenges served as barriers to community referral. Individual #689 was admitted to the Center in May 2021 and there were pending murder charges. The only restriction in place for Individual #689 was 1:1 supervision. Individual #689 was allowed to leave campus to go on overnight visits with his family every other weekend. Family visits were unsupervised by SSLC staff. According to forensic assessments and court documentation, Individual #689's charges had not been dismissed because he was considered to be a danger to himself and others. His action plan did not integrate supports to help him to understand his charges, address the barriers, and mitigate the risk of harm given his behavioral history. The Center reported that every family visit was approved by the court prior to its occurrence. Even so, it is recommended that the Center consult legal counsel with regard to restrictions and protections for Individual #689, his unsupervised visits with his family, and his access to the community

- Individual #620's living options goal was to move to a group home near his family in Dallas, TX. The action plan included one step for him to attend the annual provider fair. There were no other steps that would expose him to community options or familiarize him with community settings. Overall, the action plan did not map out a clear path to goal-achievement. Action steps included:
  - will transition to the Martin unit.
  - will attend all required medical appointments.
  - will attend the annual provider fair.
  - will have no restraints within the year.
  - will exhibit zero instances of SIB.
  - will exhibit zero instances of aggression towards others.
  - will exhibit zero instances of property destruction per month.

Outcome 2: The individual's ISP set forth a plan to achieve goals.

Summary: About three-quarters of action plans that met criteria with indicators 1 and 3 also met criteria with indicator 4 (but only a small number of personal goals met criteria with indicators 1 and 3). The others were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress. For indicator 5, most of those goals that met criteria with indicators 1 and 2 had documentation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	844	640	436	620	143	689			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	60% 3/5 71% 5/7	2/2	1/2	0/1	-/-	1/1	1/1			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	83% 5/6 90% 9/10	0/1	3/3	1/1	3/3	1/1	1/1			

Comments:

4. Five of the action plans provided sufficient detailed information for implementation, data collection, and review to occur. These were Individual #143's independence goal, Individual #689's independence goal, Individual #640's independence goal, and Individual #844's leisure and relationships goals.

When looking across all action plans, that is, including those that were not included in the scoring for this indicator, action plans did not outline specific implementation strategies, necessary supports, or criteria for documenting and evaluating progress. Examples of action steps that did not meet criterion included:

- For Individual #689
  - will purchase swim gear
  - will separate his clothes before washing them
- For Individual #436
  - will make a shopping list
  - will put preferred items in a tortilla
- For Individual #844
  - will keep a journal and document (CPAP) use
- For Individual #620
  - will work with staff on getting on the van
  - will work with staff on being around large crowds
  - will work on interviewing skills

5. Of the 11 goals that met criterion for indicators 1 and 2, nine had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. Of the two remaining goals, the indicator was not applicable to one of them, Individual #689's leisure goal because the Special Olympics season had not begun, and it was not possible to implement the action plan. The nine goals that met criterion for indicators 1 and 2, and also met criterion for this indicator were:

- Individual #143: living options goal
- Individual #689: living options goal
- Individual #436: living options goal
- Individual #640: work, independence, and living options goals
- Individual #620: leisure, relationships, and living options goals

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

Summary: Of the five goals that had data to determine progress, one was met or progressing. IDTs did not take action on those that were not progressing. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 844	640	436	620	143	689			
6	The individual met, or is making progress towards achieving, his/her overall personal goals.	25% 1/4 20% 1/5	0/2	0/1	-/-	-/-	0/1	1/1			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/3 0% 0/4	0/2	0/1	-/-	-/-	0/1				

Comments:

6–8. None of the individuals had achieved goals in any of their life areas. In general, the individuals were not making progress towards goal-achievement. One of the six individuals, Individual #689, was making progress in the living options life area. The other five individuals were not making progress in any life area. For the individuals who were not making progress, activities and/or revisions were not made to promote progress. Findings included:

- Individual #143's recreation/leisure goal was to blow bubbles using an adaptive device. According to the data, she never utilized the device. During an observation period, a DSP who had been working with Individual #143 for approximately six months, reported that she was not aware of Individual #143's goal to use the device, and that she may have seen the device once.

- Individual #436's goal to make a burrito had action steps that required Individual #436 to shop for ingredients and independently assemble his burrito. Individual #436 never made progress because his burritos were being prepared and delivered to him by the culinary staff.
- Individual #640's independence goal was to make a cheesecake. According to the data, Individual #640 never made a cheesecake. Instead of revising the action plan to promote progress, the IDT decided to discontinue the goal and replace it with a goal to make a sponge cake.

In general, action plans were not implemented consistently, and individuals were not offered the minimum number of trials needed to develop skills and demonstrate progress.

It was good to see that IDTs were reviewing action plans monthly, however, goals and/or action plans were rarely revised to promote progress during the ISP year. Instead, IDTs waited until the next annual ISP meeting to make revisions.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.

Summary: ISP overall implementation timeliness improved from the last review. Assessments were identified and obtained, moreover, the Center showed sustained high performance over this and the previous two reviews, too. Therefore, indicators 11a and 11b will be moved to the category of requiring less oversight. Indicators 9b, 10, and 11c will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 844	640	436	620	143	689			
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this sub-indicator was moved to the category of requiring less oversight.									
	b. The ISP was implemented within 30 days of the meeting or sooner if indicated.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
	c. Assessments were updated as needed in response to significant changes.	100% 2/2				1/1		1/1			

Comments:

9b. Four of the six individuals had ISPs that were implemented within 30 days of their meeting. For the other two individuals, action plans had not been fully implemented. For example:

- Individual #143's recreational/leisure goal was to blow bubbles using an adaptive device. According to the data, Individual #143 never utilized the device and staff reported that they were not aware of the goal.
- Individual #844's ISP meeting was held on 9/21/21. As of 10/22/21, the ISP was not present on his home, and staff were not aware of the new goals.

10. One of the six individuals, Individual #844, had an appropriately constituted IDT, based on his strengths, needs and preferences, that participated in the planning process and attended his ISP meeting. Four of the other individuals had speech deficits and communication needs that served as barriers to goal-achievement. A SLP should have been present to discuss and support the individuals to develop or enhance their communication skills. For example:

- Individual #143 was not able to verbally communicate. She often used maladaptive behaviors to communicate her discontent. According to her Communication Dictionary, she engaged in rocking/bucking in her wheelchair and spitting when attempting to communicate a variety of things. Individual #143 did not have supports in place to teach alternative or prosocial ways to express her needs. During the review week, the Monitoring Team visited Individual #143 (virtually) on her home. At the time of the observation, Individual #143 was alone in her room. Her music was playing very loudly, and she was rocking and bucking in her wheelchair. She was also drooling excessively. The front of her shirt was visibly wet. She appeared to be in distress at the time of arrival. According to reports, Individual #143 exhibited rocking, bucking and spitting in attempts to escape aversive situations or locations. Upon exhibiting the behaviors, staff would bring her to her room and turn on her music to calm her down. During the observation period, the music did not appear to be calming. Once the music was turned off, Individual #143 immediately quieted. She smiled and appeared to attempt to engage. Thus, it was questionable if bringing her to her room when she is engaging in challenging behaviors is calming for her, or if she perceived it as aversive. Without proper communication supports, escorting her to her room when she is engaging in maladaptive behaviors could potentially be viewed as a time-out procedure. With proper communication supports in place, Individual #143 could potentially identify her preferences and appropriately request to be relocated to her room and for her music to be turned on.
- Individual #436 had received speech services in the past. Speech services were discontinued due to his lack of progress and lack of compliance. The IDT did not consider a collaboration between the BHS and the SLP to address Individual #436's noncompliance and support him to resume speech services.

The annual ISP meeting was observed for Individual #620. It was good to see that the IDT recognized his need for communication supports and decided to refer him for speech services.

11a. For all individuals, the IDT considered what assessments the individual needed and would be relevant to the development of their ISPs prior to the annual meeting.

11b. For all individuals, the IDT arranged for and obtained the needed, relevant assessments prior to the annual meeting.

11c. The indicator was not applicable to four of the six individuals who had no significant changes that warranted updated assessments. For the other two individuals, Individual #689 and Individual #620, assessments had been updated as needed.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Performance was about the same as at the last review. Criteria were met for a small number of individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	844	640	436	620	143	689			
12	There was a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
13	a. ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
14	ISP action plans included individualized-measurable plans to educate the individual/ LAR about community living options.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
15	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			

Comments:

12. For one individual, Individual #689, the indicator was met. His goal was to move to his family's home, and there was a plan in place to facilitate it. The IDT did not discuss alternative living options because Individual #689's family members were adamant that he move in with them. For the other five individuals, living options were not thoroughly discussed. For example:

- Individual #844 had expressed his preference to remain at the Mexia SSLC due to his fear of living in the community. He was a registered sex offender and believed that there would be more restrictions in the community than at the Center. The IDT did not explore community living options and decided that Individual #844 should transfer to another Center instead of moving to the community.
- Individual #640's goal was to live with his father. The goal was not achievable because Individual #640's father would not allow Individual #640 to move in with him. The IDT never revised the goal and ever explored alternative community living options.
- Individual #620's goal was to live in a group home near his family. According to the ISP, Individual #620's IDT discussed on-campus living options and developed a plan for him to transition to the Martin unit. There was no discussion of community living options.

13a. One of the six ISPs integrated encouragement of community participation and integration. This was for Individual #689, whose recreation/leisure goal had a corresponding action plan that included swim lessons in the community. For the other five individuals, action plans generally encouraged participation in on-campus activities and singular community events.

13b. For three of the six individuals, their IDTs considered opportunities for day programming in the most integrated setting consistent with the individuals' preferences and support needs. Findings included:

- Individual #689 had recently been admitted to the Center. His work action plan consisted of steps geared toward finding an appropriate job that was consistent with his preferences and needs.
- Individual #844's work goal was to obtain employment as a laundry aide in the community. He worked on campus in laundry services, and he was developing necessary skills to achieve his goal.
- Individual #640 attended school each weekday and had a goal to work in the community bussing tables at Starbucks.

For the other three individuals, it was not evident that opportunities for day programming were consistent with their support needs and preferences. Their vocational training was not focused on building skills that might have led to achievement of their work/day goals or employment/day programming in a more integrated setting.

- Individual #143 did not have a work/day goal. She reportedly did not have an interest in working. Each weekday, she attended a day program on campus where she shredded, tore, and folded paper. Although she was not earning wages, she was engaging in activities that did not appear to align with her preferences. It was not evident that the IDT had explored day programming options that she might prefer.
- Individual #436 was 31 years old. He did not have a work/day goal due to his potential to engage in aggressive and destructive behaviors. Individual #436 was described as creative, helpful, and compliant with requests. He attended his day program each day without resistance and served as the instructor's assistant. Individual #436 could independently access the internet to research topics and window shop for items he wanted to purchase. He could also read and write. While at his day program, Individual #436 shredded paper. It was not evident that the IDT had explored day and work options that were consistent with Individual #436's skills and abilities.
- Individual #620 had a goal to work on campus in laundry services. Although it was good to see that he was working to develop skills that would lead to achievement of his work goal, it was not evident that the IDT had explored employment options in a less restrictive and more integrated setting.

14. The indicator did not apply to Individual #689, whose living options goal was to move to his family's home. Individual #689's family was supportive of his goal, and they did not want Individual #689 to explore community options. For the other five individuals, none of the ISP action plans included individualized measurable plans to educate the individuals/LARs about community living options.

15. The indicator was met for Individual #436, whose IDT agreed to refer him to the community. For the other five individuals, action plans did not address their identified obstacles to referral. For example:

- Individual #143's identified barriers were that she had resided at the Center for 11 years, and that she had developed a rapport with familiar staff. Her LAR had also expressed his preference that Individual #143 remain at the Center. It was not evident that the IDT had explored alternative living options and ways to familiarize Individual #143 with community supports. Although the LAR was in contact with the CLOIP, it was not evident that the IDT had created individualized action plans to address the LAR's opposition.
- Individual #620 had a history of unsuccessful community placements. He also had a history of aggressive and self-injurious behaviors. His behavioral challenges, as well as his aversion to female staff, served as barriers to community referral. The

action plan associated with his living options goal did not address the identified barriers. Three of the action steps were behavioral compliance objectives that did not include measurable steps to address or overcome his behavioral challenges.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: Performance was about the same as at the last review. The staff and QIDPs for about half of the individuals were knowledgeable about the individual. About three-quarters of action plans had some implementation, but not as consistently or as much as the action plan called for. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	844	640	436	620	143	689			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	60% 3/5	1/1	Attempted	1/1	0/1	0/1	1/1			
17	Action plans in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

Comments:

16. The indicator was not applicable to Individual #640. An attempt was made to visit Individual #640's home to view his room and meet with staff who were familiar with him. At the time of the observation period, there were no staff available on the home. For three individuals, Individual #689, Individual #436, and Individual #844, staff were knowledgeable of support needs, risk areas, ISP goals, and action plans. For the two other individuals, it was not evident that the staff were properly trained on goals or action plans.

Individual #620 had been engaging in rectal digging since his transition to the Martin unit. The behavior was severe and would often result in bleeding and lacerations. Individual #620's LOS was changed from 1:1 to enhanced after his transition. According to the QIDP, the change in LOS meant that Individual #620 had more private time in his room. It was concerning to hear that Individual #620's change in LOS was viewed as positive given the frequency and severity of his rectal digging and the potential for self-harm. It was not evident that the IDT had considered the potential for Individual #620 to harm himself while alone in his room.

17. None of the ISPs met criterion for the indicator. There was a total of 110 action steps evaluated. Although 73 (66%) of the action plans had been implemented, most were not consistently implemented. In most cases, individuals were not offered minimum number of teaching trials to develop skills and demonstrate progress.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Fully Implemented
Individual #143	10	7	3
Individual #689	15	11	4
Individual #436	25	16	9
Individual #844	20	15	5
Individual #640	19	11	8
Individual #620	21	13	8

18. The indicator was met for Individual #689. For the other five individuals, QIDPs were consistently reviewing goals and action plans and commenting on progress, however, goals and/or action plans were not revised when individuals were not making progress, and barriers were not addressed when services and supports were either not implemented or not effective (see comment for indicators 6 through 8).

Four of six QIDPs were recently assigned to their respective individuals. They were generally unfamiliar with historical information, and it was not evident that they had been supported to understand the needs of the individuals on their caseloads.

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 and update the IRRFs within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	The individual's risk rating is accurate.	8% 1/12	0/2	0/2	1/2	N/R	0/2	N/R	0/2	0/2	N/R
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.	0% 0/10	0/2	0/2	0/2		0/2		N/A	0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #436 – falls, and infections; Individual #844 – cardiac disease, and respiratory compromise; Individual #704 – diabetes, and infections; Individual #143 – constipation/bowel obstruction, and GI problems; Individual #108 – osteoporosis, and constipation/bowel obstruction; and Individual #689 – seizures, and falls].

a. The IDT that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines was for Individual #704 – diabetes.

b. For the individuals in the review group, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually.

However, often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individual did not have changes of status in the specified risk areas: Individual #108 – osteoporosis, and constipation/bowel obstruction.

Psychiatry

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

Summary: At Mexia SSLC, there was progress in the sub-indicators of some of the indicators in this outcome. The psychiatry department was identifying indicators for reduction and in some cases for increase. The psychiatry clinicians need to define the indicators, ensure that the relationship of the indicator to the individual's diagnosis is clearly designated, and that indicators are consistently identified. Although the psychiatric clinicians were writing goals, these were documented in the psychotropic medication consent forms and were not always consistent with the indicators identified in other psychiatric documentation. The goals were not entered into the facility's overall treatment program, the IHCP. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	0/2	0/2	0/2	0/2	1/2	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	1/2	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.	11% 1/9	1/2	0/2	0/2	1/2	0/2	1/2	1/2	0/2	2/2

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.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC 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 progress in this area as all individuals in the review group had at least one psychiatric indicator related to the reduction of psychiatric symptoms and eight individuals had an indicator for increase identified. The indicators were documented in the psychiatry goals grid included in the annual CPE or in the psychiatric quarterly. The documentation for two individuals, Individual #660 and Individual #620, included information regarding the relationship of the psychiatric indicator to the diagnosis for both the indicators for reduction and increase. The psychiatry goals grids were incomplete in the other seven examples because they did not include information regarding how the indicators related to the individual's psychiatric diagnosis.

Once an indicator is identified and related to a specific diagnosis, the next step is to define the indicator such that staff recording the presence of a specific indicator will be able to correctly identify the indicator. When indicators are the same as a behavioral health target behavior, behavioral health generally defines the indicator. When indicators are different from behavioral health target behaviors, psychiatry needs to specifically define the indicator. Individual #672, Individual #640, Individual #716, and Individual #660 had indicators for reduction designated that were either consistent with behavioral health target behaviors or were measured by a specific psychiatric rating scale. Individual #620 also had an indicator for increase that was measured by a specific psychiatric rating scale. When only a scale was identified as the measure of the indicator, a specific definition would not be necessary as the symptoms would be defined via the rating scale. In these cases, as observations were not a component of the data collection process, they were scored affirmatively. If observations were requested in addition to the designated rating scale, a specific definition of the symptoms would be necessary.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for Individual #672 and Individual #660. Criteria for psychiatric indicators for increase were not met for any of the individuals in the review group.

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.

The psychiatric goals regarding the indicators for increase and decrease were not regularly included in the psychiatric documentation (e.g., the CPE and quarterly psychiatric). While there were goals included in the psychotropic medication consent forms, these goals were not always consistent with the identified indicators. Further, while goals need to be written for the specific identified indicators, they also need to be included in the CPE and in the quarterly psychiatric documentation where they can be regularly reviewed. Following discussion during the monitoring review week, the psychiatric quarterly documentation regarding Individual #660 from the clinical encounter observed during the week included goals for both reduction and increase. This was good to see.

The second part of this indicator requires the designation of data collection methods. This would include how and when data are collected. The psychiatry goals grid did not consistently identify how data were to be collected or the frequency of data reporting. For example, the psychiatry goals grids included requirements for observations entered into CareTracker or specific rating scales. The grids did not note the frequency of completion of rating scales, who was responsible for completing the rating scales, or who would report/trend the data.

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.

Thus, both sub-indicators were not met for any of the individuals for goals for reduction and for one individual, Individual #660, for a goal 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, goals for reduction and increase were not consistently written for the identified indicators or documented in the psychiatry goals grid as noted above. There were goals included in the psychotropic medication consent forms, but these did not always correlate with the indicators identified in the psychiatric goals grid. The goals were not 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.

At Mexia SSLC, data regarding indicators for decrease were presented as a series of numbers. In addition, there were tabulated data regarding the results of specific rating scales, the subscales of which were utilized to address specific indicators. With the exception of Individual #716, all data requested for indicators for reduction were a combination of behavioral health target data, data regarding other psychiatric symptom indicators, and rating scale data. Reportedly, the behavioral health target data and data regarding other psychiatric symptom indicators were reliable for everyone except Individual #436. The data gathered via specific rating scales would have intrinsic reliability and validity based on the scale itself. For Individual #640, although a rating scale was identified as a data source, data were not reported. For Individual #15, there were no sleep data reported and although a Glasgow scale was indicated in the psychiatry goals grid as a data source, the ADAMS scale was used and reported. For Individual #844, although a Glasgow scale was indicated in the psychiatry goals grid as a data source, the ADAMS scale was used and reported.

Thus, eight individuals had a mix of data sources designated for the indicators for reduction in the psychiatry goals grid, with five individuals, Individual #672, Individual #716, Individual #660, Individual #978, and Individual #620 having reliable data reported. One individual, Individual #620, had reliable data reported for the indicator for increase. These data were gathered via a rating scale. As these data were reported via the rating scale results, which would have intrinsic validity, the data were reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: Both indicators will remain in active monitoring. Both scored about the same as at the last reviews. Some attention to content remains needed to meet criteria for these two indicators.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	33% 3/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
Comments:											

14. The Monitoring Team looks for 14 components in the CPE. Three of the CPEs, regarding Individual #716, Individual #978, and Individual #620, included all of the required components. The remaining CPEs were missing from one or two elements. The most common missing element was an adequate bio-psycho-social formulation, missing in four CPEs. Overall, three evaluations were missing one element and three evaluations were missing two elements.

- The CPE regarding Individual #672 was missing an adequate bio-psycho-social formulation.
- The CPE regarding Individual #844 was missing laboratory examinations and an adequate bio-psycho-social formulation.
- The CPE regarding Individual #640 was missing the physical examination.
- The CPE regarding Individual #436 was missing laboratory examinations and an adequate bio-psycho-social formulation.
- The CPE regarding Individual #660 was missing laboratory examinations.
- The CPE regarding Individual #15 was missing the physical examination and an adequate bio-psycho-social formulation.

16. There were six records that revealed inconsistent diagnoses, Individual #844, Individual #716, Individual #436, Individual #660, Individual #978, and Individual #15.

- Regarding Individual #844, the AMA did not include the diagnosis of Tobacco Use Disorder.
- Regarding Individual #716, the AMA included a diagnosis of Tobacco Use Disorder that was not included by psychiatry. This diagnosis was also included by behavioral health in the BHA as a diagnosis noted in the AMA.
- Regarding Individual #436, the AMA included a diagnosis of Obsessive Compulsive Disorder and did not include the diagnosis of Reactive Attachment Disorder.
- Regarding Individual #660, the AMA did not include the psychotic symptoms specifier.
- Regarding Individual #978, the AMA included diagnoses of Intermittent Explosive Disorder and Conduct Disorder.
- Regarding Individual #15, the AMA did not include the diagnoses of Intermittent Explosive Disorder or Post Traumatic Stress Disorder.

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

Summary: Psychiatrists attended ISP meetings for all individuals. Due to sustained high performance this indicator, 20, will be moved to the category of requiring less oversight. Psychiatry-related ISP documentation continued to need some improvement. Indicators 18 and 21 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
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).	13% 1/8		1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. One of the annual evaluations, regarding Individual #844, contained all of the required elements. The remaining seven evaluations were missing from one to four elements. Four evaluations were missing one element, one evaluation was missing two elements, one evaluation was missing three elements, and one evaluation was missing four elements. The most common missing element was past pharmacotherapy, missing in seven evaluations.

- The annual CPE regarding Individual #640 was missing the symptoms of the diagnosis, the psychological or Behavioral Health Assessment, the combined Behavioral Health review/formulation, and past pharmacotherapy.
- The annual CPE regarding Individual #716 was missing the symptoms of the diagnosis, the risk of medication, and past pharmacotherapy.
- The annual CPE regarding Individual #436 was missing past pharmacotherapy.
- The annual CPE regarding Individual #660 was missing past pharmacotherapy.
- The annual CPE regarding Individual #978 was missing past pharmacotherapy.
- The annual CPE regarding Individual #15 was missing past pharmacotherapy.
- The annual CPE regarding Individual #620 was missing the symptoms of the diagnosis and past pharmacotherapy.

20. The psychiatrist attended the ISP meeting for all individuals in the review group. This was good to see. 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: Mexia SSLC did not maintain high performance on this indicator for this and the previous three reviews, too. Therefore, this indicator will be returned to active monitoring. To be specific, three PSPs were reviewed in the review group. One met criteria (Individual #844). For the other two:	Individuals:

• For Individual #672, the PSP indicated that the Glasgow scale would be used to measure the indicator. The PSP did not designate who would be responsible for completing the scale, compiling, or reporting the data. • For Individual #436, the PSP indicated that data would be gathered via a rating scale, but did not indicate what rating scale would be used or who would be responsible for administering the rating scale, compiling, or reporting the data.												
#	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: Improvements were seen and all three indicators scored high. With sustained high performance, all might be moved to the category of requiring less oversight after the next review. All will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 29. The consent forms included adequate medication side effect information in all examples. While the facility included some medication side effect information on the consent forms, they also routinely include medication side effect information sheets with consent forms. This was good to see.												

30. A sufficient risk versus benefit discussion was included in the consent forms in eight examples. There was a need for improvement in the risk versus benefit discussion regarding Individual #672 given the complexity of his prescribed regimen and the prescription of two antipsychotic medications.

31. The consent forms for all individuals in the review group included alternate, non-pharmacological interventions in addition to the PBSP or PSP.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.

Summary: Mexia SSLC again showed a lot of progress since the last review. To be specific, the Center was regularly collecting IOA and DCT information and meeting monitoring criteria. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
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.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 7/7			1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
5. All individuals had interobserver agreement (IOA) assessments and data collection timeliness measures in the last six months that were at or above 80%. This represents a substantial improvement over the last review when about half of the individuals had reliable PBSP data.

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

Summary: This indicator will remain in active monitoring. With sustained high performance it might be moved to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
10	The individual has a current, and complete annual behavioral health update.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
11	The functional assessment is current (within the past 12 months).										
12	The functional assessment is complete.	100% 3/3							1/1	1/1	1/1

Comments:
Criteria for indicators 1-8 were met for Individual #640, Individual #716, Individual #436, and Individual #660. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for them.

12. This represents a dramatic improvement from the last review when 33% of functional assessments were judged to be complete.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary:			Individuals:									
#	Indicator	Overall Score										
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
14	The PBSP was current (within the past 12 months).											
15	The PBSP was complete, meeting all requirements for content and quality.											
Comments:												

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: It was positive that PCPs completed timely new-admission or annual medical assessments for eight of the nine individuals in the review group. Given the Center's sustained progress over time, Indicator a (Round 13 – 100%, Round 14 – N/A, Round 15 – 100%, Round 16 – N/A, and Round 17 – 100%), and Indicator b (Round 15 – 88%, Round 16 – 100%, and Round 17 – 86%) will move to the category requiring less oversight. PCPs completed timely IMRs for all eight individuals as well. Center staff should continue their efforts to maintain their progress in this area.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary, depending on the individual's clinical needs.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	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.	86% 6/7	1/1	1/1	N/A	0/1	1/1	1/1	1/1	N/A	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
Comments: a. and b. It was positive that PCPs completed timely medical assessments for the two newly-admitted individuals. For most of the remaining individuals in the review group, PCPs completed timely AMAs. The exception was Individual #451. On 6/23/20, a provider completed his previous AMA, but his most recent one was dated 7/19/21, making it almost a month overdue. c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). It appeared that PCPs at Mexia SSLC were following this guidance.										

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Center staff should continue to improve the quality of the medical assessments, and IMRs. For the AMAs, staff should focus on addressing, as applicable, family history, childhood illnesses, pertinent laboratory information, and thorough plans of care for each active medical problem, when appropriate. Indicators a and c will remain in active oversight.	Individuals:

#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator 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.	50% 8/16	1/2	1/2	N/A	0/2	1/2	2/2	2/2	1/2	0/2

Comments: a. It was positive that Individual #689's AMA included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining AMAs the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all AMAs addressed pre-natal histories, past medical histories, allergies or severe side effects of medications, and lists of medications with dosages at the time of the AMA. Most, but not all included social/smoking histories, complete interval histories, complete physical exams with vital signs, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, family history, childhood illnesses, pertinent laboratory information, and thorough 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 #436 – seizures, and osteoporosis; Individual #844 – sleep apnea, and tobacco use disorder; Individual #704 – iron-deficiency anemia, and chronic kidney disease (CKD); Individual #451 – gastrointestinal (GI) problems, and bilateral avascular necrosis of the femoral heads; Individual #143 – senile exudative macular degeneration, and osteoporosis; Individual #896 – hypothyroidism, and weight; Individual #108 – seizures, and osteoporosis; Individual #689 – seizures, and diabetes; and Individual #635 – seizures, and anemia].

The IMRs that followed the State Office template, and provided necessary updates related to the risks reviewed included those for: Individual #436 – seizures; Individual #844 – sleep apnea; Individual #143 – senile exudative macular degeneration; Individual #896 – hypothyroidism, and weight; Individual #108 – seizures, and osteoporosis; and Individual #689 – seizures.

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. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
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 pathways/guidelines.	N/R										

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 #436 – seizures, and osteoporosis; Individual #844 – sleep apnea, and tobacco use disorder; Individual #704 – iron-deficiency anemia, and CKD; Individual #451 – GI problems, and bilateral avascular necrosis of the femoral heads; Individual #143 – senile exudative macular degeneration, and osteoporosis; Individual #896 – hypothyroidism, and weight; Individual #108 – seizures, and osteoporosis; Individual #689 – seizures, and diabetes; and Individual #635 – seizures, and anemia).

None of these IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: The Center should continue its focus on improving the quality of dental exams and summaries. When reviewing the dental exams, the Monitoring Team noted that for three of nine applicable individuals reviewed, the annual dental exams provided for review were not within 365 days of the previous (i.e., the previous exams were dated in 2019). Unless the Center improves its performance, at the time of the next review, Indicator 3.a.ii will return to active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	Due to a decrease in performance, Indicator a.ii is at risk of returning to active oversight unless Center staff make improvements.									

	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.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1

Comments: b. For six of nine individuals reviewed, the comprehensive dental examinations addressed all required components. It was also positive 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; and,
- An odontogram;
- Treatment provided/completed.

Most, but not all, of the exams also included the following components:

- A treatment plan; 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 exams include, as applicable:

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

c. For seven of nine individuals reviewed, the annual dental summaries reviewed included all of the required components. It was also good to see that the remaining dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Provision of written oral hygiene instructions; and,
- Recommendations for the risk level for the IRRF.

Most of the remaining dental summaries included:

- 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 the six individuals reviewed, nurses completed timely annual or new-admission nursing reviews and physical assessments. Due to the Center's sustained progress with regard to timely nursing record reviews for newly-admitted individuals (i.e., Round 15 – 100%, Round 16 – N/A, and Round 17 – 100%), Indicator a.i will move to the category requiring less oversight. If the Center sustains its progress for annual record review timeliness, after the next review, Indicator a.ii might move to the less oversight category.

For four out of five applicable individuals, nurses also completed timely quarterly nursing record reviews and physical assessments. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 2/2	N/A	N/A	1/1	N/R	N/A	N/R	N/A	1/1	N/R
	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% 4/4	1/1	1/1	N/A		1/1		1/1	N/A	
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	80% 4/5	1/1	1/1	N/A		1/1		1/1	0/1	

Comments: a.i. and a.ii. All of the individuals in the review group had timely new-admission or annual comprehensive nursing reviews and physical assessments.

a.iii. On 6/14/21, Individual #689's IDT held his annual ISP meeting. The Center used this date as the anchor date for the completion of quarterly nursing assessments. For this individual, the first quarterly review was due by the end of September. On 9/7/21, the Monitoring Team submitted its Tier II document request. On the last day of the remote review (i.e., 10/21/21), the Monitoring Team

member asked about the quarterly review for this individual. Center staff submitted a physical assessment, dated 8/16/21, but they did not submit a corresponding record review.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Nursing Department staff continued to improve the quality of the annual and quarterly record reviews and physical assessments. It was positive that for five of the six individuals in the review group, nurses completed annual physical assessments that addressed the necessary components, and that all five quarterly physical assessments reviewed met criteria. If the Center sustains its progress, after the next review, Indicator b might move to the category requiring less oversight. It was positive that for about half of the risk areas reviewed, nurses included status updates in annual record reviews, and for two of the 10 risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for RNCMs to analyze this information, and offer relevant recommendations. For over half of the instances in which individuals experienced exacerbations of their chronic conditions, nurses completed assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual receives a quality annual nursing record review.	50% 3/6	0/1	0/1	0/1	N/R	1/1	N/R	1/1	1/1	N/R
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.	83% 5/6	0/1	1/1	1/1		1/1		1/1	1/1	
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% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
d.	Individual receives a quality quarterly nursing record review.	20%	0/1	0/1	N/A		1/1		0/1	0/1	

		1/5									
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.	100% 5/5	1/1	1/1	N/A		1/1		1/1	1/1	
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% 0/10	0/2	0/2	N/A		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.	60% 6/10	2/2	1/2	0/2		1/2		N/A	2/2	

Comments: a. It was positive that three annual nursing record reviews included all of the required components. In addition, all of the annual or new-admission nursing record reviews for individuals in the review group included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Procedure history;
- List of medications with dosages at the time of the ANA;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention;
- Tertiary care; and
- Allergies or severe side effects to medication.

Most, but not all included, as applicable:

- Family history;
- Immunizations; and
- Social/smoking/drug/alcohol history.

The three annual nursing record reviews that did not meet criteria included most of the required components. For Individual #844 and Individual #436, the nutrition/health portion of the social history sections had not been updated since 2018/2019. Two of them (i.e., for Individual #844, and Individual #704) had incomplete information about immunizations. For Individual #704, the nursing assessment indicated that family history was unknown, but the AMA included relevant information. With minimal effort, nurses could make continued progress on the quality of the annual nursing record reviews.

b. It was positive that for five of the six individuals in the review group, nurses completed annual physical assessments that addressed the necessary components. The exception was that Individual #436's annual physical assessment did not include assessment of the dorsalis pedis, femoral, or posterior tibial pulses.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #436 – falls, and infections; Individual #844 – cardiac disease, and respiratory compromise; Individual #704 – diabetes, and infections; Individual #143 – constipation/bowel obstruction, and GI problems; Individual #108 – osteoporosis, and constipation/bowel obstruction; and Individual #689 – seizures, and falls).

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. However, on a positive note, nurses included status updates, including relevant clinical data, for about half of the risk areas reviewed in the annual assessments (i.e., Individual #436 infections; Individual #143 – constipation/bowel obstruction, and GI problems; and Individual #108 – osteoporosis, and constipation/bowel obstruction), and for two of the 10 risk areas reviewed in the quarterly assessments (i.e., Individual #844 – cardiac disease, and Individual #108 – osteoporosis). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made necessary recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

In addition, it is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories were unclear, because dates of various events or summary data were missing.

d. It was positive that Individual #143's quarterly assessment included all of the necessary components. As noted above, Center staff did not submit a quarterly record review for Individual #689. All of the remaining quarterly nursing record reviews (i.e., the most recent one) for individuals in the review group included the following, as applicable:

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

Most, but not all of the most recent quarterly nursing record reviews for individuals in the review group included, as applicable:

- Social/smoking/drug/alcohol history; and
- Immunizations.

The four quarterly nursing record reviews that did not meet criteria included most of the required components. For Individual #844 and Individual #436, the nutrition/health portion of the social history sections had not been updated since 2018/2019. Two of them (i.e., Individual #844, and Individual #108) had incomplete information about immunizations.

e. It was positive that for the individuals reviewed, nurses completed quarterly physical assessments that addressed the necessary components.

g. The following are examples of when assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing assessment guidelines in alignment with individuals' signs and symptoms:

- On 8/19/21, Individual #436 fell while he was outside. The nurse followed the fall and skin integrity assessment guidelines. The nurse documented a cut measuring 0.5 centimeters (cm) by 0.5 cm to the middle of his right foot. He also had redness on his right shoulder, and an abrasion on his right temple, which measured 2 cm long by 2cm by 2 cm. At 11:53 a.m., the nurse attempted to notify the Advanced Practice Registered Nurse (APRN), but documented that because it was during lunch time, the APRN could not be reached. The nurse initiated pain, fall and mild head injury follow-up assessments. At 1:12 p.m., a nurse notified the PCP, who ordered implementation of the mild head injury protocol.
- Due to exposure to COVID-19, on 9/1/21, nursing staff began to implement the daily assessment guidelines for Individual #436. On 1/13/21, and 2/3/21, he had received vaccinations for COVID-19. Based on the nursing assessments, he did not exhibit any signs or symptoms. On 9/7/21, he tested positive for COVID-19. The APRN ordered monoclonal antibody therapy. He remained asymptomatic. Based on documentation submitted, nursing staff followed the guidelines for assessments for COVID-19 exposure, COVID-19 diagnosis, as well as the administration of a new medication.
- According to an IPN, dated 4/13/21, at 9:14 p.m., staff called the Campus RN to evaluate Individual #844 due to shortness of breath. When the RN arrived, the individual was on the sofa, showing signs of shortness of breath as evidenced by accessory muscle use and difficulty with speaking. The nurse obtained the individual's vital signs, and called the on-call PCP to report the individual's status. The provided gave orders for oxygen via nasal cannula to obtain an oxygen (02) saturation of at least 92%, as well as to transfer the individual to the hospital. At 9:18 p.m., the nurse applied oxygen and at 9:21 p.m., the individual's O2 saturation was 97% and his respirations were 20. He denied pain, but stated he was just tired. He was transferred to the hospital via Emergency Medical Services (EMS).

  According to an IPN, dated 4/14/21, at 12:57 p.m., the individual was able to return to the Center. His labs were normal, but his x-rays showed some infiltrates from congestive heart failure (CHF). He was given Lasix 40 milligrams (mg) and Solumedrol. Based on the individual's signs and symptoms, the nurses followed nursing guidelines for respiratory assessment. In addition, upon his return from the ED, nurses followed the guidelines for the initiation of a new medication.
- According to an IPN, dated 6/24/21, at 1:41 p.m., staff called the nurse to Individual #143's room, and the nurse assessed her due to bloating in her abdomen. According to the direct support professional (DSP), the individual had a watery bowel movement at 1:30 p.m. In an IPN, dated 6/24/21, at 2:15 p.m., a nurse documented that a Licensed Vocational Nurse (LVN) reported that the individual had abdominal distention with a flushed appearance to her face, as well as an elevated heart rate. The nurse notified sick-call. In the assessment, the nurse noted that the individual was grunting, but not talking as per normal. The APRN ordered an x-ray to check for possible constipation. On 6/25/21, medical staff documented review of the x-ray

with an impression of a bowel gas pattern suggestive of ileus. Based on the individual's reported signs and symptoms, nursing staff followed applicable standards of care in assessing her gastrointestinal system.

- On 6/11/21, at 8:20 p.m., Individual #689 experienced three consecutive seizures. Nursing staff followed the relevant assessment guidelines.
- According to a Personal Injury Report (PIR), dated 5/22/21, at 8:05 p.m., a DSP reported that Individual #689 walked into the shower room and fell forwarding hitting his head. He was wearing his helmet at the time of the fall. He sustained a 3.5 cm-by-1cm red abrasion across the top of the right eyebrow area. The nurse indicated that the individual had no other visible injuries, and denied any pain or discomfort. Her blood pressure and heart rate were slightly elevated. The nurse notified the APRN, who provided no new orders. In assessing the individual, nursing staff followed the fall assessment guidelines.

The following provide a few examples of concerns related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to exacerbations in individuals' chronic conditions (i.e., changes of status):

- On 8/2/21, at 11:00 a.m., in a Respiratory Distress/Aspiration Initial Assessment Nursing IPN, a nurse stated that: "S: It was reported today that [Individual #844] had three episodes of coughing /possible aspiration on 7/29/21, 7/30/21 and 8/1/21. Per home manger, it was reported in morning meeting [the individual] vomited during one coughing episode." The Monitoring Team's review of IPNs and IView entries for the three relevant days revealed:
  - On 7/29/21, at 12:00 p.m., a nurse wrote that while monitoring the end of the individual's meal, they noted no cough, gagging or tearing of his eyes.
  - According to an IPN, dated 7/30/21, at 1:27 p.m., the individual had an episode of coughing while eating chips. The nurse performed a lung assessment, and noted that the individual's lung sounds were clear, and no acute distress noted. However, the nurse documented no vital signs
  - In an IPN, dated 8/1/21, at 7:16 a.m., a nurse stated: "At this time DSP… [brought [Individual #844] to medication room and reports that he had coughed while eating breakfast. lung sound checked at this time, they are clear, and no signs of distress noted, Individual states, 'I'm okay'. He asked for something to drink and then asked DSP… to take him outside." According to IView entries, dated 8/1/21, at 7:16 a.m., the nurse did not complete a full set of vital signs (i.e., only temperature, and respirations), or note that the individual refused. The nurse did not follow the guidelines for respiratory distress, including completion of full vital signs, or an abdominal assessment.
- For Individual #704, the new-admission nursing physical, dated 6/15/21, at 10:30 a.m., included the following findings: "Extremities: No clubbing or cyanosis. Lower extremities with discoloration to bilateral feet, with edema +1 to left ankle. Skin to this area is extremely dry and peeling. No open areas to skin. Great toe to right foot is, also, discolored." Based on documentation submitted, the nurse did not write a subjective, objective, assessment, and plan (SOAP) note to describe a plan for follow-up. No further documentation was included in the records showing any follow-up assessments for the findings of discoloration to his extremities, 1+ edema, and/or discoloration of his right great toe. No evidence was found to show that nursing staff notified the PCP of these findings. No corresponding medical IPN/evaluation was found in the records.

  In an IPN, dated 7/15/21, at 1:15 p.m., a nurse documented the following: "S: [Individual #704] sores was [sic] reported to RNCM O. Went to sick call and asked if they would help assess [the individual] with me. I went to M1/M2 day room and [the individual] was sitting on the couch. I asked him if he would follow me to sick hall and he stated yes. A. Assess his sores on bilateral thighs and right great toe… (Sick hall nurse) was with them when we assessed [the individual] first we looked at his

bilateral thighs they were scabbed over with pink skin around scabs and warm to touch. Measured then [sic] and [sick call nurse] wrote them down. Then we assess his right great toe and it was swollen with redness going down to his foot. There was a whitish/yellow around the great toe and soft and mushy. There was clear drainage from the toe. [The] NP was called and asked to come immediately to sick call, when he arrived and took a look stated he will have to go to the ER and need IV antibiotics and possible debridement. P. Sending him to the ER." In a corresponding addendum, dated 7/15/21, medical staff documented an assessment of a diabetic foot wound with cellulitis status post fall (i.e., on 7/12/21, he fell, requiring 11 sutures to the back of his head). On 7/15/21, the PCP described the wound as: "Muscular skeletal-right great toe, with wound (diabetic ulcer?) to the distal aspect. It is draining, soft, mushy, and measures about 2 cm. the wound is circular, and it is malodorous. Yellowish clearish drainage noted. The entire great toe is significantly swollen erythematous, and tender to palpation, the redness extends halfway up the foot it is warm to touch. He does have decreased sensation to the plantar aspect of the foot." Nursing staff did not follow the guidelines for documenting the measurements, including, length, depth, and width, and they did not document his circulatory status, including his popliteal and dorsal pedis pulses. As is discussed elsewhere in this report, on 7/15/21, he was hospitalized for a diabetic right foot infection. His right great toe was amputated.

- According to an IPN, dated 6/3/21, at 3:55 p.m., nursing staff documented that Individual #143's tube had been dislodged. The individual refused a full set of vital signs. The nurse noted the gastrostomy tube (G-tube) was lying on her abdomen under her shirt. The bulb was inflated, but dry. The sediment in the tube was dry and yellow. Nursing staff attempted to replace the tube, but they were unsuccessful. At 4:03 p.m., a nurse spoke with the APRN, who ordered the individual's transport to the ED. Based on the description that the tube was inflated, nursing staff should have completed and documented an abdominal assessment, including her ostomy site, but they did not.

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: 436	844	704	451	143	896	108	689	635
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% 0/12	0/2	0/2	0/2	N/R	0/2	N/R	0/2	0/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	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% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
d.	The IHCP action steps support the goal/objective.	0%	0/2	0/2	0/2		0/2		0/2	0/2	

		0/12									
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	8% 1/12	0/2	1/2	0/2		0/2		0/2	0/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	67% 8/12	0/2	1/2	2/2		2/2		2/2	1/2	

Comments: a. through f. The IHCPs reviewed all included nursing interventions, but all were missing key nursing supports. At times, the nursing supports in the IHCPs were insufficient in that they were not measurable (e.g., used terms such as "encourage," "offer education," etc.); they included some, but not all essential assessment requirements; or they were not individualized to meet the specific needs of the person.

For example, RN Case Managers and IDTs often 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(s) or etiology(ies) 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's adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). More work is needed to include nursing interventions that meet individuals' needs into IHCPs.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc.

e. The IHCP that included specific clinical indicators for measurement was for: Individual #844 – respiratory compromise.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #844 – respiratory compromise; Individual #704 – diabetes, and infections; Individual #143 – constipation/bowel obstruction, and GI problems; Individual #108 – osteoporosis, and constipation/bowel obstruction; and Individual #689 – falls.

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: Work is needed to ensure that individuals meeting criteria are timely referred to the PNMT. It was positive that the PNMT completed timely comprehensive assessments for the two individuals requiring them. If the Center sustains its progress in this area, then after the next review, Indicator c might move to the category requiring less oversight. The Center should focus on continued improvements to the quality of the PNMT comprehensive assessments.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	40% 2/5	N/A	1/1	N/A	0/1	0/1	N/A	N/A	1/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	40% 2/5		1/1		0/1	0/1			1/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 2/2		1/1		N/A	N/A			1/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	40% 2/5		1/1		0/1	0/1			1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/5		0/1		0/1	0/1			0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3		N/A		0/1	0/1			N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2		0/1		N/A	N/A			0/1	N/A
Comments: a. through d., and f. and g. For the five individuals that should have been referred to and/or reviewed by the PNMT:											

- On 3/9/21, Individual #844 was hospitalized for CHF, pneumonia, and chronic obstructive pulmonary disease (COPD) exacerbation. He smoked, and had decided not to quit or cut back. He also had Type 2 diabetes. On 6/14/21, he was hospitalized with aspiration pneumonia. Upon his return from the hospital, on 6/23/21, he was referred to the PNMT, who completed an assessment on 7/22/21. Only the SLP electronically signed the assessment. As has been discussed in previous reports, merely listing participants does not suffice, and the Center did not provide a signature page in response to the Monitoring Team's request. Moreover, the list of participants that the Center provided did not include the PT or a PCP/medical provider. The quality of the assessment is discussed below.
- According to Individual #451's IRRF, his IDT rated him at high risk for falls. As of 8/31/21, he met the criteria for referral to the PNMT for at least a review, but he was not referred. According to the Tier II document #P.1-20, he fell on the following dates: 3/8/21, 3/11/21, 4/27/21, 6/10/21, 6/23/21, 7/16/21, 7/19/21, 7/26/21, 8/18/21, 8/29/21, and 8/31/21.
- From 10/23/20 to 10/25/20, Individual #143 was hospitalized for severe constipation, obstruction of the colon, and bowel impaction. Prior to this hospitalization, DSP staff documented regular bowel movements in CareTracker. The IDT did not refer her to the PNMT for review. Although the PNMT appeared to discuss her hospitalization during the PNMT meeting held on 10/29/20, they did not provide a rationale for not making a self-referral, and/or conducting a review. The IDT took actions related to increasing fluids, but no data were presented to show whether or not the individual had not been getting enough prior to this event. On 6/24/21, she was diagnosed with ileus again, but still not referred to the PNMT.
- On referral 6/9/21, Individual #689 was referred to the PNMT, because since his admission on 5/18/21, he fell eight times. The PNMT initiated an assessment, which they completed on 7/8/21. Only the SLP electronically signed the assessment, and the Center did not provide any other signature sheet, as the Monitoring Team requested in its Tier II document request. The quality of the assessment is discussed below.
- According to the Tier I document #III.12.n, and the Tier II document #P.1-20, between 3/23/21, and 9/16/21, Individual #635 fell 19 times. By at least 7/26/21, he met criteria for referral to the PNMT. The dates of his falls included: 3/24/21, 3/29/21, 4/24/21, 4/29/21 x 2, 5/9/21, 6/4/21, 6/6/21 x 2, 6/19/21, 6/24/21, 7/6/21, 7/11/21, 7/26/21, 8/1/21, 8/12/21, 8/15/21, 8/28/21, and 9/16/21. The PNMT should have at least conducted a review.

h. For the two PNMT assessments completed for individuals in the review group:
- It was positive that both thoroughly 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.
- For Individual #844, the following summarizes some of the concerns with the assessment:
  - It was not clear that the PNMT monitored for the existing support of head-of-bed elevation (HOBE) to 30 degrees, but rather just stated that it remained appropriate. It also was unclear why the PNMT did not make a determination as to

whether he required a new HOBE assessment, and if so, then complete one. Rather, in recommendations section, the PNMT stated the PNMT/Habilitation Therapies staff would conduct a HOBE assessment to determine if 30 degree elevation was appropriate given the newly identified high-risk rating for aspiration.
    - The PNMT identified a list of potential factors that might have contributed to the aspiration pneumonia, including his history of cardiovascular accident (CVA), obesity, altered mental status, mild to moderate oropharyngeal dysphagia, and prominence of C3-C6 towards the pharynx as evidenced on a recent modified barium swallow study (MBSS). With no observation of his bed positioning or HOBE monitoring, they also could not rule these out as potential factors, but they did not mention this or explore them.
    - The PNMT did not make a clear recommendation related to the duration of once weekly monitoring. It was not clear what they would monitor other than intervention effectiveness. No specific interventions were identified in the recommendations.
    - They also did not individualize the re-referral criteria.
- For Individual #689, the following summarizes some of the concerns with the assessment:
    - The PNMT discussed the possible reasons for the individual's falls including seizures associated with Lennox Gastaut Syndrome, a possible diagnosis of obstructive sleep apnea secondary to significant obesity, and an over-sensitivity to his new surroundings/startle response. Only one of the eight falls at the Center had a description that made reference to seizure activity. The descriptions did not address the source of the potential startle reflex. In the assessment findings, the PNMT offered no tracking of sleep time with a comparison to the fall occurrence.
    - The individual's family reported that he had up to 30 seizures daily that were reduced to one per day with the initiation of Epidiolex about a year prior to the report. The family reported that triggers for falls included excitement, anxiety, extreme heat, or being startled. However, the PNMT did not appear to track these circumstances in comparison with his seizures and/or falls. The PNMT presented no data with regard to the frequency of his seizures since admission or sleep data. He had been referred for a sleep study and to otolaryngology for evaluation.
    - The PNMT offered no measurement of his leg-length discrepancy.
    - Although they recommended a HOBE evaluation, it was not clear why they did not do this as part of this assessment.
    - The PNMT offered no recommendations to address the etiologies identified, or to conduct further exploration and data collection to obtain more definitive information related to fall occurrences.
    - Recommendations related to supports were not summarized, but scattered throughout the assessment.

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. Plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable. Because the omissions in individuals' PNMPs were minor during this review and the last one, if Center staff continue to make improvements, after the next review, Indicator c might move to the category requiring less oversight.	Individuals:

#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
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.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	1/2	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.	56% 5/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	1/2	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	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	56% 10/18	1/2	2/2	1/2	0/2	1/2	0/2	2/2	2/2	1/2

Comments: The Monitoring Team reviewed 18 PNM issues, and the related IHCPs, as available, that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included the following risk areas: Individual #436 – falls, and skin integrity; Individual #844 – aspiration, and skin integrity; Individual #704 – falls, and GI problems; Individual #451 – falls, and choking; Individual #143 – constipation/bowel obstruction, and choking; Individual #896 – weight, and falls; Individual #108 – falls, and choking; Individual #689 – weight, and falls; and Individual #635 – falls, and weight.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were for Individual #704 – GI problems; and Individual #108 – falls.

c. All individuals reviewed had PNMPs and/or Dining Plans. Five of the PNMPs included the necessary components to meet the individuals' needs.

The remaining PNMPs/Dining Plans included most of the necessary components. Three did not identify the individuals' fall risk (i.e., Individual #436, Individual #451, and Individual #896). Individual #143's PNMP stated that her vision was within normal limits, even though assessments showed she had some vision deficits, including macular degeneration.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs. Because the omissions in individuals' PNMPs were minor during this review and the last one, if Center staff continue to make improvements, after the next review, Indicator c might move to the category requiring less oversight.

e. The IHCPs that identified the necessary clinical indicators were those for: Individual #436 – falls.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #436 – falls.

g. About half of the IHCPs reviewed included the frequency of PNMP monitoring/review of progress, including those for: Individual #436 – falls, Individual #844 – aspiration, and skin integrity; Individual #704 – GI problems; Individual #143 – choking; Individual #108 – falls, and choking; Individual #689 – weight, and falls; and Individual #635 – falls.

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	436	844	704	451	143	896	108	689	635
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1					0/1				

Comments: a. and b. Individual #143 received her nutrition and hydration orally with supplementation enterally for refusals and medication administration. The IDT rated her at high risk for aspiration. According to the IRRF, she ate a regular diet and thin liquids. The rationale that the IDT presented in the IRRF was as follows: "6/26/2019: Nursing. She receives her enteral feeding per bolus QID (the current OT/PT assessment stated that she receives supplements when she does not eat enough of her regular diet). Her history indicated that she has tried several times to decrease the enteral feedings and increase to a more regular diet. These attempts have resulted in a history of weight loss and being non cooperative. She tends to cycle. Sometimes she will eat more orally and other times refused those meals. It is not in the best interest of her health at this time to change her plan of care as she is showing some stability." For her 2021 ISP, the IDT did not update this statement to reflect her current status. As a result, the IDT had not justified not having a plan in place to reduce the use of the tube, and/or remove it.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Given that over at least three reviews, newly-admitted individuals had timely OT/PT assessments (Round 12 – 100%, Round 13 – 100%, Rounds 14 through 16 – N/A, and Round 17 - 100%), Indicators a.i and a.ii will move to the category requiring less oversight. Some individuals reviewed did not have timely OT/PT assessments and/or the type of assessment they needed. The quality of OT/PT assessments also continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	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.	67% 6/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength;	N/A									

	▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. For the individuals reviewed, Occupational and Physical Therapists (OTs/PTs) did not always complete OT/PT assessments in a timely manner, or complete the types of assessments that were in accordance with the individuals' needs. The following describes concerns noted:

- For Individual #436, the Center did not provide an OT/PT assessment related to an increased frequency of falls (i.e., eight falls from April 2021 through August 2021, including five in in the span between 6/3/21 through 7/28/21) to determine if the root cause was related to motor skill performance.
- Center staff did not complete any assessment for Individual #451 since 2019, despite his having a high risk rating for falls and fractures, and a PNMP in place.
- For Individual #896, Center staff did not submit any assessment. The OT/PT section of the ISP indicated that he was independent with ambulation and transfers, with no direct PT in the last year. However, it also stated that he would benefit from the cardiovascular intervention program to address decreased muscular strength, decreased muscular endurance, and balance deficiencies.

d. As described above, the Center did not submit assessments for Individual #451 and Individual #896. None of the remaining comprehensive assessments met all criteria for a quality assessment. Overall, the Center needed to focus significant attention on ensuring that assessments address all the required criteria, as applicable:

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

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 most of the applicable 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. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	67% 6/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	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	1/1	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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/6	N/A	N/A	0/4	N/A	N/A	N/A	N/A	0/2	N/A

Comments: a. The ISPs reviewed sometimes included concise, but thorough, descriptions of individuals' OT/PT functional statuses The exceptions were for Individual #451 and Individual #635, for whom the ISP did not provide a sufficient description of motor skill performance, and Individual #896, for whom the ISP included little information related to his OT/PT functional status overall.

b. Simply including a stock statement such as "Team reviewed and approved the PNMP/Dining Plan" did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements.

c. As described above with regard to Outcome #2, Indicator d, OT/PT assessments generally did not make needed recommendations for OT/PT-related strategies, interventions, and programs. OTs/PTs should work with QIDPs to ensure assessments provide the needed recommendations for IDTs to consider.

d. For Individual #704, Center staff submitted goals for OT only after his (TIA), although it appeared that PT was also seeing him. Then he, had a toe amputated and they revised the PT goals ,but did not address whether the OT goals needed to be revised given his newest status.

For Individual #689, on 6/6/21, the therapists completed the OT/PT comprehensive assessment, but it did not specifically address right lower extremity weakness related to his previous injuries and etiology of his falls that had occurred since his admission on 5/18/21 During the ISPA held on 6/9/21, the assessment did not appear to be available to the IDT for discussion of any other findings, despite indications that the PT was in attendance, and the IDT requested a re-evaluation to specifically assess the right leg weakness due to a past injury. The ISP, dated 6/14/21, did not specifically address the etiology of fall risk, nor did the related IHCP. There was also no evidence that the IDT met regarding findings from a secondary assessment as requested by the IDT (i.e., this was not submitted) to discuss recommendations. A progress note, dated 6/25/21, outlined a PT treatment plan, but it was not clear how his needs and goals were determined without an adequate re-evaluation by the PT.

Communication

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

Summary: It was positive that almost all individuals reviewed received the type of assessment that was in accordance with their communication needs, but timeliness of the assessments was a concern. In addition, significant work was still 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 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. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
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, these indicators moved to the category requiring less oversight.									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.										
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	50% 3/6	1/1	N/A	N/A	1/1	1/1	0/1	0/1	N/A	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	N/A	N/A	0/1	0/1	N/A	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									
Comments: a. through b. Overall, most individuals reviewed received the type of assessments that were in accordance with their communication needs. However, Center staff did not always complete timely communication assessments. The following describes concerns noted: • For Individual #896 and Individual #108, Center staff did not complete communication assessments until the day of the annual ISP meeting (i.e., respectively, 7/22/21, and 8/3/21).											

- For Individual #635, the Monitoring Team could not fully evaluate whether he received an assessment that was both timely and in accordance with his needs. He received a comprehensive assessment in 2019, but it did not state what type of assessment, or when, the next one should occur. As the audit tool indicates, it is the responsibility of the SLP to evaluate and recommend the type and frequency of assessment required, based on an individual's needs. Based on the assessment in 2019, the clinician reported some social pragmatic concerns, but indicated they might resolve as he acclimated to the new living situation. His functional skills appeared to fluctuate, although these were attributed to his new surroundings. They should have reevaluated him to determine if he had true communication deficits, or if it was only related to his recent admission to the Center.

c. Neither of the two applicable individuals received a quality screening. For Individual #704 and Individual #869, the screenings provided for review did not fully address their specific medications.

d. None of the applicable comprehensive assessments submitted met all criteria for a quality assessments. While work was still needed, the communication assessments continued to improve. There was ongoing benefit from the auditing that the Habilitation Therapy Director and State Office staff conducted of the assessments. For example, it was positive that most assessments included the following components:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; and
- A comparative analysis of current communication function with previous assessments.

Going forward, the Center should focus most on the following components:

- 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;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- 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.

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: Overall, improvement is needed with regard to all of these indicators. 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	436	844	704	451	143	896	108	689	635
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.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/4	N/A	N/A	N/A	0/1	0/1	N/A	0/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	50% 1/2	N/A	N/A	N/A	N/A	1/1	N/A	0/1	N/A	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. For six of nine individuals, the ISPs did not include thorough descriptions of how individuals communicated and how staff should communicate with them. In a number of instances, information in the ISP was not consistent with information in the screenings/assessments. The following describes some of the concerns noted:

- For two individuals, the ISPs described the use of AAC devices (i.e., a tempo strip for Individual #436, and a communication wallet for Individual #451), but neither individual was currently using those devices for functional communication.
- For Individual #704, and Individual #896, the ISPs provided limited information beyond how to communicate during the ISP meeting.
- For Individual #108, and Individual #689, the ISPs did not describe how others should communicate with them.

b. For the applicable ISPs reviewed, none provided evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. As described with regard to Outcome 1 above, for the applicable individuals, the ISPs did not include needed strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs). Communication assessments often did not identify strategies to expand individuals' communication skills. SLPs should have made recommendations that addressed all relevant needs or provided adequate rationale for individuals not needing further direct supports. For example, for individuals for whom direct therapy was previously provided, the annual assessments often did not report the actual goals and/or related data to describe progress.

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 a number of SAPs; this was good to see. About two-thirds had implementation data that were regularly collected and shown to be reliable. Indicator 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.										
4	SAPs are practical, functional, and meaningful.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	65% 17/26	3/3	0/3	3/3	0/3	2/3	2/2	1/3	3/3	3/3
Comments: The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. Individual #660 had two SAPs, for a total of 26 SAPs. 5. None of Individual #844's or Individual #716's SAPs had integrity/IOA assessments. Additionally, Individual #978's bicycle safety and budgeting SAPs, and Individual #436's microwave popcorn SAP did not have integrity/IOA assessments. Ensuring that SAPs are scored reliably and implemented with integrity 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: Indicator 12 will be moved to the category of requiring less oversight due to sustained high performance.			Individuals:								
#	Indicator	Overall	672	844	640	716	436	660	978	15	620
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, these indicators were 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.										
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
Comments: 12. Individual #436's vocational assessment did not include a recommendation for skill acquisition, or a rationale why a SAP was not necessary.											

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, the Center achieved substantial compliance with the restraint outcome and indicators in this domain.
  - This resulted in the removal of one outcome and 11 indicators.
- At the last review, 31 other indicators were in the category of requiring less oversight.
- Presently, seven additional indicators will move to the category of requiring less oversight in the areas of psychiatry, behavioral health, and dental.

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, there were delays in the completion of MOSES and AIMS assessments and in the prescriber review.

Acute Illnesses/Occurrences

The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who are not meeting treatment goals or who are not considered psychiatrically stable.

It was positive that for three of the four acute illnesses/occurrences reviewed, nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines. For three of the four occurrences reviewed, nursing staff timely notified the practitioner/physician of such signs and symptoms. Nursing staff developed acute care plans for all of the acute care needs reviewed. However, more work is needed to ensure the plans include the necessary interventions, interventions are measurable, and nurses implement them.

For acute medical illnesses/occurrences treated at the Center, many problems continued to occur with regard to thorough PCP assessments, as well as follow-up. Follow-up also remained problematic when individuals returned from the ED or hospitalizations.

For the single dental emergency reviewed, the individual presented to the dental clinic independently and received necessary dental treatment. However, documentation indicated the Dental Department did not address and or document pain management consistent with the individual's needs.

Implementation of Plans

In psychiatry, Mexia SSLC was obtaining data for some psychiatric indicators, but goals were not available to allow for the determination of progress toward the specific goal.

Psychiatry's collaboration with behavioral health and neurology was met for some, but not all, individuals. Psychiatry clinics met all of the criteria for all individuals. Documentation met criteria for about half of the individuals.

In behavioral health, progress could be determined for all seven individuals because their PBSP data were reliable. Four of the seven were progressing.

All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.

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 increased risk, or that nursing interventions were implemented thoroughly.

For a number of individuals' chronic or at-risk conditions, PCPs working with IDTs had not conducted medical assessment, tests, and evaluations consistent with current standards of care, and had not identified the necessary treatment(s), interventions, and strategies, as appropriate.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For 12 of the 18 chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. Although documentation generally was found to show implementation of the few action steps assigned to the PCPs that IDTs included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Based on documentation submitted, since the last review, regression occurred with regard to the timely review of non-facility consultations, and the PCP IPNs to summarize them. In addition, PCPs did not refer applicable consultations to IDTs for review and follow-up. Work is needed to make improvements.

Medical practitioners should continue to focus on reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

It was positive that restorative dental work was completed as needed, and for individuals requiring them, extractions were only completed when restorative options were exhausted. Improvements were needed with regard to the provision of prophylactic care, as well as x-rays, and tooth brushing instruction.

Improvement is needed with regard to quality of the Quarterly Drug Regimen Reviews (QDRRs), particularly the review of lab results.

Since the last review, improvement was noted with regard to medication nurses' adherence to infection control practices during medication administration. The Center's nurse auditor continued to identify and take action to remediate the problems that did occur during remote review observations.

Areas that require focused efforts are the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

Fourteen of 20 individuals observed had assistive/adaptive equipment that appeared to be the proper fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, work is needed to make improvements. In addition, during observations, the Monitoring Team noticed that the Center's performance had declined significantly with regard to maintaining individuals' assistive/adaptive equipment in proper working condition. Unless Center staff correct this concern, after the next review, the related indicator, which has been in less oversight, since after Round 11, will return to active oversight.

Based on observations, there were still numerous instances (40% of 40 observations) in which staff were not implementing individuals' PNMPs/Dining Plans or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or not following presentation techniques, or staff not using a gait belt properly during a transfer) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Center staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

As noted in Domain #1 of this report, the Monitor found that that the Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement, including the Center's response to frequent usage of crisis intervention restraint (i.e., more than three times in any rolling 30-day period.

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: While Mexia SSLC was obtaining data for some psychiatric indicators, goals were not available to allow for the determination of progress toward the specific goal. As such, indicators 8 and 9 cannot be thoroughly assessed by the Monitoring Team. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who are not meeting treatment goals or who are not considered psychiatrically stable. This has been the case for some time and, therefore, due to this sustained high performance, indicators 10 and 11 will be moved to the category of requiring less oversight. Indicators 8 and 9 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
8	The individual is making progress and/or maintaining stability.	0% 0/9	1/2	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% 6/6	1/1		1/1	1/1	1/1			1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 6/6	1/1		1/1	1/1	1/1			1/1	1/1
Comments:											

8-9. Per a review of the individual's indicators as well as available data, there was one individual, Individual #672, who was making progress with regard to the identified indicator for reduction. Individual #672 had consistent zero scores on the identified rating scale for determining the presence of the indicator for reduction, and the treating psychiatric nurse practitioner described him as psychiatrically stable, so progress was inferred. For other individuals, given the absence of goals and no consistent zero data, it was not possible to determine progress.

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, environmental changes) were developed and implemented. There were three individuals in the review group, Individual #844, Individual #660, and Individual #978, who were noted per their treating psychiatric provider as psychiatrically stable and, therefore, did not require treatment adjustments; however, other individuals with this designation were noted to have adjustments to their medication regimen or behavior management program.

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

Summary: Progress was seen on indicator 23 and with sustained high performance, might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	57% 4/7			0/1	0/1	1/1	1/1	1/1	0/1	1/1

Comments:

23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavior assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors for all of the individuals in the review group, although there were examples where this information was inconsistent. For example, regarding Individual #15, the BHA indicated that his psychiatric illness did not have an effect on his behavior, although psychiatry indicated this individual was psychiatrically unstable and therefore, his illness would have an effect on his behavior.

24. Seven individuals in the review group had a PBSP implemented. Although there was documentation of psychiatry attending Behavior Therapy Committee on a regular basis and participating in the development of Behavior Support Plans, this was not evident in the examples regarding Individual #640, Individual #716, and Individual #15. In these three examples, the psychiatric indicators used in the PBSP were not consistent with those documented by psychiatry.

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, all criteria were met, for the other, two medications were not correctly identified or managed as per the requirements of this outcome. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	50% 1/2					0/1				1/1
26	Frequency was at least annual.	100% 2/2					1/1				1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	50% 1/2					0/1				1/1

Comments:

25 -27. These indicators applied to two individuals in the review group, Individual #436 and Individual #620.

- The example regarding Individual #620 included the proper documentation from psychiatry and neurology regarding the dual-purpose nature of his prescribed medication. A note regarding Individual #620 is that polypharmacy committee maintained a listing of individuals at the facility who were prescribed a dual-purpose medication, and Individual #620 was not included in this list.
- The example regarding Individual #436 included conflicting information. Psychiatry documented that there were no dual-purpose medications, but neurology noted that two medications were also indicated for mood. This needs to be clarified.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: It was good to see that psychiatry clinics met all of the criteria for all individuals. Documentation met criteria for about half of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	44% 4/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3				1/1		1/1	1/1		

Comments:

34. The Monitoring Team looks for nine components of the quarterly review. Four of the examples, regarding Individual #844, Individual #436, Individual #660, and Individual #978, included all the necessary components. The remaining evaluation examples were missing from one to four elements. Two evaluations were missing one element, two evaluations were missing two elements, and one evaluation was missing four elements. The most common missing element was the psychiatric diagnosis with a description of symptoms that support the diagnosis. This element was missing in five examples.

- The evaluation regarding Individual #672 was missing the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #640 was missing the basic information, pertinent laboratory examinations, the results of the most recent MOSES and AIMS, and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #716 was missing the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #15 was missing the results of the most recent MOSES and AIMS and the psychiatric diagnosis with a description of symptoms that support the diagnosis.
- The evaluation regarding Individual #620 was missing the basic information and the psychiatric diagnosis with a description of the symptoms that support the diagnosis.

35. During the virtual monitoring visit, psychiatry clinic was observed with four providers for a total of five individuals. Three of the five were individuals included in the review group who were evaluated in psychiatry clinic during the visit. The psychiatrist and nurse practitioners were all well prepared for clinic. In all encounters, the individual under review was present for all or a portion of the meeting. The psychiatrist and nurse practitioners were engaged in the clinical process, demonstrating good rapport with the individuals and soliciting information from the various disciplines represented in the IDT. While overall the clinical encounters were appropriate and met requirements, there was a need for improvement with regard to the discussion of the presented information and what that information meant clinically with regard to the need to adjust treatment interventions.

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

Summary: There were delays in the completion of MOSES and AIMS assessments and in the prescriber review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:

36. There were delays in the completion of MOSES and AIMS assessments and in the prescriber review.

- Regarding Individual #844, the MOSES dated 2/10/21 was not reviewed by the prescriber until 7/19/21.
- Regarding Individual #716, the AIMS dated 3/5/21 was not reviewed by the prescriber until 7/15/21.
- Regarding Individual #436, the AIMS dated 2/5/21 was not reviewed by the prescriber until 2/23/21 and the MOSES dated 2/8/21 was not reviewed. The MOSES and AIMS dated 3/9/21 were not reviewed by the prescriber until 7/15/21 and the MOSES and AIMS dated 4/12/21 were not reviewed by the prescriber until 7/14/21.

- Regarding Individual #660, the MOSES and AIMS dated 2/4/21 were not reviewed by the prescriber until 7/19/21. The MOSES and AIMS dated 5/12/21 were not reviewed by the prescriber util 7/19/21.
- Regarding Individual #978, there was an AIMS assessment completed 4/27/21. There should have been a follow-up AIMS assessment in July 2021, but the next assessment was not dated until 8/2/21.
- Regarding Individual #620, there was an AIMS assessment completed 10/12/20 with the next AIMS dated 3/25/21. There should have been an assessment performed in January 2021.

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:			Individuals:									
#	Indicator	Overall Score										
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.											
42	There is a treatment program in the record of individual who receives psychiatric medication.											
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.											
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: All indicators were met for one individual. Overall, criteria were met for about half of the indicators. Details about what is needed are provided in the comments below. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	57% 4/7	1/1		1/1	0/1	0/1	1/1		1/1	0/1
45	There is a tapering plan, or rationale for why not.	71% 5/7	0/1		1/1	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.	43% 3/7	1/1		0/1	1/1	0/1	1/1		0/1	0/1

Comments:

44. Of the 194 individuals participating in psychiatry clinic at the facility, 133 individuals or 69% were prescribed medication regimens that met the definition of polypharmacy.

These indicators applied to seven individuals, Individual #672, Individual #640, Individual #716, Individual #436, Individual #660, Individual #15, and Individual #620.

The justification for polypharmacy was not appropriately documented for Individual #716, Individual #436, and Individual #620.

45. There was a documentation for four of the seven individuals who met criteria for polypharmacy showing a plan to taper a psychotropic medication or a rationale as to why this was not considered.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of ongoing, regular committee meetings. After the prior monitoring visit, the facility changed the format for documenting polypharmacy meeting minutes, such that minutes were a better reflection of the review performed by the committee. Although there was documentation of annual reviews of regimens meeting criteria for polypharmacy, in some cases, there was no documentation of quarterly reviews when regimens were changed.

- Individual #640's medication regimen was reviewed during the monitoring visit, this was reportedly an annual review. He was previously reviewed October 2020. Give adjustments to his medication regimen, he should have been reviewed quarterly.
- Individual #436's medication regimen was reviewed 8/18/21, but given medication adjustments, specifically an increase in a dosage in December 20, he should have been reviewed on a quarterly basis.
- Individual #15's medication regimen was reviewed 3/17/21 and 10/20/21. Given the adjustments to his regimen, he should have been reviewed on a quarterly basis.
- Individual #620's medication regimen was reviewed 7/21/21, but given adjustments to the medication regimen, he should be reviewed on a quarterly basis.

The polypharmacy committee meeting was observed during the monitoring visit. The meeting was attended by psychiatry, primary care, behavioral health, and nursing staff. Overall, the meeting was a comprehensive review of the individual's regimen and their progress over the time period between reviews. The meeting did not include challenge to or discussion of the prescriber's rationale for a specific regimen. Generally, this meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. Individuals should be scheduled for review annually, or quarterly if medication adjustments are made, or if there is an active medication taper in progress.

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: Progress could be determined for all seven individuals because their PBSP data were reliable. Four of the seven were progressing. For the three who were not showing progress, most of the other indicators in this section were met. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
6	The individual is making expected progress	57% 4/7			1/1	1/1	1/1	1/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	100% 2/2				1/1					1/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/3							0/1	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	N/A									

Comments:

6. Individual #640, Individual #436, Individual #660, and Individual #716 were progressing. Individual #978, Individual #620, and Individual #15 were not making progress toward their targeted behavioral objectives.

7. Individual #716's aggression objective was achieved and discontinued in August 2021, and Individual #620's property destruction objective was achieved in July 2021 and discontinued. This represents another improvement from the last review when 67% of the objectives achieved were revised or discontinued.

8. Individual #978, Chris, and Individual #620 were not making progress, however, there was no evidence in their progress notes of actions to address the absence of progress. The BHS department should prioritize ensuring that progress notes are accurate and that they consistently reflect the actions taken to address the lack of progress.

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

Summary: Indicator 16 will be moved to the category of requiring less oversight. Indicator 18 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
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.	100% 3/3							1/1	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.	67% 2/3							1/1	1/1	0/1
Comments: 18. Individual #620's PBSP was written by behavioral health specialist who was not currently enrolled, or had completed, BCBA coursework.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
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.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.	100% 3/3							1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.										
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months.										
Comments: 20. This represents another improvement from the last review when 67% of the graphs were found to be useful for making data-based treatment decisions.											

Outcome 8 – Data are collected correctly and reliably.												
Summary: Indicator 26 will be moved to the category of requiring less oversight. Indicator 30 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 3/3							1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	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.	100% 3/3							1/1	1/1	1/1
Comments: 26. Mexia SSLC had added a paper data collection system in July 2020. All individuals' paper data collection system consisted of the collection of target behaviors hourly. 30. Goal frequencies and levels of IOA, data collection, and treatment integrity were achieved for all individuals. This represents another improvement from the last review when 33% of individuals goal frequencies and levels of IOA, data collection, and treatment integrity were achieved.												

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

Outcome 4 – Individuals receive preventative care.	
Summary: One of the nine individuals in the review group received the preventative care they needed. Work is needed to improve the provision of preventive care. In addition, based on review of documents, Center staff did not follow the State Office directive entitled: "IDT Decision-making Related to Medical and Dental Appointments during COVID-19."	Individuals:

For one of the nine individuals in the review group, the PCP 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. This is an area that still needs improvement.											
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual receives timely preventative care:										
	i. Immunizations	56% 5/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1
	ii. Colorectal cancer screening	50% 1/2 Cannot fully rate due to COVID-19 impact	N/A	Not rated – C19 (N/R-C)	0/1	N/A	N/A	N/A	1/1	N/A	N/A
	iii. Breast cancer screening	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	iv. Vision screen	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	v. Hearing screen	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1
	vi. Osteoporosis	71% 5/7	0/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1	0/1
	vii. Cervical cancer screening	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
Comments: a. According to the chart that State Office submitted to the Monitors entitled: "Mexia Tracking Activities on hold 10-2021," on 3/16/20, Mexia SSLC stopped sending individuals off campus for consultations and routine preventative care, but then re-opened them on 11/10/20. The chart further indicated that: "Limited bases only-high risk cases or priority need appointments are scheduled											

routine [sic] appointment will occur in coordination with the consultant and PCP as needed." Another row provided slightly different information. It stated: "Implemented no off campus appointment [sic] unless emergent." For this, the chart listed the date suspended as 3/16/20, and the date reinitiated as 5/27/20.

As referenced in the chart, after 5/27/20, the State Office expectation was that IDTs needed to document risk-benefit discussions for any delays for off-campus appointments. In a document request, the Monitoring Team specifically asked: "For any preventative care not completed due to COVID-19 precautions, please provide the ISPA showing the IDT risk-benefit discussion." For the individuals in the review group, Center staff submitted no documents in response to this request. It will be essential moving forward that staff follow the State Office procedure, and reschedule individuals for these services as soon as it is possible to do so safely.

The following provide examples of findings:

- For Individual #436:
  - On 3/10/20, he completed his last vision screening. The consultant recommended follow-up in one year. No follow-up was submitted.
  - On 8/16/18, his audiological exam showed normal hearing. His AMA only stated that he had normal hearing, but did not describe how the PCP determined this. According to State Office procedures, providers are required to screen individuals' hearing annually. For this individual, the screening should be part of the physical exam in the AMA.
  - In response to a request for DEXA scan information, Center staff indicated: "NA." However, this individual was prescribed Depakote for 11 years, was underweight, and had Vitamin D deficiency. He also had a history of falls.
- For Individual #844:
  - On 2/22/18, a colonoscopy showed three colon polyps (adenomas). In approximately February 2021, he was due for follow-up. According to the PCP, in May 2021, he was exposed to COVID-19, and could not keep an appointment with the gastroenterologist. On 8/26/21, he had a GI consultation, and at the time of the Monitoring Team's review, he was awaiting the scheduling of a colonoscopy.
  - On 11/5/18, his audiological exam showed his hearing was within normal limits, with a recommendation to return in five years. His AMA only stated that he had normal hearing, but did not describe how the PCP determined this. According to State Office procedures, providers are required to screen individuals' hearing annually.
- For Individual #704:
  - According to the Medical Director, a gastroenterologist saw the individual, and recommended a colonoscopy. The individual refused a colonoscopy, and, therefore, a fecal immunochemical test (FIT) was recommended. At the time of the Monitoring Team's review, stool fecal immunochemical testing had not been completed. Moreover, at the time of the review, there was no documentary evidence in the form of an ISPA that this issue had been referred to the IDT or Behavioral Health Services (BHS) for further review to determine how to manage the individual's refusal. During interview, the Medical Director stated that it might be necessary to have someone that the individual trusted discuss the need for a colonoscopy with him further.
  - On 6/30/21, the individual's hearing screening showed mild to moderate hearing loss. It stated: "He will be referred to Audiology to verify findings and determine further course of action if needed." It was not until 10/12/21, four months later, that the PCP made the referral. At the time of the Monitoring Team's review, it was pending.
- For Individual #143:

- On 7/2/18, her audiological exam resulted in a recommendation that she return in five years. Her AMA quoted the results of the 2018 audiological exam, as opposed to documenting an assessment of hearing as part of the physical exam.
- With regard to cervical cancer screening, the Center submitted an order, dated 9/24/19, which stated that pap smears would be discontinued. This was not consistent with the PCP's documentation in the AMA that stated on page 11: "the next pap smear which is due in 2022." The Center did not submit the most recent pap smear report as requested as part of the Monitoring Team's Tier II document request.

- Individual #896's immunization record did not include information about hepatitis vaccination, and the AMA did not include titer information.
- For Individual #108:
  - Her immunization record did not include information about the measles, mumps, and rubella (MMR) vaccination, and the AMA did not include titer information.
  - On 3/10/20, she completed her last vision screening. The consultant recommended follow-up in one year. No follow-up was submitted.
- On 5/18/21, Individual #689 was admitted to the Center, but it was not until October 2021 that he received the Hepatitis B and MMR vaccines. On 8/3/21, the PCP ordered the PSV 23 vaccine, but it had not yet been administered.
- For Individual #635:
  - The PSV 23 vaccine was pending.
  - On 8/31/20, his audiological exam recommended he return in five years. His 2021 AMA did not include a hearing screening as part of the physical exam.
  - In response to a request for DEXA scan information, Center staff indicated: "NA." However, this individual was prescribed Carbamazepine, which is one of the medications commonly associated with osteoporosis.

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.

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	436	844	704	451	143	896	108	689	635
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: a. Clinical justification was not documented for the DNR order for Individual #108. On 8/13/21, the IDT held an ISPA meeting, but it only stated that her legal guardian signed the DNR along with the Medical Director. There was no documentation in the ISPA record of discussion of the medical rationale for implementing a DNR.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: For acute medical illnesses/occurrences treated at the Center, many problems continued to occur with regard to thorough PCP assessments, as well as follow-up. Follow-up also remained problematic when individuals returned from the ED or hospitalizations. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
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% 1/6	0/1	0/1	0/1	N/A	0/1	N/A	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.	0% 0/6	0/1	0/1	0/1		0/1			0/2	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	75% 3/4	N/A	1/1	1/2	1/1	N/A	N/A	N/A	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 1/2		N/A	1/2	N/A					
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.	75% 3/4		0/1	2/2	1/1					
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, this indicator 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.	0% 0/2		0/1	0/1	N/A					
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	25% 1/4		0/1	0/2	1/1					

Comments: a. For five of the nine individuals in the review group, the Monitoring Team reviewed six acute illnesses/occurrences addressed at the Center, including: Individual #436 (COVID-19 infection on 9/7/21), Individual #844 (leg edema on 8/20/21), Individual #704 (abnormalities of lower extremities on 6/15/21), Individual #143 (ileus on 6/24/21), and Individual #689 (falls on 6/11/21, and right tympanic membrane perforation on 5/18/21).

The PCP assessed the following acute issue according to accepted clinical practice: Individual #689 (falls on 6/11/21).

b. For none of these acute illnesses or occurrences did PCPs conduct follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problem until the acute problem resolved or stabilized.

a. and b. The following provide examples of concerns noted:

- Based on the nursing documentation, it was unclear when Individual #436 was exposed to COVID-19. On 8/25/21, nursing staff documented an "Emergency rule assessment of covid-19."

  On 9/2/21, nursing staff documented that the individual was vaccinated and asymptomatic. He was in a quarantined home due to exposure to COVID-19. The plan was for him to return to his home if he remained asymptomatic and tested negative on 9/7/21.

  On 9/8/21, the PCP wrote a two-line note stating: "I discussed with guardian pros and cons of Regen monoclonal antibody treatment. Will be given subcutaneously here on campus. She did give her consent. Order placed. [Medical Director] aware. Team aware."

  The PCP provided no information on the clinical status of the individual. In the IPNs submitted, the PCP documented no examination, assessment, or discussion of the indications for the use of monoclonal antibody treatment. The last IPN was dated 9/21/21.
- On 8/20/21, Individual #844 was evaluated due to swelling in his legs. His cardiac and pulmonary exams were normal. The PCP documented that the lower extremities had 1-2+ pitting edema, and the individual's skin was warm and dry. The vascular status of the extremities was not documented. The PCP's assessment was mild lower leg edema. However, the PCP did not provide a differential diagnosis or etiology of the edema. The plan was to continue wearing compression stockings. It was not clear if the individual had undergone any vascular studies for further evaluation of this problem.

- On 6/15/21, at 10:45 a.m., nursing staff started a note for the Admission Nursing Physical Assessment for Individual #704. The encounter date for the exam was 6/15/21. On 6/17/21, the nurse finalized the note. Per nursing documentation: "Lower extremities show discoloration to bilateral feet, with +1 edema to left ankle. Skin to this area is extremely dry and peeling. No open areas to skin. Great toe to right foot is, also discolored." The skin assessment noted: "Discoloration to bilateral lower extremities (ankles)."

  On 6/15/21, the PCP documented an admission exam, and at 3:33 p.m., signed the note. The PCP did not document an exam of the skin of the lower extremities for this individual with a diagnosis of T2DM. The vascular system was noted to have "2+ pulses throughout and symmetrical." The PCP documented the findings from the exam of the extremities as: "Within normal limits. Full range of motion. No C/C/E [cyanosis, clubbing, edema]." The PCP did not document an appropriate exam of the extremities as recommended in the State Office diabetes guidelines, as well as by the American Diabetes Association (ADA). Moreover, there was a significant difference in the exams that medical and nursing staff completed on the same day (i.e., 6/15/21). There was no evidence of follow-up by medical or nursing staff regarding the abnormal nursing findings. As discussed in further detail below, on 7/12/21, the PCP documented a note related to an ED visit for a scalp laceration. There was no documentation of examination of the individual's extremities. The next PCP documentation was on 7/15/21. At that time, the individual was transferred to the ED for evaluation of a diabetic foot wound with cellulitis.
- On 6/24/21, nursing staff documented that Individual #143 had abdominal distention, a flushed face, and an elevated heart rate. The individual also had two episodes of watery diarrhea. In October 2020, this individual had been hospitalized for "constipation and bowel impaction." The PCP assessed the individual and documented a benign exam. The assessment was "diarrhea-acute/stable." The plan was to check an abdominal film and use the enteral tube if she refused meals. On 6/25/21, the PCP documented that the x-ray showed an ileus. It was noted that the individual continued to pass stool. The plan was to continue the diarrhea follow-up protocol. Additionally, the PCP documented: "We may follow-up with her Monday after x-ray depending on evolution through the weekend and x ray results."

  On 6/30/21, the PCP documented that on 6/20/21 (i.e., this appeared to be an incorrect date), the abdominal film showed a "bowel gas pattern suggestive of ongoing ileus versus distal colonic obstruction." The PCP determined "no need for further follow-up at this time." The PCP did not examine the individual to correlate the abdominal exam with the x-ray findings. Based on another provider's documentation, dated 7/9/21, an x-ray was done on 6/28/21, which showed a bowel gas pattern suggestive of ongoing ileus versus distal colonic obstruction. On 7/9/21, the report was received. With regards to this x-ray finding, the PCP wrote: "This was followed by the provider. Please see documentation."
- On 5/18/21, the PCP documented that Individual #689 had a perforation of the right tympanic membrane. The possible etiology was not discussed, and there was no discussion of the presence or absence of associated symptoms, such as pain, hearing loss, vertigo, or tinnitus. The PCP did not specify the size of the perforation. The plan was to limit swimming and continue antibiotics. There was no documentation that other measures were implemented to keep the ear dry, such as the use of ear plugs for showering. The audiology assessment was pending.

  On 6/11/21, the PCP documented that the individual was being seen for follow-up for a right tympanic membrane perforation, and a chronic history of falls and seizures. With regard to the tympanic membrane perforation, the plan was to refer the

individual to ENT and audiology. The PCP's physical exam documented that the perforation was healed. The ear, nose, and throat (ENT) consult, completed on 7/26/21, stated that there were no ENT surgical issues.

- Since Individual #689's admission on 5/18/21, he fell multiple times. As discussed above, on 6/11/21, the PCP documented that the individual was seen for follow-up of a right tympanic membrane perforation, and a chronic history of falls and seizures. With regard to the falls, the PCP documented that the falls were of unknown etiology. The neurologic exam noted negative orthostatics, but the date and actual data were not documented. The neurological exam also noted a negative Dix-Hallpike and Rhomberg. The plan was to refer the individual to ENT to rule out inner/middle ear causes for the falls. It was also noted that the falls could be related to his seizure disorder.

  The ENT consult did not address the issue of falls as it related to disturbances of the middle and inner ears. According to the consultant documentation, the individual was referred for "consultation for evaluation of 'Consult – Snoring.'" The consultant also documented: "The consult form concerns a right TM perforation and left TM scarring." The PCP asked no specific question related to disorders of dysequilibrium. The physical exam noted that the cranial nerves were grossly intact. There were no specific maneuvers to detect disorders of dysequilibrium.

  A review of the 6/24/21 neurology consult request (i.e., entered on 5/18/21) was pertinent for the lack of any documentation of the individual's history of falls. The consult was for seizures. The epileptologist provided no information to indicate that the fall history was provided or that this was part of the assessment. The PCP documented no follow-up.

c. For three of the nine individuals reviewed, the Monitoring Team reviewed four acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #844 (hospitalization for aspiration pneumonia on 6/14/21), Individual #704 (ED visit for laceration on 7/12/21, and hospitalization for osteomyelitis/amputation of right great toe on 7/15/21), and Individual #451 (ED visit for laceration on 8/31/21).

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

- It was positive to see that the following individual displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #451 (ED visit for laceration on 8/31/21).
- On 6/14/21, the APRN conducted an evaluation of Individual #844 and documented that the individual "walked into the medical building on his way to his afternoon work and was short of breath. After resting and fluids he went to work."

  According to nursing documentation at 2:39 p.m., the boiler room notified nursing staff that the individual "wasn't acting right and not able to do his work right." The individual was alert and oriented and was in no distress. His oxygen saturation was 93% on room air. The nurse notified the APRN. Based on nursing documentation, the APRN reported this was normal since he was a heavy smoker. The plan was to check him when he returned from work.

  The APRN documented that: "He came to the clinic again at 1630 and had some shortness of breath but returned to his normal breathing after resting and drinking some sips of water. He doesn't have any complaints but admits he has SOB [shortness of breath] walking in the heat." The PCP assessment was SOB with exertion/heat. The plan was to provide transportation for the individual to and from work, and use of a fan at night.

According to documentation by the Medical Director on 6/15/21, at 9:55 a.m., the individual was transported to the ED due to SOB and disorientation. His oxygen saturation on room air was 86-88%. The transfer occurred on 6/14/21, at 6:49 p.m. This was two hours after assessment by the PCP. The individual was diagnosed with a right upper lobe (RUL) pneumonia. The report of the computed tomography (CT) of the chest that was performed in the ED stated: "dense consolidation occupies nearly the entirety of the right upper lobe."

The individual was admitted for treatment of pneumonia, and on 6/23/21, he returned to the Center. The PCP's assessment was right middle lobe (RML) pneumonia. The plan was to continue oral antibiotics for five days. On 6/24/21, the PCP saw the individual again, and reported that the individual had a pulmonary appointment that day. According to the individual, the information packet was not reviewed, and it appeared that the pulmonologist was not aware that the individual was recently discharged from the hospital. The PCP documented that the pulmonologist would be contacted and made aware of the recent hospitalization. Later that day, the PCP noted that the hospital records were received, and the diagnosis was aspiration pneumonia. A GI consult was requested for a swallow study. The PCP did not address any other supports related to the diagnosis of aspiration pneumonia.

On 6/25/21, the PCP saw the individual due to nursing reports of coarse lung sounds, and the PCP documented clear lungs. On 6/28/21, the PCP saw the individual again. The individual had no complaints. The PCP documented that the pneumonia was resolved, but did not include a plan to complete a follow-up chest x-ray to assess for resolution of infection as recommended in the State Office aspiration pneumonia guidelines.

On 6/23/21, the IDT met, but did not discuss any supports to address related to aspiration risk.

- On 7/12/21, nursing staff documented that at around 10:15 a.m., Individual #704 fell in the shower and sustained a 5-cm laceration to the back of his head. The PCP was notified of the injury and per nursing documentation gave a verbal order to transfer the individual to the ED. It was not clear why the PCP did not evaluate the individual prior to transfer, which occurred at 11:19 a.m.

  At around 1:35 p.m., the individual returned to the Center. At 2:12 p.m., the PCP documented a post-ED assessment, noting that the scalp wound was repaired with 11 staples in the ED. There were no other injuries documented in the physical examination. The plan was for nursing staff to continue routine wound care, monitor, and notify the PCP of any problems.

  The ED note documented that the individual had a concussion without a loss of consciousness. Additionally, staff were to apply antibiotic ointment to the laceration. The individual had a history of a concussion with a significant injury, but the PCP did not plan to conduct any follow-up.
- On 7/12/21, the PCP documented a note related to Individual #704's ED visit for a scalp laceration. The PCP did not document any examination of the individual's extremities. The next PCP documentation was on 7/15/21. At that time, the individual was transferred to the ED for evaluation of a diabetic foot wound with cellulitis. The individual was admitted and on 7/26/21, returned to the Center. On 7/27/21, the PCP saw him. Per PCP documentation, the individual was diagnosed with

osteomyelitis and underwent amputation of his right great toe. The wound was documented to be healing well. The PCP also documented that the individual was weak and had trouble standing and walking.

On 7/28/21, the PCP noted that the individual was being seen for "visit 2/2." The PCP noted that the individual was weak and had a history of fluid retention of unknown etiology. The PCP documented no additional follow-up related to these issues. It should be noted that per State Office Policy #009: Medical Care, effective 2/29/20: "Upon the individual's return to the SSLC from a hospitalization (a 24 hour stay or longer), the PCP will conduct daily follow-up visits (there must be a 24 and 48-hour post-hospitalization note) for the first 48 hours and as dictated by clinical need…. Follow-up assessments and documentation will be at a frequency consistent with the individual's acuity status for the presenting problem; with documentation of resolution/closure/stability of the acute illness." Therefore, The PCP should not interpret this policy as requiring only two post-hospital visits.

On 8/3/21, the podiatrist documented: "I am concerned about the early wound dehiscence." It was clear that continued close follow-up was necessary.

During interview, the Medical Director stated, "It doesn't look obviously right how this happened so quickly." There was no further explanation for the discrepancies in the nursing and medical exams done on the same date (i.e., as discussed above with regard to Indicators 6.a and 6.b), and/or the lack of follow-up prior to the individual's transfer on 7/15/21.

On 8/4/21, the IDT held a post-hospital ISPA meeting. There was no discussion related to how this incident progressed or the discrepancy in medical and nursing documentation on 6/15/21. It was good to see that the IDT gave consideration to implementing a service objective for the individual to conduct a daily inspection of his feet to look for complications of T2DM. This was consistent with a recommendation of the ADA.

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

Summary: Based on documentation submitted, since the last review, regression occurred with regard to the timely review of non-facility consultations, and the PCP IPNs to summarize them. In addition, PCPs did not refer applicable consultations to IDTs for review and follow-up. Work is needed to improve upon all of the remaining indicators.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	76% 13/17	2/2	2/2	2/2	0/2	2/2	0/1	2/2	1/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	59% 10/17	2/2	2/2	2/2	0/2	2/2	0/1	1/2	1/2	0/2

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.	71% 12/17	2/2	2/2	2/2	0/2	2/2	0/1	1/2	1/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/4	N/A	N/A	0/2	N/A	N/A	0/1	0/1	N/A	N/A

Comments: For the nine individuals in the review group, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #436 for neurology on 5/27/21, and podiatry on 8/11/21; Individual #844 for sleep medicine on 6/24/21, and cardiology on 7/14/21; Individual #704 for podiatry on 8/3/21, and gastroenterology (GI) on 9/13/21; Individual #451 – GI on 4/30/21, and podiatry on 5/26/21; Individual #143 – optometry on 7/28/21, and neurology on 6/3/21; Individual #896 – ophthalmology on 3/10/21; Individual #108 – neurology on 8/19/21, and podiatry on 8/11/21; Individual #689 – neurology on 6/4/21, and ENT on 7/26/21; and Individual #635 – neurology on 5/5/21, and optometry on 4/6/21.

a., b., and c. For Individual #451's consultations for GI on 4/30/21, and podiatry on 5/26/21, Center staff only submitted the IPN, and not the consultation report.

For Individual #896's consultation with ophthalmology on 3/10/21, Center staff submitted no IPN.

For Individual #689's ENT consultation on 7/26/21, Center staff submitted no IPN. The consult noted: "Careful ENT exam looks fine today. There are no ENT surgical issues." This consult did not address the concern for disorders of the inner ear that could result in dysequilibrium and falls. The physical exam noted that his cranial nerves were grossly intact. There were no specific maneuvers to detect disorders of dysequilibrium.

The other reviews that did not occur timely included those for: Individual #635 – neurology on 5/5/21 (i.e., signed on 6/9/21), and optometry on 4/6/21 (i.e., signed on 6/8/21); and Individual #108 – neurology on 8/19/21. For Individual #108, the Center did not receive the consultation report until 9/7/21, and the PCP reviewed it on 9/9/21. However, as indicated in the audit tool, "If consultant reports are not received within two weeks, or sooner if clinically indicated, documentation should show the Facility's efforts to obtain them."

For Individual #108's neurology consultation, the PCP did not thoroughly summarize the consult. For example the neurologist made a specific recommendation that read: "The present dose of Abilify should be reassessed by the treating physician in order to be sure that the patient continues to need this dose of Abilify or whether a lower dose might be as effective." This was an important recommendation that the PCP did not include in the IPN note.

e. For Individual #704:

- The podiatrist identified a concern for the wound dehiscence, and the need for the individual's compliance with all post-operative instructions. The PCP should have referred this to the IDT for review, but did not.
- With regard to his GI consultation, the individual was diagnosed with iron deficiency, and refused a colonoscopy. The PCP should have referred this to the IDT for review, but did not. During interview, the Medical Director stated that a trusted person probably would need to talk to him.

As noted above, for Individual #896's consultation with ophthalmology on 3/10/21, Center staff submitted no IPN.

For Individual #108's neurology consultation, the PCP should have made a referral to the IDT, but did not.

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

Summary: Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For three of the 18 chronic or at-risk conditions reviewed, PCPs conducted medical assessments, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
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.	17% 3/18	0/2	0/2	0/2	0/2	0/2	1/2	2/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #436 – seizures, and osteoporosis; Individual #844 – sleep apnea, and tobacco use disorder; Individual #704 – iron-deficiency anemia, and CKD; Individual #451 – GI problems, and bilateral avascular necrosis of the femoral heads; Individual #143 – senile exudative macular degeneration, and osteoporosis; Individual #896 – hypothyroidism, and weight; Individual #108 – seizures, and osteoporosis; Individual #689 – seizures, and diabetes; and Individual #635 – seizures, and anemia).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #896 – weight; and Individual #108 – seizures, and osteoporosis.

The following provide examples of concerns noted:

- According to the PCP's documentation, Individual #436 had a diagnosis of seizure disorder. For the diagnosis of seizures, the assessment and plan section of the AMA stated: "Well controlled. He is currently seeing neurology annually. Continue Depakote and gabapentin. The last seizure was 2013."

According to the neurology consult, dated 5/27/21, the individual's last seizure was in 2013, and the individual was treated with divalproex and gabapentin, which were also used for mood. The diagnosis was seizure disorder of unknown etiology, not intractable, with no known history of status epilepticus. The plan was to continue the current medications and return to clinic in one year. The AMA provided no information on the classification of the seizure disorder, the etiology of the seizures, side effects of medications, or a plan for monitoring. There was also no discussion of the justification for using two anti-epileptic drugs (AEDs) in an individual who was seizure free for eight years.

- Individual #436 was diagnosed with Vitamin D deficiency. During interview with the Monitoring Team, the PCP commented that a DEXA scan was not done, because the individual was not at increased risk for osteoporosis. According to the neurology consult in April 2021, in 2010, he was started on Depakote. Valproic acid is associated with loss of bone mineral density (BMD). His BMI was 18, which is classified as underweight. The IHCP outlined numerous interventions related to fall prevention, which indicated this was considered to be a significant risk. In sum, his risk factors included a history of treatment with divalproex for 11 years, low body weight, Vitamin D deficiency, and a history of falls during the previous year.
- In May 2021, Individual #844 had polysomnography completed. The study showed moderate sleep apnea with an apnea-hypopnea index (AHI) of 27. The individual also had oxygen desaturations down to 80%. On 6/24/21, he had follow-up with sleep medicine. Continuous positive airway pressure (CPAP) was ordered, as well as an echocardiogram, and pulmonary function tests. The individual was to follow up in three months. During an interview with the Monitoring Team, the PCP reported that the individual had follow-up and was scheduled for additional follow-up in December 2021. While the respiratory risk section of the AMA provided information on the results of the sleep study, it did not adequately outline the individual's current status or treatment plan. The assessment section of the AMA related to obstructive sleep apnea should document the severity of the disease, the treatment prescribed, compliance with treatment, and the efficacy of treatment. The efficacy is measured objectively by the AHI, and subjectively by documenting the presence or absence of symptoms of sleep apnea. In the AMA, the assessment/plan for sleep apnea only stated that he would be followed by pulmonary. The IPNs reviewed did not provide any documentation from the PCP on the status of the sleep apnea or the treatment.

  Of note, during interview, the PCP reported that the individual was following up with a pulmonary doctor who was not a sleep medicine physician. In fact, though, the pulmonologist has additional certification in sleep medicine, but the PCP did not appear to be aware of this. PCPs should know the qualifications of the specialists to whom they refer the individuals.
- For Individual #844, the August 2021 AMA listed tobacco use disorder as an inactive problem. Therefore, there was no plan to address this diagnosis.

  Reportedly, following the individual's June 2021 hospitalization, he quit smoking. However, during interview, the PCP indicated that she believed he recently resumed smoking. The PCP indicated that she did not know the precise smoking history, but the individual smoked a pack a day for "years and years." Based on this data, the PCP acknowledged that the individual met the criteria for lung cancer screening, but this had not been done.

  It should be noted that the 2021 AMA documented the presence of a right upper lobe pulmonary nodule. This individual was 55 years old, had a long smoking history, and was a current smoker. The PCP, who completed the AMA, was not aware of the documentation in the AMA of the pulmonary nodule. Therefore, there was no risk assessment done to determine what follow-

up was needed. It was concerning that the PCP who documented this finding in the AMA reported to have "no recollection" of the pulmonary nodule or the source of the diagnosis of pulmonary nodule.

- On 7/6/21, the PCP documented in the AMA that Individual #704 was diagnosed with iron-deficiency anemia. The assessment and plan noted that the condition was stable. The plan was to continue supplementation and lab monitoring. There was no plan to identify the etiology of the iron deficiency. Stability normally indicates that there has been no significant change. Therefore, stability of a medical condition is a function of time, and it was unclear how the PCP made the determination that the anemia was stable based on a single complete blood count (CBC) for this newly-admitted individual.

  According to the Medical Director, a gastroenterologist saw the individual, and recommended a colonoscopy and workup for celiac disease. The celiac workup reportedly was negative. The individual refused a colonoscopy, and, therefore, a FIT was recommended. At the time of the Monitoring Team's review, stool fecal immunochemical testing had not been completed. Moreover, at the time of the review, there was no documentary evidence in the form of an ISPA that this issue had been referred to the IDT or BHS for further review to determine how to manage the individual's refusal. During interview, the Medical Director stated that it might be necessary to have someone that the individual trusted discuss the need for a colonoscopy with him further.

  It should be noted that this was a 48-year-old male with iron-deficiency anemia of undetermined etiology. Because the individual was receiving daily ferrous sulfate, laboratory evidence might not document the iron deficiency.
- In June 2021, Individual #704 was admitted. On 7/6/21, the PCP completed the AMA. The admission labs, from 6/16/21, documented evidence of CKD with a creatinine of 1.2, which was at the upper limits of normal. The individual also had significant urinary protein. There was no evidence that this was further investigated. The AMA did not list CKD as a problem, and, therefore, there was no plan to address CKD in an individual with the diagnoses of hypertension and Type 2 diabetes mellitus (T2DM).

  On 8/3/21, the individual's creatinine increased to 1.62 with a corresponding glomerular filtration rate (GFR) of 50. The microalbumin creatine ratio was elevated at 430.2. During interview, the PCP stated that the individual was scheduled for a nephrology evaluation the week of the Monitoring Team's review.
- Per the AMA, Individual #451 had a "chronic/inactive" problem of nonalcoholic steatohepatitis (NASH) with normal liver function tests (LFTs). Nonalcoholic fatty liver disease (NAFLD) is a spectrum of diseases ranging from more benign nonalcoholic fatty liver (NAFL) to NASH, which is at the more severe end of the spectrum. As such, NASH should be considered an active medical problem. Sources such as UpToDate recommend treatment for NASH that includes:
  - Abstaining from alcohol;
  - Providing appropriate immunizations, such as Hepatitis A and B, and pneumococcal vaccinations;
  - Rigorous management of hypertension and hyperlipidemia;
  - Optimizing blood sugar;
  - Noninvasive assessment of fibrosis; and
  - Weight loss of 7-10% is the primary therapy.

During interview, the PCP was asked about the plan of care for the diagnosis of NASH. The PCP indicated there was no specific plan of care, but lipids and metabolic syndrome were addressed. Given that the PCP provided little information about the diagnosis of NASH, it was not clear that the criteria were met to make this diagnosis. If the diagnosis was accurate, there should have been a specific plan of care to address it.

- The AMA documented that Individual #451 had bilateral avascular necrosis of the femoral heads. The etiology of the necrosis was not documented, and since this was listed as an inactive problem, the AMA included no discussion of treatment or a plan of care. During interview, the PCP was asked about the etiology of the condition, assessment of pain, and a plan of care. According to the PCP, the individual walked with a limp and might have pain. He had a standing pro re nata (PRN, or "as needed") order for pain medication. According to the IRRF, the individual fell four times during the review period. He also had a history of multiple fractures.

  The PCP did not document any assessment of the extent of involvement of the individual's hips. The PCP documented no physical examination of the hips. The management of femoral head necrosis is guided by symptoms and radiologic parameters, including the presence or absence of joint collapse. These factors should be used to make treatment decisions, which include supportive care, joint preserving pharmacologic therapy, and total hip arthroplasty. The PCP addressed none of these issues in the assessment.
- According to the AMA, Individual #143 had senile exudative macular degeneration and was legally blind. On 7/28/21, based on exam, the optometrist stated the individual was legally and permanently blind, and had macular degeneration. No beneficial treatment was recommended. The individual was not prescribed the AREDS 2 vitamin supplementation. In 2015, based on an exam under anesthesia, the ophthalmologist reported: "Under general anesthesia, the patient was examined. Tonometry was 13 and 14. Anterior statement unremarkable with exception of mild map dot changes and dryness. Retinoscopy was plano ou. Indirect ophthalmoscopy indicated a normal fundus exam with c/d 0.2 ou and no retinitis or retinal hemorrhage. " It was not clear when the diagnosis of macular degeneration was made or which provider made the diagnosis.

  The individual's ISP included goals and preferences that would be challenging for a legally blind individual. For example one goal included using different color wands to independently blow bubbles. Other goals included riding a tricycle, dialing numbers, and pressing buttons.

  When asked about the individual's functional vision, the PCP read the 2015 ophthalmology report. There was no evidence that the individual had any recent follow-up with an ophthalmologist or a retinal specialist to determine if she was a candidate for any treatment.
- In 2008, Individual #143 was diagnosed with osteoporosis. Until 2014, she was treated with Reclast. In 2014 and 2015, DEXA scans showed mild osteopenia of the left forearm. In 2018, a DEXA was normal. There was no documentation of a fracture risk assessment. When asked when the next DEXA would be performed, the PCP responded that it "Will be repeated briefly."
- Individual #896 was diagnosed with hypothyroidism and was treated with Synthroid. The plan was to monitor. The PCP did not document any information on the clinical status of the individual, such as whether or not the individual was clinically euthyroid. The plan of "will continue to monitor" did not specify how this would be done.
- According to the AMA, Individual #689 was diagnosed with a seizure disorder. On 6/24/21, a neurology consult stated: "Lennox Gastaut Syndrome, intractable, unknown h/o [history of] status epilepticus." The plan was to obtain records from the

previous neurologist and continue the five AEDs. The neurologist provided vagus nerve stimulator (VNS) information to the family, and the next consultation was scheduled for three months.

During interview, the medical staff was asked about the status of the individual. It was reported that on 9/9/21, the individual saw the neurologist. The PCP read the neurology assessment aloud. The information the PCP read was essentially the same as the assessment and plan from the June consult. Apparently, staff had not obtained the records from the previous neurologist, and there was no progress in conducting further evaluation of an individual with a drug-resistant seizure disorder that required treatment with five AEDs.

As the primary care providers, the Center staff are the gatekeepers of the medical care, and should and take the steps necessary to ensure that the neurologist has the information required to complete the evaluation.

- The PCP documented that Individual #689 was young, probably sedentary, obese, and treated with medications that increase the risk for metabolic syndrome. At admission, his weight was 294 pounds with a BMI of 43. This BMI met the criteria for Class 3 severe obesity, which is the most severe obesity rating. Notwithstanding this information, the PCP rated the individual at low risk for diabetes and metabolic syndrome.

  This individual was treated with a second-generation antipsychotic (SGA), had a waist circumference of 56.5 inches, triglycerides of 197, a family history of diabetes, and had Class 3 severe obesity. A low risk rating resulted in the lack of an IHCP to address the risk.

  During interview, the PCP indicated that the individual was started on a heart healthy diet, and since admission, this resulted in the loss of 30 pounds. Labs were scheduled to be repeated in November (six months after admission).
- According to the AMA, Individual #635 was diagnosed with a seizure disorder. The assessment and plan was documented as "Chronic, stable, Continue AEDs. Followed by neurology annually." In the assessment, the PCP did not document the type of seizures the individual had or the seizure frequency. The PCP did not document the AEDs or the monitoring parameters.

  According to the neurology consult, completed on 5/5/21, since the last consult, the individual had no reported seizures, and staff could not provide any information on the number of falls. The assessment was: “Seizure disorder/generalized epilepsy. ? intractable" and falls of unknown etiology. The recommendation was to continue medications and keep a detailed seizure log. Additional recommendations included tracking falls with consideration given to obtaining an ambulatory electroencephalograph (EEG), if the individual fell more than once per week.

  The individual’s sodium level was 131, and the neurologist recommended monitoring this, and giving consideration to changing AEDs if the sodium continued to drop. The neurologist also recommended that the PCP discuss with psychiatry if the carbamazepine was being used for mood. The PCP did not address these issues in the AMA, and the IMR, dated 7/14/21, included a cut-and-paste of the information, but did not provide any information that addressed the neurologist’s recommendations.
- Per the AMA, Individual #635 was diagnosed with anemia. The assessment and plan stated: "Anemia of chronic disease-Chronic, stable. Continue supplementation and monitoring labs q [every] 6 months."

The PCP's discussion provided no information on the evaluation of the anemia. There was no documentation to support the diagnosis of anemia of chronic disease in this 30-year-old male. The QDRR indicated that anemia was associated with several of the medications that were prescribed to the individual.

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. For 12 of the 18 chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. However, for five of the IHCPs reviewed, documentation was found to show implementation of those few action steps that IDTs had assigned to PCPs and included in IHCPs/ISPs. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. 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	436	844	704	451	143	896	108	689	635
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	83% 5/6	2/2	N/A	N/A	1/1	0/1	N/A	N/A	1/1	1/1

Comments: a. As noted above, none of the 18 IHCPs reviewed included a full set of action steps to address individuals' medical needs. The remaining IHCPs did not include a full set of medical interventions as necessary to meet the individuals' needs. For 12 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP.

However, the action steps assigned to the PCPs were implemented for the following: Individual #436 – seizures (i.e., diagnostics and labs for therapeutic medication levels quarterly), and osteoporosis (i.e., diagnostic labs/tests such as Vitamin D and calcium levels); Individual #451 – bilateral avascular necrosis of the femoral heads (i.e., monitor medications for efficacy and lab results for abnormal results quarterly); Individual #689 – seizures (i.e., diagnostics and labs for therapeutic medication levels, and follow-up neurology appointment), and Individual #635 – seizures (i.e., diagnostics and labs for therapeutic medication levels, and follow-up neurology appointment, as needed).

Individual #143's IHCP for osteoporosis included an action step for the PCP to order DEXA scans every two years. The individual was overdue, and the PCP needed to order one.

Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

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	436	844	704	451	143	896	108	689	635
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. Due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate these indicators.											

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 quality of the QDRRs, particularly the review of lab results.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator 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;	47% 8/17	0/2	2/2	0/1	0/2	0/2	2/2	2/2	2/2	0/2
	ii. Benzodiazepine use;	100% 17/17	2/2	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 17/17	2/2	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100%	2/2	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2

		17/17									
	v. Anticholinergic burden.	100% 17/17	2/2	2/2	1/1	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, these indicators 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.	67% 2/3	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/2	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.	Not rated (N/R)									

Comments: b. The following summarizes concerns noted:

- For Individual #436, the Clinical Pharmacist provided no recommendation or discussion related to the individual's Vitamin D level of 76 on 5/4/21. State Office guidelines for osteoporosis recommend a level of 30 to 50 with justification required for levels above 50. The individual also had an 11-year history of treatment with divalproex, low body weight, and Vitamin D deficiency. The Pharmacist made no recommendation to assess BMD based on drug use and multiple risk factors. In the 4/30/21 QDRR, the Pharmacist indicated that the Vitamin D of 82 on 12/1/20 was normal.
- Individual #844's QDRR stated he reached his blood pressure goal, but the Pharmacist did not clearly define the goal for this individual with hypertension and diabetes. During interview, the Clinical Pharmacist stated that the goal would be less than 140/90, which came from "guidelines." This was not the goal that the PCP reported during interview, and was not consistent with the State Office guidelines issued in July 2021. State Office informed the Monitoring Team that Center staff were to implement the revised guidelines immediately.
- The Clinical Pharmacist wrote that Individual #704 had "no overt renal disease." This individual was diagnosed with hypertension, T2DM, and hyperlipidemia. The urine microalbumin/creatine ratio was elevated, and the creatinine was at the upper limits of normal. The individual had subsequent increases in both values, and at the time of the review, was referred to nephrology. Additionally, this male was prescribed ferrous sulfate for iron-deficiency anemia without any laboratory evidence to support the diagnosis of iron deficiency. The Clinical Pharmacist made no comments or recommendations in this QDRR related to the use of iron supplementation in an individual with no supporting laboratory evidence of iron deficiency.
- Individual #451 was diagnosed with chronic kidney disease (CKD), but the Pharmacist documented: "no apparent overt renal disease." Thus, the Pharmacist did not address the CKD and the use of lithium. The PCP documented in the AMA that the individual had a diagnosis of renal insufficiency. It should be noted that the term renal insufficiency has been supplanted by the term chronic kidney disease, including a notation of the specific stage of disease.

During the Monitoring Team's interview, the Pharmacy Director asked the Clinical Pharmacist if the lithium levels were "out of range?" The Clinical Pharmacist responded that there was recent documentation of two elevated lithium levels. These findings were not appropriately addressed.

- The Clinical Pharmacist noted that Individual #143's Vitamin D levels of 57 and 62 were within normal limits. However, both values were outside the range recommended in the State Office clinical guidelines on osteoporosis, which require justification for levels over 50.
- In Individual #689's QDRR, dated 6/18/21, Sertraline was documented as a medication, but the Pharmacist noted the individual did not receive psychotropic medications. The individual had a history of long-term treatment with phenytoin. While the pharmacist listed many adverse events associated with phenytoin use, there was no discussion of the effect of phenytoin on bone mineral density (BMD).
- Individual #635 was diagnosed with hyponatremia. On 5/5/21, the neurologist associated the hyponatremia with the individual's AED regimen. The consultant noted that the sodium should be monitored and should the sodium continue to decrease, then the carbamazepine should be replaced with an alternative agent. It was further recommended that the PCP determine if the carbamazepine was also being used for mood stabilization. The Clinical Pharmacist made no comments regarding the hyponatremia and use of carbamazepine.

d. Most QDRRs included no recommendations. As noted above, there were times when the Clinical Pharmacist should have made recommendations, but did not.

For Individual #689, the Pharmacist included the same recommendation in the 8/11/21 QDRR that she did in the 6/18/21 QDRR. Although it was vaguely written, it did not appear that the provider implemented it after agreeing to it in June. It read: "Order lab for med type."

e. As noted with regard to Outcome #1, due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate this indicator.

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: N/A	Individuals:
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.	

Outcome 4 – Individuals maintain optimal oral hygiene.
This outcome is no longer rated.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Individuals reviewed did not always receive needed dental care, as applicable. In addition, as a part of it review of overall dental care, the Monitoring Team noted that performance with regard to providing individuals with needed toothbrushing instruction and x-rays had declined. If Center staff do not improve their performance in these areas in the future, Indicator b and Indicator c might return to active oversight.

It was positive that Center staff generally provided restorative care that individuals needed [Round 14 – 100%, Round 15 – 75% (i.e., 3/4), Round 16 – N/A, and Round 17 – 100%]. As a result, Indicator e will move to the category requiring less oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
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.	67% 6/9	1/1	1/1	1/1	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, these indicators moved to the category requiring less oversight. However, these indicators are at risk of returning to active oversight due to a decline in performance.									
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.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 4/4	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A	1/1
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1

Comments: a. Three of six individuals did not receive needed prophylactic care at least twice a year, or more frequently based on their oral hygiene needs, and the Center did not provide clinical justification.

- Individual #896 received only one documented prophylaxis on 7/1/21.
- Based on documentations submitted for review, Individual #143 and Individual #108 did not receive any prophylactic care in the preceding year. Of note, the documentation also indicated that Individual #108 did not have any visit to the dental clinic in 2020. The Center dentist confirmed this during interview.

d. through f. It was positive that restorative work was completed as needed, and for individuals requiring them, extractions were only completed when restorative options were exhausted.

Individual #143 and Individual #896, both of whom had increased caries risk, did not receive at least two topical fluoride applications per year.

Outcome 7 – Individuals receive timely, complete emergency dental care.

Summary: For the single dental emergency reviewed, the individual presented to the Dental clinic independently and received necessary dental treatment. Due to the Center's sustained progress, Indicator a (Round 15 – 100%, Round 16 – 100%, and Round 17 – 100%) and Indicator b (Round 15 – 100%, Round 16 – N/A, and Round 17 – 100%) will move to the category requiring less oversight.

However, documentation indicated the Dental Department did not address and or document pain management consistent with the individual's needs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1						1/1			
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1						1/1			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1						0/1			

Comments: a. through c. On 5/14/21, Individual #896 went to the dental clinic, holding his filling in his hand. The dental documentation indicated this was reported by nursing, but the Center provided no nursing documentation related to this event. The x-ray of tooth #15 showed a large pulpal exposure with gross decay. Dental staff applied a sedative filling and the individual was informed that the tooth would require extraction. The dental documentation did not address ongoing pain management other than the application of the sedative filling (e.g., no documentation of an assessment for the need of oral analgesia). On 8/16/21, the tooth was extracted with local anesthesia.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for suction tooth brushing plans and their implementation are now assessed as part of the Section F – ISP audit tool.

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
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, this indicator moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: b. 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: It was positive that for three of the four acute illnesses/occurrences reviewed, nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines. If the Center sustains its progress in this area, after the next review, Indicator a might move to the category requiring less oversight. For three of the four occurrences reviewed, nursing staff timely notified the practitioner/physician of such signs and symptoms. Nursing staff developed acute care plans for all of the acute care needs reviewed. However, more work is needed to ensure the plans include the necessary interventions, interventions are measurable, and nurses implement them. Currently, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	75% 3/4	1/1	1/1	1/1	N/R	0/1	N/R	N/A	N/A	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.	75% 3/4	1/1	1/1	1/1		0/1		N/A	N/A	

c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/2	0/1	N/A	N/A		0/1		N/A	N/A	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 1/2	N/A	1/1	0/1		N/A		N/A	N/A	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/4	0/1	0/1	0/1		0/1		N/A	N/A	
f.	The individual's acute care plan is implemented.	0% 0/4	0/1	0/1	0/1		0/1		N/A	N/A	

Comments: The Monitoring Team reviewed four acute illnesses and/or acute occurrences for four individuals, including Individual #436 – rash/open areas on lower extremities on 4/5/21; Individual #844 – hospitalization for pneumococcal pneumonia, acute on chronic renal failure, obstructive sleep apnea, and diabetes mellitus on 6/14/21; Individual #704 – ED visit for fall with laceration requiring 11 sutures, and moderate head injury on 7/12/21; and Individual #143 – hand wound on 3/10/21. In the six months prior to the review, Individual #108, and Individual #689 did not experience an acute illness/occurrence that required an acute care plan.

a. The acute illnesses/occurrences for which nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines were for Individual #436 – rash/open areas on lower extremities on 4/5/21; Individual #844 – hospitalization for pneumococcal pneumonia, acute on chronic renal failure, obstructive sleep apnea, and diabetes mellitus on 6/14/21; and Individual #704 – ED visit for fall with laceration requiring 11 sutures, and moderate head injury on 7/12/21.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing guidelines entitled: "When contacting the PCP" were: Individual #436 – rash/open areas on lower extremities on 4/5/21; Individual #844 – hospitalization for pneumococcal pneumonia, acute on chronic renal failure, obstructive sleep apnea, and diabetes mellitus on 6/14/21; and Individual #704 – ED visit for fall with laceration requiring 11 sutures, and moderate head injury on 7/12/21.

a. through e. The following provide some examples of findings related to this outcome:

- On 4/5/21, when Individual #436 presented with a rash on his lower extremities, nursing staff followed the assessment guidelines for skin integrity issues, including measuring and documenting multiple areas of the rash, as well as open areas on his ankles. The nurse contacted the PCP, who indicated that she did not need to see the individual, but wrote an order for treatment to the open areas.

  On 4/6/21, nursing staff initiated an acute care plan. It was not consistent with the nursing care guidelines for skin integrity, because it did not specify the need to take measurements of the skin integrity issues, including length, width, and depth, as well as the dynamic locations. Based on the documentation submitted, nurses did not consistently implement the interventions. As a result, at times, the status of the rash was unclear, and/or whether nursing staff administered the correct treatment.

- In response to Individual #844's signs and symptoms of shortness of breath, low oxygen saturation (i.e., 86% to 88%), and altered mental status, nursing staff assessed him in accordance with the respiratory distress guidelines, applied oxygen, called EMS, and contacted the on-call provider. On 6/14/21, the individual was admitted to the hospital.

  Upon his return from the hospital, on 6/23/21, a nurse conducted a comprehensive post-hospital assessment. Nursing staff also developed an acute care plan. The plan was missing a number of necessary interventions. For example, for this individual who was diagnosed with pneumonia, the respiratory assessment intervention stated: "weekly and PRN lung assessments." The plan contained no assessment intervention for pain. His discharge diagnoses also included obstructive sleep apnea, but the acute care plan did not address this diagnosis. It was unclear whether he returned with an order for bilevel positive airway pressure (BiPap), and no interventions were included for vital sign assessments, including oxygen saturation. In addition, the interventions often were not measurable (e.g., did not identify the day of the week), making it difficult to determine implementation.
- On 7/12/21, according to the Licensed Vocational Nurse (LVN), Individual #704 fell in the shower. A DSP said he fell while putting on his pants. He sustained a laceration to the back of his head that measured 5 centimeters (cm) by 2 cm. The individual reported no pain. Nursing staff cleaned the area, and notified the PCP, who ordered transport to the ED. The nurse followed the guidelines for falls, including a neurological assessment.

  Upon the individual's return from the ED, the nurse conducted an assessment that was in alignment with the guidelines for a moderate head injury, and a suspected fall. The nurse also assessed the laceration. However, the nurse did not conduct and/or document a head-to-toe assessment that included the individual's lower extremities. This is significant because three days later he was hospitalized for a foot infection that resulted in the amputation of his great right toe.

  On 7/12/21, at 3:36 p.m., nursing staff initiated an acute care plan. The plan did not reflect interventions consistent with the diagnosis of a moderate head injury, and/or a suspected fall. In addition, some of the interventions included were not measurable, because they did not include a frequency of implementation.
- According to an IPN, dated 3/12/21, at 8:18 a.m., a nurse conducted a follow-up on the use of Doxycycline (i.e., ordered by the PCP on 3/10/21) for a wound on Individual #143's right hand. However, an initial nursing assessment of the wound was not found in the documents submitted. According to a medical note, the cause of the abscess was unknown, but was suspected to be a bug bite. The provider ordered Doxycycline. The next IPN showing a nursing assessment of the individual's hand was dated 3/15/21, at 7:00 a.m.

  On 3/12/21, nursing staff initiated an acute care plan. It is unclear why this plan was not initiated on 3/10/21, when the provider prescribed antibiotic treatment. The plan did not include a frequency for assessing the individual's pain in alignment with the prescription of PRN Tylenol for pain, and did not identify the pain scale nurses should use. It also did not include an intervention to measure the wound to allow determination of whether or not it was healing (i.e., the intervention read: "assess the right hand daily"). Based on documents submitted, no assessment occurred of the individual's hand on 3/13/21, 3/14/21, or 3/17/21. On days that nurses assessed the wound, they included no measurements. As a result, it was unclear whether or not further notification of the PCP should 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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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 that were sufficient 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: 436	844	704	451	143	896	108	689	635
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% 0/12	0/2	0/2	0/2	N/R	0/2	N/R	0/2	0/2	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/10	0/2	0/2	0/2		0/2		N/A	0/2	
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not nurses implemented them. 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 nurses implemented the interventions thoroughly.

A significant problem was the lack of measurability of the supports. For example, some of the individuals' IHCPs used terms such as "encourage," "offer education," etc.; and/or they did not include a frequency of expected implementation. In addition, for some of the interventions, the IHCPs did not specify where nurses would document implementation. As a result, it was difficult, if not impossible, to identify whether or not and where nurses had documented the findings from the interventions/assessments included in the IHCPs reviewed.

In other instances, nurses/staff did not consistently document implementation of interventions included in individuals' IHCPs. At times, this placed individuals at significant risk. For example:

- Individual #704 was diagnosed with T2DM. In his diabetes IHCP, the IDT included an intervention for the RNCM to complete foot checks every 30 days. This intervention was not sufficient to address his needs given that his new-admission nursing physical, dated 6/15/21, included the following findings: "Extremities: No clubbing or cyanosis. Lower extremities with discoloration to bilateral feet, with edema +1 to left ankle. Skin to this area is extremely dry and peeling. No open areas to skin. Great toe to right foot is, also, discolored." Based on a sample of documentation, from 7/1/21 to 7/13/21, nursing staff completed and/or documented no assessments of his feet. On 7/15/21, he was hospitalized for a diabetic right foot infection. On 7/21/21, his right great toe was amputated with a diagnosis of osteomyelitis. Even after the amputation of his great right toe, nursing staff did not appear to consistently implement the inadequate intervention. For example, in September 2021, nursing staff did not complete and/or document an assessment of his feet.

b. As illustrated below, a continuing 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, and modifications to plans to address their needs. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- In the six months prior to the Monitoring Team's review, Individual #436 fell several times. According to Document #TX-MX-2110-II.P.1-20, he fell on the following dates: 4/7/21, 5/17/21, 6/3/21, 6/11/21, 6/21/21, 7/3/21, 7/28/21, and 8/19/21. On 8/19/21, when he fell on the sidewalk, he sustained a head injury.

  The IHCP for falls that the IDT developed, on 6/15/21, did not meet his needs. Although it included interventions to teach him that while walking/dancing, he needed to be aware of furniture/staff/other individuals, and to have him state two ways to decrease falls (i.e., pick up room, proper foot wear), the IDT did not specify the frequency and/or methodology for implementing these activities.

  Subsequent to his ISP meeting, on 6/21/21, the IDT held an ISPA meeting. The reason listed was to discuss his recent dental appointment with TIVA and a peer-to-peer aggression incident. During this meeting, the IDT also noted that as of 6/17/21, the individual fell four times in the past 30 days. The IDT determined the falls were "behavioral," and one was a "true fall" due to him walking around while sleepy. The IDT discussed/documented no descriptions of where the falls occurred, the dates on which they occurred, or whether or not he had injuries. They did not review the IHCP or revise it to better meet his needs. On 8/25/21, after the fall resulting in a head injury, the IDT documented in an ISPA that they completed a General Action Plan Review that listed osteoporosis risk, and described three falls, but they did not include the fall on 8/19/21. During this meeting, the IDT did not review the interventions in his IHCP, and merely stated to continue to monitor.
- On 9/7/21, Individual #436 tested positive for COVID-19. He received monoclonal antibody infusions. Based on a review of ISPAs, when the IDT met on 9/9/21, they did not discuss follow -up to his positive COVID-19 test, that he had received the antibodies, what the plans were for his discharge from quarantine, or if this diagnosis would affect his upcoming transition to the community.
- From 3/9/21 to 3/11/21, Individual #844 was hospitalized for pneumonia, congestive heart failure (CHF), and an acute exacerbation of chronic obstructive airway disease. He also had a history stroke, and was prescribed the blood thinner Plavix.

He also had diagnoses of coronary calcification on his chest, morbid obesity, hyperlipidemia, a history of tobacco use, and T2DM. On 3/11/21, the IDT met to discuss emergency restrictions, and his hospitalization. They did not review the related acute nursing care plan. Moreover, at an ISPA meeting on 4/19/21, the IDT did not address his 4/13/21 ED visit or the resulting change in medication. A chest x-ray showed infiltrates of CHF, and his prescription for Lasix was increased from 20 milligrams (mg) to 40 mg. The IDT did not conduct a review of the acute care plan or the nursing interventions included in the IHCP. The interventions did not describe how the intermittent claudication would be assessed. The IHCP also did not include interventions for assessing the individual's extremities, including measurements to assess for edema, and/or taking popliteal, pedal pulses.

- As noted above, from 3/9/21 to 3/11/21, Individual #844 was hospitalized, and his diagnoses included pneumonia, CHF, and an acute exacerbation of chronic obstructive airway disease. During an ISPA meeting on 5/17/21, despite his diagnoses in March, the IDT conducted an action plan review, including a review of the IHCPs, and noted no concerns, including for aspiration/respiratory compromise, for which the individual was rated at low risk. On 4/13/21, he went to the ED for shortness of breath (SOB). As noted above, when the IDT met on 4/19/21, they did not address this ED visit. On 6/8/21, a CPAP device was ordered. From 6/14/21 to 6/23/21, the individual was hospitalized again for aspiration pneumonia. On 6/23/21, the IDT held a post-hospital ISPA meeting. They noted a CPAP machine was on order, but gave no date for the order or status update on its arrival. They noted his respiratory risk would change from low to high due to the aspiration pneumonia diagnosis. They did not review the interventions for a respiratory/aspiration IHCP, nor did they review the acute care plan for his respiratory/cardiac issues.
- Individual #704 was diagnosed with T2DM. On 6/16/21, his hemoglobin A1c was 6%. He smoked on pack of cigarettes per day. As discussed in more detail elsewhere in this report, on 7/15/21, he was hospitalized for a diabetic right foot infection. He was started on Vancomycin and Zosyn in the ED. On 7/21/21, his right great toe was amputated. On 8/18/21, the IDT held a change-of-status (CoS) ISPA meeting, and reviewed his diabetes/metabolic syndrome risk area. They increased his risk rating from medium to high due his recent hospitalization with a diagnosis of osteomyelitis to his right great toe, which led to amputation. The IDT indicated that they felt this outcome was due to limited sensation to his feet, and resulted from his diagnosis of diabetes. The IDT indicated that the purpose of the CoS was to increase awareness and his level of care, and concluded that it was possible that diabetes could cause further complications. They reviewed the interventions and determined they should remain in place with some small adjustment to the plan. The IDT had included an intervention for the RNCM to complete foot checks every 30 days. Based on this individual's history of amputation, the frequency of these checks did not meet his needs, and the IDT did not modify it. In addition, the IDT did not include interventions from the nursing guidelines for nurses to report blood glucose readings outside of specific individualized parameters to the PCP.
- On 10/23/20, Individual #143 had an ED visit for severe constipation, obstruction of the colon, and fecal impaction. On 5/24/21, the IDT developed an IHCP for constipation as part of her annual planning meeting. It did not meet her needs. For example, it included no preventive interventions, and included no proactive nursing assessments. On 6/24/21, at 2:10 p.m., she had two episodes of diarrhea and did not eat breakfast or lunch. An x-ray of her abdomen showed an improving bowel gas pattern suggestive of ongoing ileus. On 6/30/21, her bowel gas pattern was suggestive of ongoing ileus versus distal colonic obstruction. Her diarrhea resolved.
- According to an IPN, dated 6/3/21, at 3:55 p.m., nursing staff documented that Individual #143's tube had been dislodged. The individual refused a full set of vital signs. The nurse noted the G-tube was lying on her abdomen under her shirt. The bulb was inflated, but dry. The sediment in the tube was dry and yellow. Nursing staff attempted to replace the tube, but they were

unsuccessful. At 4:03 p.m., a nurse spoke with the APRN, who ordered the individual's transport to the ED. No evidence was found to show that the IDT reviewed this dislodgement of the individual's enteral tube to gain an understanding of the cause, and/or revise supports as needed.

- Since his admission on 5/18/21, Individual #689 fell numerous times. According to Document #TX-MX-2110-II.P.1-20, he fell on the following dates: 5/21/21, 5/22/21, 5/26/21, 6/1/21 x2, 6/4/21, 6/7/21, 6/8/21, 6/10/21, 6/14/21, 6/18/21, 6/24/21, 6/25/21 x2, 6/26/21, 7/1/21, 7/4/21, 7/5/21, 7/7/21 x2, 7/15/21, 7/21/21, 7/25/21, 7/27/21, 8/2/21, 8/7/21, 8/26/21, 9/14/21, and 9/20/21. At an ISPA meeting on 5/28/21, the IDT discussed three falls in May, two of which occurred in the bathroom/shower area. The IDT agreed mats would be ordered. However, the ISPA did not show that the IDT discussed ways to increase his bathroom safety, such as non-skid shower shoes. His initial nursing assessment included a falls risk score of 15, which is high. The individual had seizures, but the IDT did not consider what data would be collected, or how it would be analyzed, including any correlations between his seizures and falls. The seizure IHCP did not clearly set forth his seizure management plan. Although his family shared that his startle reflex sometimes triggered falls and/or seizures, his IHCP(s) did not include interventions to address how staff or others should approach him, or other ways to support him in a congregate living situation.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: Since the last review, improvement was noted with regard to medication nurses' adherence to infection control practices during medication administration. The Center's nurse auditor continued to identify and take action to remediate the problems that did occur. If the Center sustains its progress in this area, after the next review, Indicator g might move to the category requiring less oversight.

Areas that require focused efforts are the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports. When an individual experienced a coughing episode during medication pass, the Center's nurse auditor needed to guide the medication nurse in the proper placement of the stethoscope to accurately assess the individual's lung sounds. At this time, the remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

	time, right reason, right medium/texture, right form, and right documentation).										
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
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% 0/2	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0% 0/4	N/A	0/1	0/1	0/1	0/1	N/A	N/A	N/A	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										

	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	78% 7/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
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 for the nine individuals in the physical health review group.

d. For the individuals in the review group, the Monitoring Team identified a number of concerns related to necessary respiratory assessments. During medication administration observations, it was positive that when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following provide examples of the Monitoring Team's findings:

- From 6/14/21 to 6/23/21, Individual #844 was hospitalized with a diagnosis of aspiration pneumonia. On 6/27/21, his IDT developed a CoS IHCP, and added an intervention for nurses to assess his breath sounds each shift for three days, then twice a day (BID) for three days, then once a day for three days, and then quarterly and PRN. Based on documentation submitted, nursing staff conducted the assessments only once a day on 6/27/21, and 6/28/21. On 6/29/21, nursing staff documented no respiratory assessments. They also did not conduct the required assessment for the following six days. As part of the quarterly assessment, on 7/19/21, an RN completed a respiratory assessment.

- On 7/15/21, Individual #704 was hospitalized with diagnoses of acute trachea-bronchitis, and acute diastolic congestive heart failure. His IDT did not add an intervention for regular respiratory assessments. They previously rated him at low risk for aspiration/respiratory compromise, despite his smoking habit.
- During Individual #451's medication administration observation, when he drank red liquid mixed with Fiberstat, he began to repeatedly cough, and then stopped after several coughs. The medication nurse immediately assessed the individual, and the Center's nurse auditor (i.e., Nurse Educator) also listened using a double stethoscope. The nurse reported clear lung sounds anteriorly and posteriorly. However, the medication nurse required guidance from the Center's nurse auditor with regard to placement of the stethoscope.
- Individual #143 was at high risk for aspiration/respiratory compromise, and received medications enterally. Her IHCP included no interventions for ongoing respiratory assessments.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. It was positive that when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following concerns were noted:

- During Individual #844's medication administration observation, the nurse did not change gloves after performing a blood glucose check. The nurse also reached into the glove box after administering medications without first sanitizing their hands. Both of these practices potentially resulted in cross-contamination. The Center' nurse auditor identified the problems, and offered the medication nurse examples of ways to avoid such concerns in the future.
- For Individual #704, the medication nurse did not use sanitizer after removing their gloves and before putting on new gloves. The Center's nurse auditor identified this issue and provided on-the-spot training.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.

The Monitoring Team no longer rates most of the indicators related to this outcome. The Center's responsibilities for PNM-related personal goals/objectives are now assessed as part of the Section F – ISP audit tool. Information about the Center's compliance related to the referral of individuals to the PNMT is provided below

Summary: Improvements are needed with regard to referral of individuals meeting criteria to the PNMT.		Individuals									
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
b.	Individuals are referred to the PNMT as appropriate:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	40% 2/5	N/A	1/1	N/A	0/1	0/1	N/A	N/A	1/1	0/1

Comments: b.i. The Monitoring Team reviewed five areas of need for five individuals that met criteria for PNMT involvement. These areas of need included those for: Individual #844 – aspiration, Individual #451 – falls, Individual #143 – constipation/bowel obstruction, Individual #689 – falls, and Individual #635 – falls.

The following individuals should have been referred or referred sooner to the PNMT:

- According to Individual #451's IRRF, his IDT rated him at high risk for falls. As of 8/31/21, he met the criteria for referral to the PNMT for at least a review, but he was not referred. According to the Tier II document #P.1-20, he fell on the following dates: 3/8/21, 3/11/21, 4/27/21, 6/10/21, 6/23/21, 7/16/21, 7/19/21, 7/26/21, 8/18/21, 8/29/21, and 8/31/21.
- From 10/23/20 to 10/25/20, Individual #143 was hospitalized for severe constipation, obstruction of the colon, and bowel impaction. Prior to this hospitalization, DSP staff documented regular bowel movements in CareTracker. The IDT did not refer her to the PNMT for review. Although the PNMT appeared to discuss her hospitalization during the PNMT meeting held on 10/29/20, they did not provide a rationale for not making a self-referral, and/or conducting a review. The IDT took actions related to increasing fluids, but no data were presented to show whether or not the individual had not been getting enough prior to this event. On 6/24/21, she was diagnosed with ileus.
- According to the Tier I document #III.12.n, and the Tier II document #P.1-20, between 3/23/21, and 9/16/21, Individual #635 fell 19 times. By at least 7/26/21, he met criteria for referral to the PNMT. The dates of his falls included: 3/24/21, 3/29/21, 4/24/21, 4/29/21 x 2, 5/9/21, 6/4/21, 6/6/21 x 2, 6/19/21, 6/24/21, 7/6/21, 7/11/21, 7/26/21, 8/1/21, 8/12/21, 8/15/21, 8/28/21, and 9/16/21.

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. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. 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	436	844	704	451	143	896	108	689	635
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.	18% 2/11	1/2	0/1	1/1	0/1	0/1	0/1	N/A	0/2	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, the IHCPs reviewed generally did not include all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews often provided no specific information or data about the status of the implementation of the action

steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- On 6/21/21, Individual #436's IDT held an ISPA meeting to address an increase in falls in the previous 30 days (i.e., as of 6/17/21). The IDT attributed the falls to an increase in behavioral issues and peer-to-peer aggression events. On 7/7/21, the IDT held another ISPA meeting during which the RNCM indicated that the individual needed a new pair of glasses and follow-up was needed. The IDT did not develop specific action step/plan for follow-up, including a deadline. They indicated that his level of supervision was one-to-one (1:1) from 7:30 a.m. to 7 p.m. and routine supervision from 7 p.m. to 7:30 a.m. to minimize falls and behaviors. Despite the 1:1 supervision, he fell on 7/3/21. On 7/28/21, he also fell. Based on documentation submitted, the IDT held no other ISPA meetings to discuss the occurrence of falls. Between 4/7/21, and 8/19/21, he fell at least eight times. However, the IDT did do not appear to have a clear understanding on why he was falling, especially unrelated to peer-to-peer altercations, which was the topic of the majority of the ISPAs.
- Individual #436 had a chronic area on his left calf where his boots caused an abrasion. He then would pick and scratch at that area, which became more inflamed when he wore his boots without socks. According to his IRRF, staff removed the boots and replaced them with tennis shoes and long socks. As of 5/31/21, the individual was no longer wearing boots. It was positive that the IDT provided a solution that worked well for the individual.
- Following Individual #844's hospitalization on 6/14/21, for aspiration pneumonia, the PNMT completed a comprehensive assessment. As discussed elsewhere in this report, they recommended a HOBE evaluation, but did not conduct one at the time of their assessment, but provided no rationale for waiting. Moving forward, any assessment of HOBE to address GERD should be coordinated with a sleep apnea specialist, because the individual was currently prescribed a CPAP machine. Per the PNMT meeting minutes, dated 9/16/21, at an ISPA meeting on 9/13/21, the PNMT/IDT laid out a plan for the following goal: Within the next 12 months, [Individual #844] will use his CPAP for a minimum of six hours. Steps included: will sanitize his mask after each use, will keep a CPAP journal and document after each use, will document in this CPAP journal each time the machine is filled with water, and every four months he will increase his CPAP usage by two hours. At the time of the Monitoring Team's review, they had initiated discharge discussion, but they had not yet clearly outlined the criteria for this.
- According to an ISPA, dated 7/15/21, Individual #704 experienced a change of status secondary to a transient ischemic attack (TIA) presenting as left-sided weakness at time of his admission assessment. At that time, the OT/PT outlined goals and an intervention plan. IDT members did not sign the ISPA until 8/2/21. Subsequently on 7/27/21, the goals for PT were revised to address the amputation of the individual's great right toe. These were clearly outlined. OT goals related to bathing and dressing, safety, and endurance were implemented. Although the QIDP did not appear to complete the ISPA documentation timely, it did appear that the OT/PT reassessed the individual, and made changes to the individual's plan of care in response to his changes of status.
- According to the Tier II document #P.1-20, Individual #451 fell on the following dates: 3/8/21, 3/11/21, 4/27/21, 6/10/21, 6/23/21, 7/16/21, 7/19/21, 7/26/21, 8/18/21, 8/29/21, and 8/31/21. He had no recent OT/PT assessment to address the frequency and etiology of falls, and the IDT made no referral to PNMT, despite his meeting criteria.
- On 6/24/21, Individual #143 was diagnosed with ileus. Based on the ISPAs submitted, the IDT did not meet to discuss this change of status, and review and revise the IHCP, as needed.

- Individual #896's IDT rated him at medium risk for weight, even though his body mass index (BMI) was 26.1. He weighed 237 pounds with an estimated desired weight range of 151 to 171 pounds. In the year prior to his 2021 IRRF, he had an overall net weight loss of 18 pounds. The IDT established an IHCP goal for planned weight loss of one to two pounds per month towards his EDWR during the year. However, the only action related to his activity level was to "encourage" daily exercise, and the IDT included also stated to "encourage" heart healthy food, snacks, and drinks. Despite Habilitation Therapy maintaining a cardiovascular exercise program, the IDT made no referral of the individual to this program. The OT/PT provided no screening or assessment to assist the IDT in planning.
- Similarly, Individual #689's IDT did not set forth a sufficient plan to address his weight concerns. His BMI was 43.5, and he weighed 294 pounds with an EDWR of 142 to 169, according to his IRRF, dated 6/14/21. The IDT did not make a referral to the cardiovascular program that Habilitation Therapy staff ran. The IHCP that the IDT developed only included actions to monitor his weight monthly; attempt to provide nutrition education once over the next 12 months; "encourage" healthy foods, snacks, and drinks; and daily exercise over the next 12 months. These interventions either were not measurable, and/or were not sufficient to address his level of risk.
- Between 5/21/21, and 9/20/21, Individual #689 fell 29 times. On 6/9/21, his IDT referred him to the PNMT for an assessment. At an ISPA meeting on 6/11/21, the IDT held a high-risk discussion, and reported one fall on 5/22/21. He hit his head. He had his helmet on at time of this fall. The IDT decided no action was needed, because he was not at high risk for substantial physical harm otherwise due to no problem behaviors.

  At an ISPA meeting on 7/22/21, the IDT noted eight falls since his admission on 5/18/21. Although the IDT posed the question regarding what the root cause was of the falls, the ISPA included no evidence of discussion related to this question. The actions on which the IDT decided to mitigate risk included to continue PT, a HOBE evaluation to assess the efficacy of the 30-degree wedge, referral to the orthotic clinic for fitting of orthopedic shoes and a shoe lift due to a leg-length discrepancy to improve gait pattern, a possible sleep study, and an ENT consult. The PNMT proposed a goal, and the PT presented evaluation findings and a treatment plan for direct PT at this meeting. The PT recommended revision of the individual's PNMP for staff to hold his gait belt while he ambulated.

  Although the individual fell at least seven times after this meeting, the IDT held no further ISPAs related to falls. Based on the ISPAs submitted, the IDT did not discuss the etiology(ies) of his falls, but rather focused on supports that might protect the individual from injury. Without identification of and a plan to address the cause(s) of the falls, the individual remained at high risk for serious injury.
- Individual #635 was at high risk for weight. He was considered obese, and was 79 pounds over his EDWR. His IDT had not developed an IHCP to address his weight risk.
- According to the Tier I document #III.12.n, and the Tier II document #P.1-20, between 3/23/21, and 9/16/21, Individual #635 fell 19 times. The dates of his falls included: 3/24/21, 3/29/21, 4/24/21, 4/29/21 x 2, 5/9/21, 6/4/21, 6/6/21 x 2, 6/19/21, 6/24/21, 7/6/21, 7/11/21, 7/26/21, 8/1/21, 8/12/21, 8/15/21, 8/28/21, and 9/16/21. By at least 7/26/21, he met criteria for referral to the PNMT. As discussed elsewhere in this report, the IDT did not refer him to the PNMT. The IDT also did not conduct necessary assessments, and/or analyze data to identify the cause(s) of his falls, and then develop and implement action plans to address them. For example:

- On 5/4/21, the PT completed a consult related to falls, and recommended that he continue to wear his insoles. The PT stated that the number of falls was less than the previous year. On 5/11/21, he was referred to the orthotic clinic. A related IPN stated that the individual would benefit from a more supportive shoe and the multi-density insoles. It was not until 9/20/21, that these were delivered in the clinic. They were to decrease blisters and provide a more comfortable fit (i.e., the PT made no reference to the support level and a correlation with falls).
- On 6/17/21, the IDT met to discuss his move to a different home. They stated it was a concern that he was still included in the weekly fall data with an increase in the number of falls over the last 30 days. Without further assessment or analysis, they stated that they did not recommend additional supports, because the recent falls were behaviorally related (i.e., "for attention").
- In an ISPA, dated 5/29/21, the IDT documented discussion of three or more falls with the most recent occurring on 6/23/21 (i.e., the IDT documented one or more of these dates incorrectly). The IDT stated they could not determine if there was a correlation between seizure activity and the increase in falls, but that the IDT did not believe there was a correlation with falls and his behavior. The IDT agreed to follow-up and prompt him to be careful when walking and running. The neurologist was to complete an ambulatory EEG.
- On 8/31/21, the IDT held an ISPA meeting in response to Incident Management Review Team (IMRT) recommendations related to an increase in falls over the last 30 days. The IDT discussed a possible pattern of falls, and his history of right leg weakness. They concluded that there was no correlation between seizures or behaviors and falls. He had a neurology appointment scheduled in September. The IDT agreed to continue to encourage him to use the hand rails in the home, and encourage daily exercises when waking and after resting. His current risk rating was medium for falls. The IDT determined that he did not need a high risk rating, because he had sustained only one injury (i.e., a two-inch laceration to his head on 8/28/21). The IDT's rationale for this decision was not clinically justified, given that his ongoing and unresolved falls placed him at high risk for injury.
- Despite ongoing falls, no further ISPAs were submitted, and those that were submitted did not show discussion of issues outlined in the PNMP, including right-leg weakness, twitches, and foot pain.

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 positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or not following presentation techniques) placed individuals at significant risk of harm. Based on observations, staff completed two of three transfers correctly. Center staff, 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 or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. These indicators will continue in active oversight.	

#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	60% 24/40	
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.	N/R	

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during 14 out of 25 observations (56%). Staff followed individuals' dining plans during eight out of 12 mealtime observations (67%). Staff completed transfers correctly during two out of three observations (67%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, it was good to see that texture/consistency was correct, adaptive equipment was correct, and staff and the individuals observed were positioned correctly at mealtimes. All of the errors related to staff not using correct techniques. Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, presented food too quickly, or did not follow specific presentation techniques. In one instance, staff were supposed to assist the individual using hand-over-hand assistance, but instead fed the individual. According to staff, the individual no longer participated in the self-feeding process. Review of the PNMP/Dining Plan and the individual's status/skills was needed.
- With regard to positioning, problems varied, but the most common problem was that individuals were not positioned correctly. During all of the observations, necessary adaptive equipment/supports were present, and with three exceptions, staff used the equipment correctly.
- For two of the three transfers observed, staff followed proper procedures. For the remaining transfer, staff did not complete the set-up correctly. Specifically, the gait belt was too loose for a safe transfer and for ambulation between the wheelchair and the dining chair.

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	436	844	704	451	143	896	108	689	635
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A					N/A				

Comments: a. None.

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

Summary: Most individuals reviewed did not have clinically relevant and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. OTs/PTs should work with QIDPs to make improvements. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 436	844	704	451	143	896	108	689	635
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	8% 1/13	0/1	N/A	0/4	0/1	0/1	0/1	1/2	0/2	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	8% 1/13	0/1		0/4	0/1	0/1	0/1	1/2	0/2	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/11	0/1		0/4	0/1	0/1	0/1	N/A	0/2	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11	0/1		0/4	0/1	0/1	0/1	N/A	0/2	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11	0/1		0/4	0/1	0/1	0/1	N/A	0/2	0/1

Comments: a. and b. Individual #844 did not have needs identified that would require OT/PT goals/objectives, but did require OT/PT-related supports and services (e.g., an active PNMP). The remaining individuals did have identified needs for formal OT/PT services and supports.

The goal/objective that was clinically relevant was for Individual #108 (i.e., ambulate 350 feet), but it was not measurable because it did not state criteria for achievement (e.g., ambulate 350 feet for four of six consecutive trials). Another goal/objective for Individual #108 (i.e., improve Berg Balance Score) was written in measurable terms, but it was not clinically relevant because there was no baseline data to show why she needed improvement in this area.

It was positive that Individual #108 had goals/objectives that were clinically relevant or measurable. However, her IDT did not integrate those into her ISPA/ISPA. With the exception of the IDT for Individual #704, for the remaining individuals who had goals/objectives, none of their IDTs integrated their individuals' goals/objectives into the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT approved the OT/PT goals/objectives, and was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan.

c. through e. For Individual #108, the relevant QIDP monthly reviews were outside of this monitoring period, so Monitoring Team could not evaluate whether the QIDP provided data and analysis for her goals/objectives. Individual #704 and Individual #689 also had at least one OT/PT-related goal/objective, but progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

The Monitoring Team conducted full reviews for all nine individuals. This included Individual #844 who did not have needs identified that would require OT/PT goals/objectives, but did require OT/PT–related supports and services.

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

Summary: For most individuals reviewed, needed measurable goals/objectives and actions steps were not included in their ISPs/ISPAs, and QIDP monthly integrated reviews did not consistently provide evidence that OT/PT supports were implemented. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	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.	N/A									

Comments: a. and b. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As described above with regard to Outcome 1, most of the goals/objectives were not measurable, and individuals' ISPs often did not include those strategies and action plans. As a result, data were not reflected in the QIDP monthly integrated progress reports. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

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

Summary: Fourteen of 20 individuals observed had assistive/adaptive equipment that appeared to be the proper fit. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. Of note, during observations, the Monitoring Team noticed that the	Individuals:

Center's performance had declined significantly with regard to maintaining individuals' assistive/adaptive equipment in proper working condition. Unless Center staff correct this concern, after the next review, Indicator b will return to active oversight. [**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."]											
#	Indicator	Overall Score	185	494	577	108	291	160	175	427	66
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category of requiring less oversight. However, due to a decline in performance, Indicator b is in jeopardy of returning to active 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.	70% 14/20	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		140	533	500	456	202	633	385	637	195
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/2	1/1	1/1	1/1	0/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		143								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: b. Indicator b has been in less oversight since after Round 11 of monitoring. However, during this review, problems were noted with the working condition of seven of the 20 pieces of adaptive equipment (i.e., adherence to the Settlement Agreement requirement was only 65%). If Center staff do not take steps to correct this concern, then after the next review, Indicator b will return to active oversight.

c. Based on observations of 20 pieces of assistive/adaptive equipment, many appeared to be the proper fit for the individuals. Exceptions included assistive/adaptive equipment for Individual #577, Individual #140, and Individual #533, for whom the outcome was that they were not positioned correctly in their wheelchairs. 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. In addition, three individuals did not have their assistive adaptive equipment available. The unavailable equipment was for Individual #533 (i.e., weighted vest), Individual #633 (i.e., foot brace), and Individual #385 (i.e., orthopedic shoes with custom insoles). In each instance, Center staff reported the individuals did not like the equipment and would not wear it. Center OT/PT staff should work with the IDTs to address this.

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, four indicators were in or were moved to the category of requiring less oversight. At this review, no other indicators will be moved 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.

In skill acquisition, one area for improvement is for the Center to take action when SAPs are not progressing.

About half of the SAPs met criteria for inclusion of all required components. Three-quarters of the individuals had their SAPs implemented as written. The errors in the others were primarily around the recording of the data about the individual's performance and the types of prompts that were used. About two-thirds of the SAPs had integrity data.

All of the individuals participated in community outings and many had SAPs conducted in the community. This was good to see. The Center needs to establish goals for these activities.

The Center had a good working relationship with the public school district. Some actions were needed by the Center, however, to meet monitoring criteria.

Center staff should review their protocol for the maintenance of hearing aids, given that a number were not in working order.

Of note, the Monitoring Team identified only a limited number of AAC supports for individuals living at the Center. While this is not entirely unexpected given the population the Center supports, the Monitoring Team's review of communication assessments raised some concerns about the sufficient evaluation of the need for communication supports.

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: Performance on all three indicators was about the same as at the last review. One area for improvement is for the Center to take action when SAPs are not progressing. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
6	The individual is progressing on his/her SAPs.	29% 7/24	2/3	0/3	2/3	0/3	0/1	1/2	1/3	1/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	75% 3/4				2/2			1/2		
8	If the individual was not making progress, actions were taken.	10% 1/10	0/1	0/1	0/1		0/1	1/1		0/2	0/3
9	(No longer scored)										

Comments:

6. Seven individuals' SAPs were scored as progressing (e.g., Chris's reading SAP). Ten individuals' SAPs were not progressing (e.g., Individual #620's fold pants SAP). Five individuals' SAPs were progressing, but scored as 0 because their data were not demonstrated to be reliable (e.g., Individual #844's fold towels SAP). Two SAPs had insufficient data to score, however, were scored as 0 because their data were not determined to be reliable (e.g., Individual #716's combine money SAP). Finally, two other SAPs had insufficient data to determine progress, and, therefore, were not scored for this indicator (e.g., Individual #436's write a letter SAP).

7. Individual #716's track his phone bill and use a calendar SAPs achieved one training step and were moved to the next step. Similarly, Individual #978's interview skills SAP mastered one step and was moved to the next training step. Individual #978's bicycle safety signs SAP was moved to the next step in April and again in June of 2021, however, the data suggested that he did not achieve his training objective prior to moving to the next step.

8. Individual #660's measuring SAP was not progressing, however, actions (i.e., modifying the SAP location and time) to address the lack of progress were documented. For the other nine SAPs that were not progressing, there was no action to address their lack of progress (e.g., Individual #620's math SAP). Mexia SSLC needs to ensure that decisions to continue, discontinue, or modify SAPs are data-based.

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

Summary: Again, about half of the SAPs met criteria for inclusion of all required components. Specific comments are provided below. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
13	The individual's SAPs are complete.	54% 14/26	2/3 29/30	2/3 27/28	2/3 26/28	3/3 30/30	0/3 26/30	1/2 17/20	0/3 26/30	1/3 26/28	3/3 29/29

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
number of components that were present for all of the SAPs chosen/available for review.

Fourteen of the SAPs (54%) were judged to be complete (e.g., Individual #672's interview skills SAP). All of the SAPs, however, contained the majority of these components. For example, at least 85% of the SAPs had a plan that included:

- a task analysis (when appropriate),
- behavioral objectives
- operational definitions of target behaviors
- 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

Regarding common missing components:

- Several multiple step SAPs that had objective training levels of independence included instructions for DSPs to verbally prompt the completion of each step. For example, Individual #436's microwave popcorn SAP established independence in microwaving his popcorn as the objective. The SAP training sheet, however, instructed staff to verbally prompt Individual #436 to complete each step (e.g., step 2 instructed staff to tell Individual #436 to now turn the dial on the microwave). Individual #436 can't be independent in this task if the instructions include verbal prompts.
- Another problem with several multiple step SAPs was that the desired amount of prompting on the untrained steps was not specified. For example, Individual #978's interview skills SAP instructed staff to start each session on step 1, and conduct the skill steps in order. There was, however, no instructions concerning the desired level of prompting (e.g., use the least intrusive prompts necessary) on the untrained steps.

Regarding other missing components:

- A few SAPs would benefit from operational definitions of the steps. For example the first step of Chris's create art SAP was that he write down an art theme. In order to ensure that staff are consistently implementing this SAP, an art theme should be operationally defined.
- There was a discrepancy between the number of problems established in the training objective section of the SAP training sheet and the task analysis (skill steps) section in Individual #640's make change SAP.
- Individual #978's identify bicycle safety signs SAP had an incomplete maintenance plan.
- The instruction for how to respond to an incorrect response in Chris's budgeting SAP, appeared to be related to a different SAP.

Outcome 5- SAPs are implemented with integrity.											
Summary: Three-quarters of the individuals had their SAPs implemented as written. The errors in the others were primarily around the recording of the data about the individual's performance and the types of prompts that were used. About two-thirds of the SAPs had integrity data. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
14	SAPs are implemented as written.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	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.	65% 17/26	3/3	0/3	3/3	0/3	2/3	2/2	1/3	3/3	3/3

Comments:

14. The Monitoring Team observed the implementation of nine SAPs. Individual #620's fold shirts SAP, Chris's reading SAP, Individual #640's reading SAP, Individual #660's measuring SAP, Individual #716's fill out a job application SAP, Individual #844's math SAP, and Individual #672's point to the correct car cleaning products SAPs were judged to be implemented as written and scored accurately.

Individual #978's label his music sheet SAP, and Individual #436's write a letter SAP, were implemented as written, however, they were recorded incorrectly. The DSP implementing Individual #436's write a letter SAP indicated that she will record the step as performed independently, however, she was observed to use several verbal and gestural prompts during the SAP. Similarly, the DSP implementing Individual #978's label his music SAP indicated that he required verbal cues to complete the task, however, she used several gestural cues on the training step.

Nevertheless, this represents an increase in the observed integrity of SAPs from the last review when 50% of SAPs were judged to be implemented as written and scored accurately, reflecting the overall improvement in the quality of skill acquisition plans at Mexia SSLC.

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%. Sixty-five percent of the SAPs had integrity checks.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Three-quarters of SAPs had a data-based monthly review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620

16	There is evidence that SAPs are reviewed monthly.	77% 20/26	3/3	3/3	3/3	2/3	3/3	2/2	1/3	3/3	0/3
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
16. The QIDP monthly reviews of many SAPs included a data-based review (e.g., Individual #640's budgeting SAP). Some SAPs, however, were not reviewed (e.g., Individual #978's bicycle safety signs SAP). Individual #620's review was last conducted in July 2021, and therefore was not judged to be completed monthly.

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

Summary: Indicator 18 scored higher than ever before. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620
18	The individual is meaningfully engaged in residential and treatment sites.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.										

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the review week. The Monitoring Team found all individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations), with the exception of Individual #620. This represents another improvement from the last review when 50% of the individuals were judged to be engaged.

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

Summary: All of the individuals participated in community outings and many had SAPs conducted in the community. This was good to see. The Center needs to establish goals for these activities, too, in order to meet criteria with these indicators. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 672	844	640	716	436	660	978	15	620

22	For the individual, goal frequencies of community recreational activities 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
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. All of the 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. It was encouraging to see that Individual #844, Individual #978, Individual #640, Individual #716, Individual #660, Individual #15 and Individual #620 all had SAPs conducted in community over the last six months. There were not, however, established goals for this activity. Mexia SSLC should establish a goal frequency of SAP training in the community for each individual, and demonstrate that the goal is achieved.

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

Summary: This indicator will remain in active monitoring. The Center had a good working relationship with the public school district. Some actions were needed by the Center, however, to meet criteria with this indicator. It will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	672	844	640	716	436	660	978	15	620
25	The student receives educational services that are integrated with the ISP.	0% 0/1			0/1						

Comments:
25. Individual #640 was under 22 years of age and attended public school at the time of the remote review. His ISP and ISPAs indicated that his educational services were not integrated into his ISP.

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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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: Substantial work is still required to provide individuals with clinically relevant and measurable goals/objectives to meet their communication needs. SLP assessments often lacked recommendations to assist teams to develop supports and services to expand individuals' communications skills. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/4	N/A	N/A	N/A	0/1	0/1	N/A	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/4				0/1	0/1		0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/4				0/1	0/1		0/1	0/1	
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/4				0/1	0/1		0/1	0/1	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/4				0/1	0/1		0/1	0/1	

Comments: a. through e. Based on the documentation submitted, Individual #436, Individual #844, Individual #704, Individual #896, and Individual #635 had functional communication skills, and did not require formal communication goals/objectives. None of the remaining four applicable individuals reviewed had goals/objectives related to communication included in their ISPs that were clinically relevant to their needs and/or measurable, but they should have.

c. through e. For the two applicable individuals who had a goal/objective (i.e., Individual #143 and Individual #108), QIDP monthly integrated progress reviews, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

The Monitoring Team completed full reviews for all nine individuals. This included Individual #436, Individual #844, who had functional communication skills and did not require formal communication goals/objectives, but the Monitoring Team selected them for a full review. The Monitoring Team also completed full reviews for other individuals with functional communication skills, including

Individual #708, who was newly admitted, Individual #896, who had communication strategies detailed in his ISP, and Individual #635, who part of the core group.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: Most applicable individuals reviewed did not have measurable strategies and action plans included in the ISPs/ISPAs related to communication. To move forward, QIDPs and SLPs should work together to make improvements with regard to the inclusion of strategies in ISPs, and to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	436	844	704	451	143	896	108	689	635
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. and b. As indicated in the audit tool, the Monitoring Team reviews the ISP integrated reviews to determine whether or not the IDTs implemented any measurable strategies related to communication needs. As described above with regard to Outcome 1, for the individuals reviewed who had needs for formal communication supports, their ISPs/ISPAs did not include measurable strategies. SLPs should work with IDTs to ensure that assessments include recommendations for measurable strategies and action plan for the IDTs to consider, and that resulting goals/objectives meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.											

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 Monitoring Team identified only a limited number of AAC supports for individuals living at Mexia SSLC. Assessments sometimes did not show that the SLPs thoroughly evaluated the individuals' potential to benefit from AAC supports. For those who did have AAC supports, SLPs needed to continue to work with direct support professional staff and their supervisors to ensure individuals have their AAC devices readily available and in working order for functional use. In particular, Center staff should review their protocol for maintenance of hearing aids. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	617	622	651	713					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	40% 2/5	1/2	1/1	0/1	0/1					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	25% 1/4	0/1	1/1	0/1	0/1					
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.	N/R									

Comments: a. and b. Based on observations, three of the four individuals reviewed did not have ready access to needed AAC devices for functional use. The hearing aids for Individual #617, Individual #651, and Individual #713 were not in working order. Of note, for the Individual #622, his hearing aids were functioning, but were broken and had to be taped for use. Overall, Center staff should review their protocol for maintenance of hearing aids.

Of note, the Monitoring Team identified only a limited number of AAC supports for individuals living at Mexia SSLC. While this is not entirely unexpected given the population the Center supports, the Monitoring Team's review of communication assessments raised some concerns about the sufficient evaluation of the need for communication supports. In some cases, the SLPs referenced previous attempts to provide AAC, but they generally did not provide specific data to justify that these were not successful. Clear documentation of assessment, history of previous use, and, in some cases, trials are necessary to determine if an individual would benefit from AAC supports beyond communication dictionaries and strategies.

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, four of these indicators were in 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.

The Center continued to transition individuals to the community at a rapid pace, with approximately 27 such transitions having occurred since the last review in January 2021. This was a tremendous effort on the part of the Center as a whole and by the transition staff.

Center staff continued to make videos of pre-move trainings for providers. The videos appeared to be useful tools for provider staff to have available, for new provider staff training, as well as refresher training for existing provider staff. In particular, the video prepared by the home manager for one of the individuals was very effective.

The Monitoring Team observed, remotely, a PMM visit for one of the individuals. While remote participation tends to limit how well the Monitoring Team can assess the thoroughness of the PMM's review, overall, the PMM was methodical, covering every support. It was very positive to see the PMM use role-play as a strategy for testing the continued competency of provide staff.

Center staff continued to refine how they ensured a transition between the Center's PBSP to the community PBSP. For one individual, it was good to see the IDT laid out a methodical process for a collaborative effort between the Center and community BCBAs, including a review of the community interim PBSP by the Center BCBA.

The adequacy and measurability of pre-move provider staff training supports continued to vary. While the pre-move training supports included much detailed information about the individuals' needs in the areas of nursing, behavioral health, nutrition and social, it was not clear if Center staff intended this information to be the competency criteria. The training videos for one of the individuals did not include all of the details listed in the corresponding pre-move supports. Similarly, the pre-move competency testing quizzes did not address many of the requirements listed in the pre-move supports.

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: Many individuals transitioned from Mexia SSLC during the review period and there were many improvements in the transition planning (CLDPs) as	Individuals:

evidenced in the review of the CLDPs for two individuals. As indicated below, more work is needed to meet substantial compliance with these indicators. They will remain in active monitoring.											
#	Indicator	Overall Score	177	845							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Twenty-seven individuals transitioned from the Center to the community since the last review. It was impressive to see this high number of individuals the Center had assisted to transition to community living during the past year, especially with the continued limitations and restrictions of COVID-19. This was a tremendous effort on the part of the Center as a whole and by the transition staff. Two of the 27 transitions were included in this review (Individual #177, Individual #845). 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. The Monitoring Team continued to be impressed with the hard work and thoughtful approaches on the part of the transition staff, especially in light of the high volume of transitions occurring at the Center.

1. Overall, this indicator did not meet criterion. 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. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 12 pre-move supports for Individual #177 and 17 pre-move supports for Individual #845. Some pre-move supports detailed actions the Center or provider would need to take to ensure needed items were delivered to the provider. These were typically measurable. Otherwise, the majority of pre-move supports addressed training for provider staff and other information-sharing with the provider. In order to be measurable, pre-move training supports need to 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, and should also define the provider staff competencies to be achieved and how those will be reliably measured. The following comments are with regard to measurability:
    - For these two CLDPs, pre-move training supports typically described who would be trained and who would do the training, and stated the topics of training. In addition, most of the pre-move training supports (i.e., behavioral health, nursing, social and nutrition) included extensive detail with regard to the specific content of the training. The following further describes progress noted and areas for continued improvement:

- Center staff continued to make videos of pre-move trainings for providers. Overall, while improvements to the process were still needed, the videos appeared to be useful tools for provider staff to have available, for new provider staff training, as well as refresher training for existing provider staff. In particular, the video prepared by the home manager for one of the individuals was very effective. However, as described further below, the videos did not address all of the details in the pre-move training videos.
- Overall, the thoroughness of competency testing was improved, but, as described further below, still did not address all competency criteria or all important needs.
- It was positive the IDTs provided specific details with regard to training content, but still needed to clarify if this information constituted the specific competency criteria that provider staff would need to achieve. As noted above, competency criteria should spell out the important things provider staff will need to know and know how to do in order to demonstrate they are sufficiently competent to meet an individual's needs. As such, the IDTs need to carefully consider these criteria and then construct both training and competency testing that address those criteria. For example, as indicated for both these individuals, if the IDT determines that provider staff must show competence with all aspects of the current positive behavior support plan (PBSP), then the training and competency testing must address all those aspects. Similarly, because the nutrition pre-move training supports for these individuals stated that provider staff would receive training that included, among other things, potential food/medication interactions, and listed those in the supports, it appeared these were considered competency criteria that provide staff must know. If so, then there needed to be a corresponding means to test provider staff knowledge competency. Overall, based on review of the competency training videos and the competency testing instruments, the training videos did not consistently cover all of the information listed in the supports and the competency quizzes did not cover all of the material in the training videos provided for review. Center staff should review the pre-move supports for these two individuals and consider how they might be made more concise, but still cover the important things provider staff would need to know and know how to do.
- It was very positive that the pre-move support for Individual #177 included a description of his forensic history, but it was not clear that it would be important for provider staff to know the specific juvenile detention center he was taken to at one point or the type of admission category when he arrived at Mexia SSLC. The description of his forensic history might have been more effective, and more conducive to competency testing, if it had summarized key points. An example of such a summary follows: "Between 2007 through 2010, his history included throwing rocks and other items, resulting in property damage; and, physically assaulting children and his grandmother, at times causing significant bodily injury. These incidents led to criminal charges of assault and criminal mischief and resulted in probation. As a result of his physical aggression toward children, in particular, provider staff must know that the individual should never be left alone with anyone under 25 and never supervise children." In addition, the behavioral health pre-move training video did not include the historical material, although it appeared the social pre-move training covered some of it. Other than to ask why he was admitted to the Center (i.e., assault and bodily injury), the competency quiz did not address provider staff knowledge of some important details of the forensic/behavioral training (e.g., history of aggression toward children and need for supervision around them.).

        - For Individual #845, the training covered the requirements of the Center's PBSP, and the competency quiz provided for review covered these requirements in some detail. However, at the time of his transition, this PBSP had been replaced by the community interim version, which, upon review, relied on a number of different strategies. It therefore seemed potentially confusing to train provider staff on the Center's strategies. In addition, it was unclear how provider staff were trained on the behavioral strategies they were to actually use or how their competency was assessed. The PMM only documented receiving signature sheets at the time of the pre-move site review (PMSR).
- Post-Move: The respective IDTs developed 43 post-move supports for Individual #177 and 49 post-move supports for Individual #845. Many post-move supports were measurable, but this was not the case for all. Examples included, but were not limited to, the following:
    - For both CLDPs, the primary post-move supports that did not meet criterion were those for training and competency testing for any new staff. These supports again did not provide for adequate competency testing.
    - For Individual #177, a post-move support called for the provider to take him to the nearest emergency center or to call 911 for any psychiatric emergency, including "deterioration of psychiatric condition." Further, pre-move training did not address his psychiatric symptoms or what might constitute deterioration. From a reading of the CLDP narrative, it appeared the IDT had a meaningful discussion about this, but the information was not captured in the support. Individual #845 had a similar support, but it did not provide any criteria to define what would constitute a psychiatric emergency.
    - A post-move support for Individual #845 indicated he would take a phone card with him on the day of move, but did not specify an expectation for how much money should be loaded onto it. Another support called for provider staff to prompt him to brush his teeth, but did not indicate how many times provider staff should do that in a day.

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:
    - As described above, Individual #177's pre-move training support included a specific description of his forensic, behavioral and psychiatric history, which was positive, but did not specify any of the successful strategies to address them.

      Individual #845's pre-move support indicated his forensic behavioral history was to be included, but the support did not provide any specific information. However, according to the social training provided, from 2016-2017, Individual #845's criminal history included assault on a public servant, obstruction and retaliation, and family violence and assault. He had a history of severe aggression towards family members and others that included kicking, hitting, and attempting to stab others. His challenging behaviors included unauthorized departure, physical aggression, verbal threats, screams, yells, and throwing things. Prior to his admission to the Center, it was noted that Individual #845 entered his peers' bedroom and got in their bed naked. During a November 2014 hospitalization, he was reported to have inappropriately touched a male peer. While it was positive the pre-move training included these details, the

competency testing did not address provider staff knowledge of any of these concerns. Also, the historical information was not specifically included in a post-move support for training of the staff at his public school setting.

- For Individual #845, it was positive that pre-move supports outlined a series of steps for development and implementation of an interim PBSP, including obtaining the community PBSP for the Center BCBA to review for the purpose of identifying and discussing any concerns that might need to be brought to the attention of the community behavioral provider. However, the CLDP did not include any post-move supports for the PMM to probe provider staff knowledge during or to review behavioral data to determine if there were any problem areas. In other words, even when the provider has taken primary responsibility for the design and implementation of an individual's PBSP, it is still incumbent on the Center to continue to track and evaluate provider staff knowledge and implementation, as well as the individual's adjustment and any related concerns.
- For Individual #845, the behavioral health assessment indicated that counseling should be offered in the community and should focus not only on discussing and managing any difficulties with the transition or anything that might be different or less desirable than he expected, but also identifying situations that might contribute to a high risk for re-offending and develop strategies to avoid or cope in such situations. The CLDP did include a post-move support for counseling, but it did not provide information about these important criteria.

- 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 supports in these areas that were both clear and comprehensive. The following provides examples:
  - Neither individual had a post-move support that addressed their supervision needs in a comprehensive manner. Based on Individual #177's 14-day ISPA, the IDT noted his history of aggression toward children and indicated he should never be left alone with anyone under 25 and could never supervise children. The ISPA further documented that the provider would need to in-service anyone who might supervise him vising about these requirements. The CLDP post-move support for supervision did not provide this information. Similarly, for Individual #845, the 14-day ISPA indicated the IDT recommended that provider staff should perform bathroom sweeps in the community for the first 90 days after transition, but the CLDP did not include this in the supervision support or document why it was no longer needed.
  - Both individuals had medication side effects, as well as signs and symptoms of health conditions that required direct support staff to monitor and report to nursing, but the CLDP did not include specific supports for these requirements.
  - Both individuals had needs for nurse monitoring of health conditions, but the CLDP did not include these supports.
  - For Individual #845, who had numerous allergies that could result in anaphylaxis, the CLDP did not include pre or post-move supports that required provider staff to show competency for when and how to use his epi-pens. Instead, the CLDP included a support for him to take three pens with him when he transitioned. Based on this construction, the PMM reviewed this support at the time of the seven-day PMM visit, but thereafter considered it completed and no longer in need of monitoring.
  - For Individual #845, the IDT held an ISPA on 3/29/21 to complete a fall review, after three falls in 30 days. The IDT indicated his falls appeared to be sports related and that he needed to make sure that he is wearing appropriate

footwear that it is tied snugly during sports, as well as to take a break if he gets too excited during a game. The CLDP did not include related pre- or post-move supports.

- 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. IDTs identified increasing independence as the primary outcome for both individuals. Overall, there were some supports for increasing independence (i.e., skill acquisition plans) in these two CLDPs, but these were limited and sometimes not measurable. In addition, based on a review of the ISP and other documentation, the IDTs had worked with the individuals to identify personal goals that would be very appropriate for implementation in a community setting, but the CLDPs did not address them. For example, Individual #177 hoped to complete his high school diploma, while Individual #845 aspired to become a mechanic.

- Need/desire for employment, and/or other meaningful day activities: As described below, neither CLDP met criterion. The following describes findings noted:
  - Individual #177 wanted to find community employment (i.e., preferably in a veterinarian hospital or as a stocker in a retail store). The CLDP included post-supports calling for him to apply for a job with the provider within 30 days and to be working with the provider (i.e., on the road crew or lawn crew) within 30 days. As a result of the provider indicating they could offer the individual employment, the IDT decided not to include a recommended post-move support for referral to the Texas Workforce Commission (TWC). As discussed in interview, Center staff should have considered Individual #177's stated work preferences and his longer term goal of increased independence, and provided him with the opportunity for continued job exploration and, possibly, integrated employment. Overall, the CLDP did not contain post-move supports that required meaningful day activities in integrated environments. Individual #177 had one related post-move support, calling for him to engage in monthly leisure activities.
  - Individual #845 was attending public school, which was positive. However, his CLDP contained limited post-move supports for meaningful day activities in integrated environments (i.e., leisure activities monthly and attendance at one Dallas Cowboys within a year of transition).

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: The CLDP for Individual #177 included a post-move support with specific reinforcement strategies and met criterion. However, for Individual #845 the CLDP did not have any specific post-move supports in this area and did not meet criterion.

- Teaching, maintenance, participation, and acquisition of specific skills: It was positive that both CLDPs addressed supports in this area, including skill acquisition needs included in their ISPs and/or Functional Skills Assessments (FSAs). Both CLDPs met criterion. However, going forward, to maintain compliance, the Center will need to provide measurable expectations about the frequency of training.
  - For Individual #177, the CLDP included a support that broadly called for him to have training his area of need within 45 days of his move. It was positive that the support referenced specific possible training needs, as identified in his

FSA (e.g., budgeting, checking/savings account use, job-seeking skills, etc.). However, the support did not cite expectations for how often he should receive training or that it should be ongoing.
    - Individual #845's FSA indicated he had needs in the areas of meal prep, budgeting, reading, math and combining coins and bills to make a purchase, and meal preparation, among other things, and that he received training on skill acquisition plans (SAPs) in budgeting, reading and meal preparation. His IDT developed a post-move support calling for him to work on reading and money skills within three months. However, while the support indicated it would be ongoing monthly, it did not provide any expectations for frequency of training.

- 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 and measurability. Still for this review, the IDTs did not yet address all recommendations with supports or otherwise adequately justify why they did not do so. The following describes examples:
    - As described above for Individual #177, despite his elevated dental risk, the IDT deleted the recommendation in the dental discharge assessment for provider staff to prompt tooth brushing, and indicated all parties agreed to the change. However, the signature roster indicated that no dental staff participated in the CLDP meeting and the IDT did not document they verified that dental staff supported this change.
    - In some cases, it appeared the IDTs discussed and agreed upon assessment recommendations, but failed to include them in the final recommendations and CLDP supports. For example, for Individual #845, the IDT discussed the need for appropriate footwear with snugly-tied shoelaces during sports activities (i.e., as described above in this section), but the final recommendations and post-move supports only referenced the need for bilateral custom insoles.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: Post move monitoring was occurring as needed and a lot of information was assessed and recorded regarding the status of supports. As noted below, although these were improvements, some gaps remained in the documentation of post move monitoring. During observation by the Monitoring Team, post move monitoring addressed each support, including asking for role-play demonstration. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	845							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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	0% 0/2	0/1	0/1							

	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.										
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.	100% 1/1	1/1								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	1/1								

Comments:

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, and as described with regard to Outcome 1 above, 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 provider staff knowledge supports often specified competency criteria the PMM needed to be able to accurately collect reliable and valid data, which was positive. However, the adequacy and measurability of these supports continued to vary. While they included extensive detailed information about the individuals' needs in the areas of nursing, behavioral health, nutrition, and social, it was not clear if Center staff intended this information to be the competency criteria. In some instances, it appeared there might be opportunities to provide some of the information in a more concise fashion, which could, in turn, assist the PMM to focus the monitoring process.
- While the PMM often provided comments that were succinct and thorough, which was positive, there was a need to continue to focus on ensuring comments included sufficient detail or relevant evidence that provider staff were fully knowledgeable of individuals' needs and that supports had been provided as required. Examples included:
  - It was positive the Post-Move Monitor documented interviews with provider staff to probe their knowledge and competency for various supports, but still needed to consistently provide additional detail to clearly show that these probes addressed the requirements for each support. In many instances, the PMM's comments were limited to stating that the staff could answer questions or that they were able to demonstrate competency. There was no further description of the evidence obtained to substantiate that finding. In other words, the comment was essentially a reiteration of the finding that the support was met, but provided no actual data with regard to the specific criteria listed in each support.
  - In a related vein, the CLDP included many supports with extensive criteria, but the PMM often did not comment on all of the requirements, instead relying on the broad statements described above.
- The post-move supports did not consistently specify that the PMM should ensure the collection of valid and reliable data by reviewing more than one type of evidence. As the Monitoring Team has discussed with transition staff in the past, the IDT

should consider three prongs of evidence, including documentation, staff and individual interviews and observations, and include at least two whenever possible. There continued to be a number of instances for which the IDT only specified one form of evidence, when additional verification was both needed and feasible to complete. For example, for both individuals, several nursing supports only required nursing documentation, but should have also required interviews with nursing staff. Similarly, for Individual #177's post-move support for training objectives, the PMM did not document reviewing any documentation, instead relying on interviews to attest to implementation.

5. As described above with regard to Indicator 4, as well as for Indicator 6 below, the Monitoring Team sometimes could not evaluate or confirm whether either individual had received supports due to the lack of clarity and measurability in the supports as written and/or a lack of reliable and valid evidence that demonstrated whether supports were in place as required.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still exceptions in which the evidence provided did not clearly substantiate the finding, due to a lack of valid and reliable data. In other words, as described above in Indicator #4, the PMM often marked staff knowledge supports as in place, but provided no factual data to support those conclusions.

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. Without that data, the Monitoring Team could not reliably determine whether follow-up activity is needed. The following provides examples of additional findings:

- For Individual #845, the 45-day PMM Checklist indicated he had not seen the pulmonologist as needed. On 9/14/21, the PMM documented that the IDT would need to meet. However, the Center did not submit any post-move ISPA to show this occurred.
- Individual #845's CLDP included a post-move support for provider staff to provide behavioral training to the staff at his public school during the transfer Admission, Review and Dismissal meeting (ARD). At the time of the seven-day PMM visit on 8/10/21, the PMM marked the support as not applicable, because he had not yet started attending school. Further, the comment indicated he was scheduled to start school on 8/16/21. On 9/14/21, at the time if the 45-day PMM visit, the PMM noted that he had begun attending school, but did not provide the date. The PMM again marked the support for behavioral training for school staff as not applicable because the transfer ARD had not been held. However, given that the individual had already started school, and perhaps as much as a month earlier, in practicality, this essential training was long overdue. The PMM should have brought this to the attention of all parties so that the training could be provided as soon as possible. Of note, it was also unclear why the transfer ARD had not yet occurred or when it would be scheduled. This was also a matter requiring follow-up.

9-10. During this review, the Monitoring Team participated remotely in Individual #177's 180-day PMM visit and, while remote participation tends to limit how well the Monitoring Team can assess the thoroughness of the PMM's review, overall, a number of positive practices were observed. For example, the PMM was methodical, going through each post-move support one by one. He

separately interviewed the individual and then the staff member. It was also very positive to see the PMM use role-play as a strategy for testing the continued competency of provide staff. The report was consistent with what the Monitoring Team observed.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: Neither individual experienced a negative event since transition. As a result of sustained high performance on this indicator, it will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	177	845								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1								
Comments: 11. Individual #177 did not experience a PDCT event. Individual #845 changed homes due to a desire to live with a friend, but this was not a negative event. Of note, the APC indicated there had been an increase in PDCT events over the past ten months. This appeared to be accurate, based on documentation provided in response to the Monitor's Tier I document request, which showed PDCT events for five individuals during that timeframe. It was very positive to hear, though, that the APC's office was approaching this as a formal quality improvement need and would be presenting the data to the QA/QI Council in November 2021.												

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: Progress was seen in all indicators. Some was reflected in the higher scoring. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	177	845								
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	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										

	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.										
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.	50% 1/2	1/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	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.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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 yet consistently meet criterion for this indicator, but some progress was noted. It was good to hear that transition staff had been continuing to provide training to disciplines about the expectations for discipline transition assessments, with a goal of improving pre-move training and provider competency testing. Some of the early steps in this effort had focused on training for nursing, nutrition, and behavioral health staff. Based on the findings for Indicator 1 above, this had resulted in progress with regard to defining the needed competency criteria provider staff needed to achieve. The Monitoring Team considers the following four sub-indicators when evaluating compliance. Findings for each of these are provided below:

- Assessments updated within 45 Days of transition: Most assessments provided for review met criterion for timeliness. The sole exception was for Individual #845, for whom the IDT did not provide a current social assessment with 45 days of transition. The document provided was dated 1/15/21, but the transition occurred on 8/5/21.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Overall, it appeared that discipline assessments provided a summary of relevant facts in the available assessments, which was positive.
- 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: As noted at the time of the last monitoring visit, it will be important for the Center as a whole to prioritize work toward improving discharge assessment content and recommendations. In particular, each discipline should describe the pre-

move training that needs to take place, including the competency criteria and how competency need to be measured. Transition staff can assist the IDT members, but must rely on them, as the people who best know the individual's needs, to develop comprehensive supports. It was positive to see that several disciplines had begun to include recommendations for pre-move training, but most of these continued to need work, especially in terms of appropriately defining competency criteria. In addition, assessments generally did not provide recommendations that could be used to promote community participation and integration for either individual.

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: While progress was noted, 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, safety and behavioral needs, on the first day of transition. The following summarizes progress, as well as areas for continued improvement:

- As described with regard to Indicator 1 above, Center staff continued to make videos of pre-move trainings for providers. Overall, while improvements to the process were still needed, the videos appeared to be useful tools for provider staff to have available for new provider staff training, as well as refresher training for existing provider staff. In particular, the video prepared by the home manager for one of the individuals was very effective. However, the videos did not consistently cover all important needs.
- The IDTs made some progress in identifying the expected provider staff knowledge and competencies, which was positive, but continued improvement was needed. In particular, IDTs needed to carefully consider, for each area of need, what the important things provider staff would need to know and know how to do in order to demonstrate they are sufficiently competent to meet an individual's needs, and what might be extraneous or of little consequence in meeting the individual's 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. While improved overall, competency testing instruments submitted for review did not yet clearly document provider staff had knowledge of all essential supports based on each individual's needs. The Center provided evidence consisting of written quizzes that did not cover many of the individuals' important needs and/or all the criteria referenced in the pre-move training supports.

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 previously, the Center had initiated a standard protocol for requiring a support for nurse-to-nurse collaboration for all transitions, which was a positive practice. Both 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 collaboration included a list of broad topics to be covered (e.g., 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 progress notes in IRIS for the nurse-to-nurse consultations for both individuals and found these provided sufficient specific detail with regard to the individuals' needs. This was positive.

- For Individual #845, the CLDP called for a collaboration between the Center and community behavioral staff, and outlined a clear methodology for completing it (i.e., as described above with regard to Indicator 2). The PMM documentation indicated the collaboration was completed on 5/27/21 and the interim PBSP developed and reviewed by 6/10/21. However, the Center could not provide documentation to evidence any of this. Going forward, Center staff should ensure to maintain sufficient documentation to show the fulfillment of supports.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should include a specific statement in the CLDP, based on each individual's needs and preferences, whether any settings assessments are needed and/or describe any completed assessment of settings and the results. This indicator met criterion. For both individuals, Center staff documented that there were no needs foe settings assessments, but also noted that the IDTs had viewed the home, either in-person or remotely.

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 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. For both Individual #177 and Individual #845, the CLDPs did not specifically address this requirement. Instead, the narrative focused on the individuals' interaction with IDT and DSPs. However, based on review of the training videos prepared by the respective Center home managers, these provided an excellent opportunity for SSLC direct support staff to engage with community provider staff. Both CLDPs met criterion, however, going forward the IDTs should include a pertinent statement describing how the SSLC and community provider staff should interact to meet an individual's needs and preferences, and describe how this was accomplished.

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 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. Because the training videos and competency quizzes did not cover all of the requirements listed in the supports and/or evidenced in the assessments, reliance on those quizzes was not enough to demonstrate provider staff had all the knowledge and skills they needed to meet the individual's needs. In addition, while Center staff completed some documentation to show that they asked staff questions related to Individual #177's needs, they only relied on the signed competency quizzes for Individual #845. For example, Center staff did not document any evidence to show that provider staff for Individual #845 knew to limit conversation and discourage talking during meals. This approach did not ensure the Center could be sure the provider staff had all required competencies and knowledge.

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 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