United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: June 12-16, 2017

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

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

Status of Compliance with the Settlement Agreement

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

This domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. At the last review, 14 of these indicators were moved to the category of requiring less oversight. During this review, two other indicators sustained high performance scores and will be moved to the category of requiring less oversight. These were in incident management.

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

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

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

Restraint

Overall, there was very good management of crisis intervention restraint at Richmond SSLC. The director of behavioral health services and the facility's restraint manager worked very well together to this end. The facility had an active restraint review program that included regular quarterly presentations to the QAQI Council. In addition, each month, the behavioral health services director and restraint manager convened a meeting to review any applications of crisis intervention horizontal physical restraint. This included watching video of the restraint application and discussing the incident.

The overall rate of crisis intervention usage showed a descending trend over this period and across the last three nine-month periods. There were few instances of crisis intervention chemical and mechanical restraints (mittens), one and three, respectively. The average duration of a crisis intervention physical restraint, however, had increased, to about six minutes. There was no use of protective mechanical restraint for self-injurious behavior. The facility was not, but should be, trending/graphing the data it already collected regarding the usage of pretreatment sedation, TIVA, and non-chemical restraints for medical and dental procedures.

Center staff are encouraged to continue to focus on the following areas with regard to nursing restraint monitoring: completing timely and complete assessments of individuals' vital signs and mental status, following up on abnormalities as needed, and clearly documenting whether or not restraint-related injuries occurred.

Abuse, Neglect, and Incident Management

Supports were in place to reduce the likelihood of the event occurring (or there was no history of prior occurrence) for all but one investigation. This was good to see, however, for the one exception, a serious error in systems management occurred resulting in injury/hospitalization to the individual. As a result of examining this investigation and as a result of other monitoring activities during the onsite week, the Monitoring Team found that Richmond SSLC needed to ensure that systems were in place to ensure that (a) post hospitalization medication order reconciliation is correct, and (b) outside consultations are handled correctly.

Required elements of a thorough investigation were present for all of these investigations though some did not take advantage of video camera recordings. Many DFPS investigations were not completed in a timely manner. Recommendations in investigations were related to findings in all cases, but implementation of these recommendations had decreased since the last review.

It was good to see that the Richmond SSLC quality review of investigations protocol was still in place, however, it did not detect a number of problems with a number of investigations. While onsite, the Monitoring Team learned that the incident management department had been understaffed over the past few months and that, moreover, some trained investigators at the facility were no longer employed there.

Other

There was some improvement in IDTs attending to pretreatment sedation needs of individuals. A few IDTs correctly reviewed the need and usage of pretreatment sedation. Likely, some individuals would benefit from some strategies, but none were developed and put into place.

In addition to needing to focus more on the specific goals of a Drug Utilization Evaluation (DUE), the Pharmacy and Therapeutics Committee needs to develop and implement plans of action to address the findings of DUEs. These issues have been raised in previous reports, and have not been corrected.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Overall, crisis intervention restraint was being managed at Richmond SSLC and the usage of crisis intervention restraint was decreasing. This was very	Individuals:

good to see. The facility had a strong, and varied, system for restraint review. The facility should be trending/graphing the data it already collected regarding the usage of pretreatment sedation, TIVA, and non-chemical restraints for medical and dental procedures. These two indicators will remain in active monitoring.											
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	77% 10/13	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (August 2016 through April 2017) were reviewed. During the week of the onsite review, the Monitoring Team learned that not all facilities were counting the frequency of crisis intervention physical restraint in the same manner. As a result, at this time, census-adjusted cross-facility comparisons of crisis intervention restraint, crisis intervention physical restraint, and average duration of a crisis intervention cannot be validly made and, therefore, won't be included in these comments.

Even so, trends within the Richmond SSLC across the last nine months can still be made. For instance, the overall rate of crisis intervention usage showed a descending trend over this period, though there was slight ascension during the last few months of the period, one worthy of continued attention by the restraint managers and behavioral health services director. That being said, when one looks at the overall rate of crisis intervention restraint across the last three nine-month periods, a descending trend is evident. Given that the majority of crisis intervention restraints were crisis intervention physical restraints, the trend of the latter parallels that of the former. The average duration of a crisis intervention physical restraint, however, had increased, to about six minutes. There were few instances of crisis intervention chemical and mechanical restraints, one and three, respectively. Crisis intervention mechanical restraints were the use of mittens for one individual. There was no use of protective mechanical restraint for self-injurious behavior (PMR-SIB) and there were no instances of PMR-SIB having been moved to a medical restraint classification.

The number of injuries that occurred during crisis intervention restraint was low, that is, there were two non-serious injuries. The number of individuals for whom crisis intervention restraint was implemented was stable for this review period, at about five individuals per month during this period. At the time of the last review, it was about nine individuals per month.

The facility kept track of the use of non-chemical restraints for medical and dental procedures, as well as for pretreatment sedation for medical and dental procedures, and TIVA for dental procedures. The facility, however, did not trend this information to determine if using was increasing, decreasing, or stable. Similarly, the Monitoring Team could not determine a trend. Perhaps this information could be trended, graphed, and included in the facility's restraint review QA program.

Thus, facility data showed low/zero usage and/or decreases in seven of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; restraint-related injuries; number of

individuals who had crisis intervention restraint; and use of PMR-SIB).

The facility had an active restraint review program that included regular quarterly presentations to the QAQI Council. In addition, each month, the behavioral health services director and restraint manager convened a meeting to review any applications of crisis intervention horizontal physical restraint. The review included the playing of any available video of the restraint, completion of a video review checklist (signed by those in attendance), and discussion. Attendance included relevant members of the individual's IDT, a CTD PMAB trainer, and a security department video specialist. The Monitoring Team attended this meeting and observed very good discussion, including regarding follow-up actions and how they would be tracked.

The Monitoring Team also attended a number of morning unit meetings. At one, for Four Rivers, there was discussion of a crisis intervention restraint that occurred the previous day. There was relevant presentation of what happened and the staff's response. There was good dialogue among team members.

2. Three of the individuals selected for review by the Monitoring Team were subject to restraint. The Monitoring Team also reviewed a restraint for each of four additional individuals. Of these seven individuals, five received crisis intervention physical restraints (Individual #787, Individual #54, Individual #15, Individual #475, Individual #795), one received crisis intervention chemical restraint (Individual #447), and received crisis intervention mechanical restraint (Individual #542). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the seven (Individual #447, Individual #475, Individual #542, Individual #795). The other six individuals selected by the Monitoring Team had no restraints making a total of 10 of the 13 individuals meeting the criteria for this indicator.

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

Summary: All indicators rose to 100% scoring. With sustained high performance, they might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	787	447	54	15	475	542	795		
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
8	There was no evidence that the restraint was used for punishment or	Due to the Center's sustained performance, this indicator was moved to the									

	for the convenience of staff.	category of requiring less oversight.									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	100% 3/3	1/1	Not rated	1/1	1/1	Not rated	Not rated	Not rated		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for seven different individuals (Individual #787, Individual #447, Individual #54, Individual #15, Individual #475, Individual #542, Individual #795). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a crisis intervention mechanical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was not scored for them.

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

Summary: All of the questions asked by the Monitoring Team were answered correctly, except for some staff who did not identify the prohibition against prone restraint. This indicator will remain in active monitoring.		Individuals:									
#	Indicator	Overall Score	787	447	54	15	475	542	795		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	67% 2/3	0/1	Not rated	1/1	1/1	Not rated	Not rated	Not rated		

Comments:
12. Because criteria for indicators 2 through 11 were met for four individuals, this indicator was not scored for them. Two of Individual #787's staff did not identify prone restraint as a prohibited restraint.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Summary: Restraint monitoring and documentation occurred and met criteria for all cases except one late arrival of a restraint monitor. The infrequent occurrence of a lengthy restraint (in this case mechanical/mittens) had correct implementation of the criteria for indicator 14. Both indicators will remain in active monitoring, but	Individuals:

with sustained high performance, might be moved to the category of requiring less oversight after the next review.											
#	Indicator	Overall Score	787	447	54	15	475	542	795		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	86% 6/7	1/1	0/1	1/1	1/1	1/1	1/1	1/1		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A		
Comments: 13. For Individual #447 1/14/17, the restraint monitor arrived late, at about 40 minutes.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Center staff are encouraged to continue to focus on the following areas with regard to nursing restraint monitoring: completing timely and complete assessments of individuals' vital signs and mental status, following up on abnormalities as needed, and clearly documenting whether or not restraint-related injuries occurred. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	787	447	54	15	475	542	795		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	43% 3/7	0/1	0/1	0/1	1/1	1/1	1/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	71% 5/7	1/1	0/1	0/1	1/1	1/1	1/1	1/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	57% 4/7	0/1	0/1	0/1	1/1	1/1	1/1	1/1		
Comments: The restraints reviewed included those for: Individual #787 on 2/28/17 at 10:28 a.m., Individual #447 on 1/14/17 at 10:41 p.m. (chemical), Individual #54 on 4/22/17 at 12:50 a.m., Individual #15 at 4/27/17 at 11:50 a.m., Individual #475 on 1/9/17 at 8:08 a.m., Individual #542 on 4/18/17 at 4:35 p.m. (mechanical), and Individual #795 on 3/8/17 at 4:11 p.m. a. For three of the seven crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint, including those for Individual #15 at 4/27/17 at 11:50 a.m., Individual #475 on 1/9/17 at 8:08 a.m., and Individual #542 on 4/18/17 at 4:35 p.m.											

For five of the seven restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- For Individual #787's restraint on 2/28/17 at 10:28 a.m., an LVN's IPN, dated 2/28/17, indicated the individual was not assessed within 30 minutes of the initial restraint. The note was not clear regarding exactly what time the individual was assessed. The IPN indicated the individual refused vital signs, but the flowsheet indicated that a set of vital signs was taken at 12:30 p.m. IPNs need to be clear in stating the time that assessments/care was provided.
- For Individual #447's chemical restraint on 1/14/17 at 10:41 p.m., no IPN was provided for the day of the restraint that noted that this individual received a chemical restraint consisting of Haldol 10 milligrams (mg) by mouth (PO) and Ativan 2 mg PO. An LVN's IPN, dated 1/15/17 at 2:07 a.m., appeared to relate to the chemical restraint on 1/14/17, but was not documented as a late entry. Moreover, the IPN did not describe the individual's behavior while taking the oral chemical restraint, and no follow-up IPNs were provided indicating that the individual was monitored consistent with applicable standards. In addition, no PCP order was found for the chemical restraints. Of major concern, the documentation provided was not clear regarding what time these medications were given (i.e., either on 1/14/17 at 10:41 p.m. or on 1/15/17 at 12:52 a.m.). Although it appeared that vital signs were documented, it was not clear which nurse obtained them (e.g., the LVN who wrote the IPN on 1/15/17).

Nursing staff documented and monitored mental status of the individuals for five of the seven restraints. The exceptions were for: Individual #447 on 1/14/17 at 10:41 p.m. (chemical), and Individual #54 on 4/22/17 at 12:50 a.m.

b. For Individual #447 on 1/14/17 at 10:41 p.m. (chemical), and Individual #54 on 4/22/17 at 12:50 a.m., clear documentation was not provided regarding injuries or the lack thereof.

- For Individual #447, there was no indication whether or not the individual sustained any restraint-related injuries.
- For Individual #54, the IPN noted: "bilateral forearm is reopened scab with no active bleeding." It was unclear what "bilateral" refers to or if the injury happened during the restraint procedure.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary:			Individuals:									
#	Indicator	Overall Score										
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. Both will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	787	447	54	15	475	542	795			

16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 5/5	1/1	1/1	1/1	1/1	N/A	1/1	N/A		
Comments:											

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
Summary: These indicators did not meet criteria and will remain in active monitoring. Given the low usage of crisis intervention chemical restraint at Richmond SSLC, the facility should consider including these indicators in the restraint review committee/processes that are managed by the behavioral health services department and the QAQI program.			Individuals:								
#	Indicator	Overall Score	447								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/1	0/1								
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 47. There was only one episode of chemical restraint during this review period. Individual #447 was administered a combination of Haldol and Ativan via an intramuscular injection on 1/14/17. The review of the chemical restraint documentation by the Pharm.D was completed on 2/10/17, which was beyond the required 10-day timeline. The review by the psychiatrist occurred on 1/17/17, which was within the allotted time frame. 48. Information that would suggest that the combination of multiple medications was warranted could not be identified.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.	
Summary: For all but one investigation, supports were in place to reduce the likelihood of the event occurring (or there was no history of prior occurrence). This was good to see, however, for the one exception, a serious error in systems management occurred resulting in injury/hospitalization to the individual. This	Individuals:

indicator will remain in active monitoring.											
#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	89% 8/9	1/1	2/2	1/1	1/1	1/1	1/1	1/1	0/1	

Comments:

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

- Individual #346, UIR 17-059, discovered laceration, head, 2/20/17
- Individual #682, UIR 17-035, DFPS 45056244, confirmed allegation of neglect, 12/31/16
- Individual #682, UIR 17-075, discovered laceration, forehead, 3/21/17
- Individual #118, UIR 17-086, DFPS 45218410, unconfirmed allegation of physical abuse, 3/31/17
- Individual #447, UIR 17-033, DFPS 45038548, unfounded allegation of physical abuse, 12/29/16
- Individual #54, UIR 17-077, DFPS 45208932, confirmed allegation of neglect, 3/24/17
- Individual #13, UIR 17-069, DFPS 45190361, unfounded allegation of verbal abuse, streamlined investigation, 3/10/17
- Individual #227, UIR 17-095, discovered fracture, ankle, 4/26/17
- Individual #500, UIR 17-068, medication error, 3/7/17

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

Eight of the nine investigations met all four of these sub-indicator criteria. Examples included the presence of a relevant PNMP, osteoporosis monitoring, and a behavior plan to reduce the making of false allegations. The exception was Individual #500 UIR 17-068 for an absence of having a system in place to determine if, and to ensure that, an individual's medications were correct post-hospitalization.

As a result of examining this investigation and as a result of other monitoring activities during the onsite week, the Monitoring Team found that Richmond SSLC needed to ensure that two systems were in place:

- A system to ensure that post hospitalization medication order reconciliation is correct.
- A system to ensure that outside consultations are handled correctly.

The Monitoring Team requests that it be sent a copy of the facility's plan/policy/protocol for these two systems, a description of how the facility will ensure that the systems are being implemented correctly, and a monthly update for three months (beginning in July 2017) that includes data and a description of the status of these two systems. At the time of submission of this report, the facility submitted their action plans for both of these systems, both of which included updated or new policies for the facility.

Further, based upon observations, document reviews, and discussions with various staff, the Monitoring Team suggests the facility examine the following:

- For Individual #118, whether his IDT is incorporating trauma informed care into his treatment plans, and whether his consumption of highly caffeinated drinks might be a variable to manage.
- For Individual #109, ensuring that his shoes are on the correct feet, especially given his frequent falls.
- For Individual #346, exploring whether he can safely remove his helmet at certain times, such as when eating or working at his workstation.
- For Individual #447, whether the dementia diagnosis is correct.
- For Individual #206, a full assessment of his neurological condition, especially regarding his ability to walk and whether or not his plan should promote additional walking and, if so, how much.

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

Summary: Performance decreased for this review period. In the last report, 100% of the investigations met criteria and the report highlighted a number of actions the facility had taken to support this high performance. For this review, three investigations did not meet criteria due to inconsistencies in reporting and in the facility's reconciliation/exploration of these inconsistencies. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	67% 6/9	1/1	0/2	1/1	1/1	0/1	1/1	1/1	1/1	

Comments:

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

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

- For Individual #682 UIR 17-035: The UIR showed that the injury occurred at 19:20 and the individual was assessed by the LVN

at 19:30. The facility director/designee was notified at 21:29, that is, longer than one hour. Even so, the UIR noted that the injury was reported timely and that both the facility director/designee and executive duty officer were notified within one hour, which was incorrect. Furthermore, DFPS received the report of alleged neglect on 1/4/17, which was four days after the injury occurred, but there is nothing in UIR to explain this. While onsite, the facility provided documentation that showed a series of reviews that led up to the decision to report this as an allegation, but nothing like this was in the UIR, which is the official investigation report. Finally, because it was reported late to DFPS, it was also reported late to OIG (which ultimately made a confirmation determination).

- For Individual #682 UIR 17-075, the injury was discovered at 6:50 am and coded serious at noon. The UIR noted that the incident was reported to the facility director/designee at 1:45 pm, that is, more than one hour later.
- For Individual #54 UIR 17-077, DFPS reported that the incident occurred on 2/25/17 and was reported on 3/24/17. There was nothing in the UIR to explain this. While onsite, the IMC explained that the breach of supervision was discovered by DFPS while reviewing video from 2/25/17. DFPS then reported the breach as an allegation of neglect (which was confirmed). Even so, none of this explanation could be discerned from the UIR, which is where any issues with late reporting should be explained.
- For Individual #500 UIR 17-068, although reporting met the criteria for this indicator, it seemed that one or more nurses (or maybe pharmacy) should have detected the absence of a Dilantin order and initiated conversation among the individual's health care providers and/or the full IDT.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: Indicator 3 will remain in active monitoring. Also, see comment below regarding the placement and availability of posters with reporting phone numbers for some individuals.

Individuals:

#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	0/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										

Comments:

3. Because indicator #1 was met for seven of the individuals, this indicator was not scored for them. The Monitoring Team, however, over the course of the onsite week, spoke with 10 different direct support professionals about abuse and neglect reporting. Overall, questions were answered correctly, but three staff did not correctly state that DFPS needed to be contacted and/or that there was a one-hour reporting requirement. Given the performance on this indicator and on indicator 2, attention should be paid to ensuring that

staff can accurately state the required reporting protocols.

4. For four individuals, posters that indicate reporting phone numbers were either not in the living area or were in a staff area not accessible to individuals. The facility ADOP reported that they would review these incorrect placements, their facility policy, and correctly place posters, as required.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

Summary: Performance on this indicator also slipped since the last review (cf. indicator 2) and will, as a result, remain in active monitoring.

Individuals:

#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	78% 7/9	1/1	1/2	0/1	1/1	1/1	1/1	1/1	1/1	

Comments:

6. For Individual #682 UIR 17-035, the UIR did not note alleged perpetrator reassignment. Additional documentation provided onsite did not contain validation that reassignment occurred.

For Individual #118 UIR 17-086, the incident was reported to DFPS and the facility director/designee at 2:28 am. The alleged perpetrator was removed from contact with individuals at 8:30 am. The UIR (and the facility while the Monitoring Team was onsite) did not provide any detail on the delay, such as perhaps that the alleged perpetrator was not on duty at 2:30 am and reported to work at 8:30 am at which time he or she was removed from contact with individuals.

Outcome 5– Staff cooperate with investigations.

Summary: Overall, staff cooperated with investigations, however, in one serious injury occurrence, staff cooperation probably impeded the thoroughness and validity of the conclusions ultimately drawn. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
7	Facility staff cooperated with the investigation.	89% 8/9	1/1	2/2	1/1	1/1	1/1	1/1	1/1	0/1	

Comments:

7. For Individual #500 UIR 17-068, the UIR noted a lack of cooperation from a facility LVN. Based on review of the investigation report, her statements could have been important in determining how the post-hospitalization resumption of Dilantin was missed. She never was interviewed.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: Some of the investigations did not take advantage of video camera recordings resulting in evidentiary review not meeting criteria. Thus, indicators 9 and 10 will remain in active monitoring. On the other hand, required elements of a thorough investigation were present for all of these investigations for this review and the previous two reviews, therefore, indicator 8 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 9/9	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	67% 6/9	0/1	1/2	1/1	1/1	1/1	1/1	1/1	0/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	67% 6/9	0/1	1/2	1/1	1/1	1/1	1/1	1/1	0/1	

Comments:

9-10: For three investigations, there were problems with the collection and analysis of evidence and with the resultant conclusions.

- For Individual #346 UIR 17-059, the incident occurred in the bathroom. Video was not reviewed to determine whether or not anyone entered or exited the bathroom (i.e., to rule out any alleged perpetrators). Further, the UIR based its conclusion that the fall was accidental based on Individual #346's testimony, however, the client injury report stated that the individual cannot be considered a reliable reporter. If video review was done (and no one was observed entering or leaving), there would be a higher degree of certainty that the cause of the fall was not another individual or staff.
- For Individual #682 UIR 17-075, similarly, video was not reviewed to determine if anyone entered or exited the bedroom (i.e., to rule out any alleged perpetrators). Extensive video review occurred from the time after the injury was discovered, however, review should have also looked at the time period preceding the injury discovery to determine if any staff or individuals entered her bedroom. When a serious discovered injury occurs in a location that is not monitored by camera (e.g., typically a bedroom or bathroom), it is important that the investigation determine who, if anyone, entered or left, the location.
- For Individual #500 UIR 17-068, rather than the conclusion that there was no system in place since the time that the electronic health record was initiated, a more accurate conclusion would have been that a system was in place, but was not implemented (regarding accurate resumption of medications upon return from a hospitalization).

Outcome 7– Investigations are conducted and reviewed as required.	
Summary: Attention and collaborative work probably needs to occur to ensure that DFPS investigations are completed in a timely manner. The Richmond SSLC quality review of investigations protocol was still in place, which was good to see, however,	Individuals:

it did not detect a number of problems with a number of investigations. Indicator 13 will remain in active monitoring.											
#	Indicator	Overall Score	346	682	118	447	54	13	227	500	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, see comments below for indicator 12 regarding problems with DFPS timely completion of investigations.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).										
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	44% 4/9	0/1	0/2	1/1	1/1	0/1	1/1	1/1	0/1	

Comments:

12. Although in less oversight and although it will remain in less oversight, two of the DFPS investigations did not meet criteria for timeliness and, further, these and other investigations were not completed in a timely manner due to DFPS extraordinary circumstances, which were often due to caseload size and staff shortages. Even though these conditions may exist, timely investigation completion is important and required by the Settlement Agreement. The facility should work with DFPS and possibly with the SSLC state office to address this need. Without improvement, this indicator is likely to be moved back into active monitoring.

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

The Richmond SSLC facility review process was very thorough and the facility was praised for this in the past. The process remained in effect, however, it did not pick up on lack of complete video review, late reporting, and absence of extension request specificity and acceptability. In addition, for Individual #500 UIR 17-068, facility review did not identify cause (or root cause) and any necessary follow-up action plan. Two weeks prior to the onsite review, however, a protocol was put in place, yet there were no checks to ensure it was being implemented properly.

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
Summary:			Individuals:								
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant	Due to the Center's sustained performance, these indicators were moved to the									

	injuries for this individual were reported for investigation.	category of requiring less oversight.
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	
	Comments:	

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

Summary: Recommendations in investigations were related to findings in all cases for this review and for the previous two reviews, too. Therefore, indicator 16 will be moved to the category of requiring less oversight. Problematic, however, was implementation of these recommendations; this had decreased since the last review when 100% of recommendations were implemented. Therefore, indicators 17 and 18 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 346	682	118	447	54	13	227	500	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 9/9	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	75% 3/4	N/A	1/1	1/1	N/A	0/1	N/A	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	38% 3/8	1/1	0/2	N/A	1/1	1/1	0/1	0/1	0/1	

Comments:

17. For Individual #54 UIR 17-077, there were no recommendations for this investigation, which had a confirmation of a specific staff member for neglect.

During this review period, two staff in two cases were confirmed for physical abuse category 2. Employment was not maintained for both employees.

18. For eight of the investigations, there were from one to six programmatic recommendations. For the four that did not meet criteria, some, but not all, of the recommendations were implemented. The fifth investigation that did not meet criteria with this indicator was Individual #500 UIR 17-038 because, although re-training of staff regarding IRIS and reconciliation of medications occurred, it was not done timely.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Richmond SSLC collected a lot of data, which was good to see, but drawing conclusions from the data was not yet occurring. The facility took lots of actions regarding reducing falls. Tying these activities into the QA program is also needed. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	No										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										

Comments:

19-20. Richmond SSLC collected and presented a great deal of data, but too often there was not a narrative summation tying various data together into a logical conclusion as to whether the variable being measured was getting better or worse (i.e., conclusions), and whether informal actions or a formal CAP should be initiated.

21-23. Negative patterns regarding falls were identified and a CAP was implemented, as well as a work group. After the onsite review, the facility provided additional documents to show all the actions that had been taken to address falls. This was good to see and pointed to the facility's efforts to address falls. The action steps that were taken, however, were not described in the CAP, as they should have been, and they were not included/displayed in either the quarterly trend reports or QAQI Council minutes.

Richmond SSLC had a number of performance improvement work group groups addressing a variety of issues, in addition to falls. These included weight gain/loss, pretreatment sedation, use of protective devices, and mealtime monitoring.

The facility/QA program should include well-defined action steps and expected outcomes (in either informal plans or formal CAPs) in order to set the occasion for effective tracking of completion and of outcome. There was not an organized method of presenting data related to CAPs, informal action plans, implementation, and outcome assessment. This is an important responsibility for the QAQI Council and a recommended area of focus.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies/procedures with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. The Center submitted two procedures related to medical clearance. Dental Procedures - General Anesthesia Medical Clearance was a one-page procedure that documented five steps related to the PCP conducting medical clearance. It became effective 2/6/17. Dental Procedures - Total Intravenous Anesthesia Clearance provided four steps primarily concerning obtaining consent. A third procedure, entitled TIVA Selection Criteria effective 6/1/17, described a series of medical problems and the requirements for proceeding with anesthesia in the face of these conditions. None of the procedures indicated the departments involved in the development of the procedures. It also was not clear if these "procedures" had gone through the appropriate review and approval process.

The Medical Department and anesthesiologist must be involved in development of policies, procedures, and guidelines related to selection criteria for general anesthesia and TIVA, preoperative evaluation, and perioperative management.

For these three instances of the use of TIVA, informed consent for the TIVA was not present, nothing-by-mouth status was not confirmed, and the start and stop times for anesthesia were not submitted to allow assessment of post-operative vital sign assessment. In addition, for Individual #570, the Center did not submit an operative note defining the procedures and assessment completed during this off-site administration of TIVA.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									

Comments: a. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical procedures.

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

Summary: Although scores were low, there was some improvement since the last review. Few IDTs correctly reviewed the need and usage of pretreatment sedation. Likely, some individuals would benefit from some strategies, but none were developed and put into place. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	67	346	447	682	54			
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	33% 2/6	1/1	0/1	0/1	1/1	0/1	0/1			
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
4	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:
1-6. This outcome and its indicators applied to Individual #51, Individual #67, Individual #346, Individual #447, Individual #682, and Individual #54, who all received pretreatment sedation in the last year.

1. There was evidence that Individual #51 and Individual #447's IDT discussed behaviors observed during the procedure, other supports and interventions provided, additional supports or interventions that could be provided for future appointments, and the risk and benefit of the procedure without PTS versus with PTS. Additionally, there was informed consent from the LAR/Facility Director. Individual #54, Individual #682, Individual #346, and Individual #67 's ISPAs/ISPs, however, did not have evidence that their IDTs discussed PTS usage and effectiveness or supports/interventions that could be provided for future appointments.

2. Individual #51's 11/14/16 ISPA indicated that her IDT determined, based her past history, that any action to reduce the use of PTS would be counter-therapeutic.

3-6. There were no treatments or strategies developed to minimize the need for PTS for any of the individuals.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.

Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	404	693	220						
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% 3/3	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% 0/3	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% 0/3	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% 0/3	0/1	0/1	0/1						
e.	Recommendations are followed through to closure.	0% 0/3	0/1	0/1	0/1						

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

- On 2/7/17, Individual #404 died at the age of 55 with causes of death listed as cardiac arrest, pneumonia, and aspiration;
- On 2/10/17, Individual #220 died at the age of 53 with causes of death listed as complications following blunt force head trauma with right subdural hematoma; and
- On 3/6/17, Individual #693 died at the age of 93 with causes of death listed as aspiration pneumonia, chronic systolic congestive heart failure, and chronic atrial fibrillation.

b. through d. The Quality Improvement Death Review of Nursing Services for these mortalities did not represent a comprehensive and

systematic review of nursing care and the associated documentation. Although the Conclusions sections of theses report noted some significant issues that generated associated recommendations, the reviews did not address crucial nursing documentation and activities, such as the annual and quarterly nursing reviews, IHCPs, all recent acute care plans, and nursing assessments and documentation included in the IPNs. Given the systemic problems the Monitoring Team has noted with all of these basic nursing functions, thorough reviews of individuals' supports as part of the mortality review process should have resulted in findings similar to those of the Monitoring Team, and the clinical and administrative Death reviews should have included recommendations to address the problems identified. Based on the Monitoring Team's review of the Center's mortality reviews, this was not the case. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

Overall, it was not clear that the morality reviews the Center conducted identified and addressed root causes. Some examples of concerns included:

- None of the IHCPs the Monitoring Team reviewed showed a truly interdisciplinary approach to identifying the underlying issues impacting individuals' chronic and at risk conditions. However, none of the clinical death reviews contained recommendations related to improving the IDT processes used to analyze clinical data, and develop meaningful and interdisciplinary IHCPs to address individuals' needs.
- Individual #404 had fungemia, as did Individual #603, who also was part of the review group. The mortality review noted that the hospital alerted the Center that several individuals from the Center had been diagnosed with fungemia. It was unclear if root cause analysis occurred to determine the etiology of these serious infections. In its comments on the draft report, the State asserted that: "The clinical death review provided the root cause analysis for the deaths… stating fungemia. Possible causes of fungemia were also discussed…." The State offered to provide the Monitor with the documentation to which it referred, which the Monitor requested. In its response, the State described actions the Infection Control Committee took in January 2017, including "environmental services evaluating cleaning schedules and developing a system to ensure that equipment and furniture coming into contact with the individuals were properly cleaned. The facility reviewed the type of cleaning materials uses to determine its effectiveness. The Infection Control Nurse retrained DSP [direct support professionals] on appropriate perineal care to prevent tinea infections or potential candida UTIs. Residential staff agreed to assist nursing staff with the monitoring of perineal care. Increased spot checks for appropriate perineal care will be implemented with the support to the Infection Control Nurse." As the Monitoring Team concluded in the draft report after reviewing this same information, the evidence the State submitted did not constitute a root cause analysis. Moreover, it did not even represent a good basic analysis of existing data (e.g., commonalities between the individuals the Center supported that had been diagnosed with fungemia, possible use of multiple or long-term use broad spectrum antibiotics, determination of whether or not individuals involved were diagnosed with diabetes or on dialysis and with compromised immune systems, etc.). The Clinical Death Review did not include an analysis of clinical issues/practices in relation to fungemia. Of note, Individual #603 was diagnosed and treated twice for fungemia, including in November 2015, and November 2016. Although the limited review the Center did do identified possible issues related to cleanliness, it was not clear that the recommendations related to environmental issues were completed.
- On 2/9/17, Individual #220 was admitted to the hospital with a subdural hematoma. Video confirmed that the individual had fallen and stuck his head one month earlier. A nurse assessed him, but did not notify the physician, so the physician did not evaluate him. On 2/10/17, the family signed a Do Not Resuscitate Order (DNR) and the individual was extubated and died.

The nursing death review stated that on 2/8/17, the nurse checked the individual for complaints of meal refusal and weakness. He had a large bowel movement prior to the assessment. An RN assessment was done and the individual was noted to be lethargic but not in pain. He was placed on morning sick call. On 2/9/17 at 10 a.m., the PCP saw the individual and requested transfer to the hospital. It would be important to identify specific causes for the various system failures in addressing this individual's unwitnessed fall.

The Monitoring Team is also concerned that the State indicated in its comments on the draft report that: "RSSLC provided the monitors with the Clinical Death Review reports **written by the Medical Director** that we believe contains clinical recommendations identified areas across disciplines that require improvement…" (emphasis added). The development of Clinical Death Reviews should be an interdisciplinary activity, and not be a product "written by the Medical Director."

e. Although some progress was noted with regard to including follow-up activities to assess the impact of the implementation of recommendations, the methodology of auditing processes for these recommendations called into question the reliability of the data generated (e.g., audit tools lacked essential indicators to assess resolution of the identified problems). In addition, a number of the recommendations were not written in a way that ensured that Center practice had improved. Documentation also was not provided to support completion of all recommendations.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: The Center provided conflicting information about an ADR for one of the individuals reviewed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	ADRs are reported immediately.	0% 0/1				0/1					
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/1				0/1					
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1				0/1					
d.	Reportable ADRs are sent to MedWatch.	0% 0/1				0/1					
Comments: a. through d. Based on the Center's response to the Tier II document request, Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed. However, the Center provided conflicting information with regard to Individual #570. The Tier I document request #TX-RI-1706-III.12.z indicated that on 11/30/16, Individual #570 experienced a "true ADR." The adverse event was "elevated AST and ALT levels," and the suspected drug was ethinyl estradiol-levonorgestrel. In response											

to Tier II document request #TX-RI-1706-II.022, the Center indicated she had not experienced an ADR in the six months for which documents were requested.

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: In addition to needing to focus more on the specific goals of a DUE, the Pharmacy and Therapeutics Committee needs to develop and implement plans of action to address the findings of DUEs. These issues have been raised in previous reports, and have not been corrected. These indicators will remain in active oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

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

- On 1/26/17, the Pharmacy and Therapeutics (P&T) Committee reviewed a DUE that stated: "The rational for conducting this drug utilization evaluation was to determine the overall effectiveness of Lithium as either monotherapy or as a component of combination drug therapy for patients with bipolar disorder and the individual safety concerns." The P&T Committee discussed the findings of the DUE, but there was no clear plan of correction documented.
- On 5/11/17, the P&T Committee reviewed a DUE that stated: "The rational for conducting this drug utilization evaluation was to determine the overall effectiveness of warfarin for prophylaxis and treatment of thromboembolic disorders and embolic complications arising from atrial fibrillation or cardiac valve replacement and to ensure adherence to monitoring guidelines." The P&T Committee discussed the findings of the DUE, but there was no clear plan of correction documented.

The efficacy for the use of both of these agents is well documented and is based on data from many years of clinical use and scientific studies. The findings of an evaluation based on a limited sample size in a small group of individuals, with numerous confounding factors, cannot be extrapolated to the general population. The goal of a DUE is to promote optimal medication therapy and ensure that drug therapy meets current standards of care. DUEs are also helpful in establishing criteria for appropriate drug utilization, evaluating the effectives at the individual level, controlling costs, identifying adverse drug reactions, and identifying opportunities for educational activities. The Pharmacy Director should review the fundamental components of a DUE and ensure that future DUEs focus on these various aspects of drug utilization.

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, 14 of these indicators were moved the category of requiring less oversight. For this review, eight other indicators were moved to this category, in ISPs, psychiatry, and psychology/behavioral health. On the other hand, three indicators were returned to active monitoring due to poor performance. These were in dental and nursing.

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.

There were a variety of forums created at Richmond SSLC to support and set the occasion for interdisciplinary collaboration. These included:

- Unit morning meetings. The Monitoring Team observed these in most of the units and saw good participation and discussion regarding topics such as restraints, incidents, and protocol/policy announcements. The unit directors were an experienced set of managers who appeared to be knowledgeable about what was going on in their units.
- The Director of Residential Services' weekly unit directors meeting. This was open to all departments to attend and included the presentation of unit QA projects, such as peer-to-peer aggression, falls, pneumonia, and head of bed elevation.
- Morning medical meeting. Many disciplines attended and there was an educational component, such as a training topic on Friday of the onsite week.
- Medical grand rounds. Periodically, the medical director called for, and led, a review of one individual who was having problems. This allowed for about an hour's intense discussion from the many disciplines as well as members of the individual's IDT. During the onsite week, this was held for Individual #447. Input was presented by psychiatry, behavioral health services, medical/PCP, speech and language, pharmacy, nursing, dietary, and residential. Action plans were suggested and assigned for follow-up and/or more data.

<u>Assessments</u>

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

IDTs were not considering and, thereby, not obtaining needed assessments. The need for conduct of monthly reviews was evident and has been discussed in this and in previous reports, too.

Some attention to content of the comprehensive psychiatric evaluations was needed, especially for older CPEs that were not formatted as per Appendix B. CPE annual updates were done for all individuals for this review and for the past two reviews, too.

Richmond SSLC met criteria with the currency, content, and completeness of behavioral assessments and functional assessments for all individuals.

Efforts were needed to improve both the timeliness and the quality of the medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

At the time of the last review, the indicator for timely completion of dental exams moved to the category requiring less oversight. However, based on the Monitoring Team's review of the dental exams for other indicators, many of them did not meet criteria for timeliness, particularly the requirement that the dentist complete exams no earlier than 90 days prior to the ISP meeting. As a result, this indicator will move back to active monitoring. In addition, the Dental Department should continue its efforts to improve the quality of dental exams and summaries.

Due to previous high performance with regard to the completion of annual nursing reviews and physical assessments, the related indicators moved to the category requiring less oversight. However, based on the annual nursing assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. As a result, these indicators will move back to active oversight. It appeared that these issues related to the conversion to IRIS. The State Office Nursing Discipline Lead is working to make the necessary changes.

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

Although some improvement was noted with regard to the timely referral of individuals to the PNMT and completion of the PNMT reviews, these areas still needed focus. The Center also should concentrate on completion of PNMT comprehensive

assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus as numerous problems were noted.

Numerous concerns were noted with the comprehensive communication assessments and the update reviewed.

Individualized Support Plans

ISPs were revised annually. The development of individualized, meaningful personal goals in six different areas was not yet at criteria, but progress was evident. When considering the full set of ISP action plans, the various criteria included in outcome 3 were not met, though there was some minimal progress seen for some indicators.

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

`The Monitoring Team attended three annual ISP meetings. Two were very upbeat with lots of participation from the individual, family/LAR, and team members (Individual #321, Individual #125). The third, for Individual #118, included the occurrence of problem aggressive behavior.

In psychiatry, some progress was demonstrated during discussions with the psychiatrists, however, the ISPs and other psychiatry documents did not yet show individualized psychiatry goals/objectives.

In behavioral health services, reliable and valid data were available that reported/summarized the individual's status and progress for almost all. This was an excellent accomplishment.

About half of the individuals had less than three SAPs. A renewed focus on SAPs was described by the facility, including assignment of behavior analyst from the behavioral health services department to oversee this.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not	Individuals:

yet at criteria, but progress was evident as described below. Four ISPs, for instance, included one goal that met criteria, which was progress since the last review, and overall, nine goals met criteria with indicator 1, compared with three last time. These indicators will remain in active monitoring.

#	Indicator	Overall Score	51	118	206	447	603	109			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	1/6	4/6	2/6	0/6	2/6			
2	The personal goals are measurable.	0% 0/6	0/6	1/6	4/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #51, Individual #118, Individual #206, Individual #447, Individual #603, Individual #109). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Richmond SSLC campus.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. The Center's QIDPs had received training on Writing Good Goals (Good, Better, Best) and the Monitoring Team did identify some progress in the development of personal goals that were aspirational and reflective of individualized preferences and strengths, as described below.

1. It was an indicator of progress that the IDTs had defined nine personal goals that were individualized and clearly based on the individual's preferences and strengths. During the previous monitoring visit, three personal goals met criterion.

- The ISP with the highest number of personal goals that met criterion was for Individual #206. These personal goals included leisure/recreation, relationships, job/school/work and living options.
- Other personal goals that met criterion included the leisure/recreation for Individual #118 and the relationships and greater independence goals for Individual #447.
- The final personal goal that met criterion was the job/school/work goal for Individual #109, to be a dining room attendant.

This was a clearly aspirational goal for which the IDT described the specific preferences and strengths that supported this as a realistic determination. Other goals defined by the IDTs often failed to define an outcome that was aspirational. More often they appeared to be action plans that might be related to a more aspirational outcome, but the IDT did not specify what that might be.

2. Of the nine personal goals that met criterion for indicator 1, five met criterion for measurability. These goals included the personal goals for Individual #206 and the recreation/leisure goal for Individual #118. The Monitoring Team reviewed the personal goals and their underlying action plans in making this determination. For example, for Individual #109's job/school/work goal, the IDT developed three action plans, but the only one that was clearly related to the goal was for the QIDP to send a referral to obtain an assessment. The action plans did not provide a clear path toward achieving the goal that could be measured.

3. For the nine personal goals that met criterion in indicator 1, one had reliable and valid data. This was the living options goal for Individual #206.

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

Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators refer to the full set of action plans. That is, the qualities that are being monitored by these indicators may be evident in different action plans within the set of goals and action plans for the individual. Of these 11 indicators, five showed improvement (albeit slight) and one showed a decrease. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	118	206	447	603	109			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	3/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

	health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.										
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	0/1	1/1	1/1	0/1	0/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
As Richmond SSLC further develops more individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

8. ISP goals generally did not have a clear set of action plans that would serve as a road map for their ultimate achievement. None of the personal goals met criterion. Examples of those that did not meet criterion included Individual #109's job/school/work goal described above. Other examples are described below:

- Like Individual #109's, Individual #206's job/school/work action plans addressed his goal to work in landscaping solely with obtaining an assessment.
- Individual #109 also had a personal goal to make a friend at the Arc of Ft. Bend, but the IDT did not develop any specific or measurable action plans that would support that goal, other than to attend activities at the ARC. The other action plans were to obtain doctor's orders for Individual #109 to participate in the splash pad or swimming pool, to send a service request to the lifeguard, and to attend off-campus trips once a month with his peers. Individual #109's social and communication needs dictated he would need substantial support to establish an ongoing friendship.
- Individual #447's ISP did not define specific action plans for most of his goals.

9. One of six ISPs (for Individual #118) contained a set of action plans that clearly integrated preferences and opportunities for choice. In particular, the action plans minimally integrated opportunities for day-to-day choice making. For example, Individual #603 had very limited meaningful activity in her life, particularly following her hospitalization and tracheostomy. The IDT did not focus attention on enhancing her ability to communicate and make choices.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. Self-advocacy activities, such as the self-advocacy committee (which met regularly, but not during the onsite week), can provide opportunities for teaching and practicing decision-making.

11. The ISP for Individual #206 met criterion for this indicator. Otherwise, action plans did not assertively promote enhanced independence for the other individuals. Examples included:

- At the time of the last monitoring period, the Monitoring Team found that, overall, the IDT did not adequately consider what barriers existed to Individual #51's ability to live and work in integrated settings and create goals and action plans that addressed these barriers. Overall skill acquisition was minimal, with two SAPs. Neither of these was consistently implemented, reviewed, and revised and were, therefore, meaningless as action plans to support her enhanced independence.
- The IDT did not provide any focus on communication as a fundamental need for independence for Individual #603. The goal to use a switch to operate her radio had been continued from the previous year, but the ISP did not discuss how the switch might be used for communication in the future, nor did it focus on any other means of communication.
- Individual #109's current ISP had minimal opportunity for skill acquisition, with one SAP to make a snack in the microwave.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans as described throughout this report. Overall, IDTs still needed to be much more assertive when addressing health, safety, and behavioral needs of individuals living at Richmond SSLC. For example:

- Individual #118's ISP did not identify or integrate his needs related to a history of sexual abuse. He was identified for streamlined investigation by DFPS. Updated policies will require that the specified criteria are met to remain on this list. Given his history, the IDT needed to develop any action plans to ensure a heightened scrutiny of allegations of sexual abuse.
- Individual #118's positive behavior support plan (PBSP) had been discontinued in favor of a psychiatric support plan (PSP) without the consultation of the IDT and in the face of significant behavioral needs.
- IDTs did not consistently address falls risk as needed. For example:
    - Two of six individuals (Individual #206, Individual #109) had a significant number of falls, but the IDTs had not acted assertively to address this risk.
        - Individual #206 was at high risk for falls. Physical and nutritional management team (PNMT) and/or falls assessment had not been completed. A comprehensive assessment for falls was needed, considering various behavioral and medical issues. For example, the IDT reported that falls were decreasing, but had not completed a data-based evaluation of whether this was perhaps because he was choosing to use his wheelchair more often.
        - For Individual #109, the annual nursing assessment documented 17 falls between 4/13/16 and 12/14/16. Per the falls record obtained by the Monitoring Team onsite, he had sustained another 11 falls since 12/14/16. PNMT minutes reflected an awareness of the falls and referred them back to the IDT. Interdisciplinary Progress Notes (IPNs) stated that falls continued to be due to client being clumsy, careless, and not paying attention to his surroundings, but no PNMT and/or falls assessment had been completed.
    - Individual #447 was being treated with Aricept for possible dementia, but had not had a dementia work-up. The IDT had provided some anecdotal evidence that this apparent cognitive decline was due to a medication toxicity and had largely resolved. The IDT needed to prioritize a series of steps to rule out dementia, beginning with an evaluation of his current skills as compared to his previous baseline.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy,

dental), and any other adaptive needs were also not well-integrated, also as described throughout this report. In addition to the examples provided in indicators 11 and 12 above, other examples included:

- The IDT for Individual #109 did not assertively identify and address communication needs. His most recent speech and language assessment was dated 3/4/14 and indicated that he had no needs in the area of communication. It indicated that his speech was intelligible to both familiar and unfamiliar communication partners and that his expressive skills were functional for this environment and in a community setting. It also indicated his receptive skills were not evaluated during the current assessment because they were not found to be impaired to prevent him accomplishing his daily activities or achieving his wants and needs. He did not currently have a communication dictionary, per the 2014 speech assessment's finding that he was an independent communicator. The IDT needed to obtain a current speech assessment to ascertain if his skills were changing. For example, during observations, Individual #109 used gestures and physically leading staff to things he wanted to show, but did not use speech intelligible to the Monitoring Team member. This was of even more importance because two of his goals were focused on making new acquaintances and friendships in the community.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals, with few specific, measurable action plans for community participation that promoted any meaningful integration. Examples included:

- At the time of the last monitoring visit, the Monitoring Team noted there was some progress evident in the development of action plans that encouraged community participation and integration in Individual #51's ISP. An action plan for learning to dance included participation in off-campus dance classes and dance competitions, which was positive. Another action plan had been developed to join a local community church, which was positive in intent, but there was no clear methodology for how integration would be supported during the upcoming year, only that it would occur on an ongoing basis. These action plans were never been implemented, rendering them meaningless, rather than meaningful. At the ISP preparation meeting on 5/1/17, the IDT tentatively proposed to continue both goals with revised action plans, but should have met much earlier to address the lack of implementation and make timely revisions. Even after the ISP preparation meeting, the IDT did not act to make revisions for, or to ensure, implementation of the existing action plans prior to the upcoming ISP.
- It was positive to see that Individual #109's IDT considered participation in the Arc of Ft. Bend, but the ISP included minimal action plans to support implementation based on his social and communication needs.
- Individual #118's ISP also had action plans that appeared to support meaningful community integration, such as participating in a comic book club and working as a service assistant at the local video gaming store. If implemented, these could have represented substantial opportunity for community integration. Again, the action plans had not been implemented across a full year.

  Per the monitoring protocol, when the Monitoring Team attends an annual ISP meeting during the onsite week, the personal goals discussed at that ISP meeting are not scored for this indicator. Instead, the personal goals on the existing ISP are scored (though the Monitoring Team may also comment on the goals presented at the onsite meeting). In this instance, the scoring of the personal goal for joining a comic book club was based on the information available to the IDT at the time that the existing IDT was developed. At that time, the documentation available indicated Individual #118, who was newly admitted, had a strong interest in comic books and would benefit from opportunities for community integration and development of socialization skills and relationships and the Monitoring Team credited the IDT for developing a creative personal goal that appeared to reflect both preferences and needs. On the other hand, the Monitoring Team found that the IDT did not take any

actions to support or otherwise revise this goal over the course of the year and, therefore, rated this indicator as not meeting criterion.

During the annual ISP meeting during the onsite week, it became clear that Individual #118 had little knowledge about this goal and, in fact, expressed a good deal of apprehension about participating in such an activity. Given this new information and the lack of any action/evidence over the past year to indicate that it continued to be meaningful to Individual #118 (and appropriate to his needs), the Monitoring Team would find this same personal goal for the upcoming year to again not meet criterion.

15. Three of six ISPs (Individual #118, Individual #206, Individual #109) considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. These ISPs, however, did not include a set of action plans that effectively supported the implementation of these goals.

At the last onsite review, the Center's apprenticeship program was touted as a new opportunity that would support individuals to explore, seek out, and prepare for community (or Center-based) employment, including general job preparation skills (e.g., interviewing, resume) and job-specific performance skills. At this visit, however, zero individuals were in the apprenticeship program.

The Center had four workshop areas, a day program, a computer lab area, and a program called Forever Young. Multiple observations by the Monitoring Team found about 30 individuals at the Forever Young program. Almost all were engaged and alert. Various activities were available and staff were interacting in a pleasant manner. On Friday morning of the onsite week, the Monitoring Team observed individuals in attendance and engaged at the Main Workshop program just after 9:00 am. This was also good to see.

16. One of six ISPs, for Individual #206, had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. The IDTs did not place significant focus on skill acquisition. For example, Individual #109's ISP had one formal skill acquisition plan, despite many needs.

17. The IDT did not consistently address barriers to achieving goals. Examples included:

- IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described in indicator 26.
- The ISPs for Individual #118 and Individual #51 did not address barriers to implementation of goals across many months.

18. ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements and data had not been demonstrated to be valid or reliable, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.	
Summary: Criterion was met for some indicators for some individuals, but overall, performance was about the same as last time, with some indicators scoring slightly higher and some scoring slightly lower. More focus was needed to ensure that all of	Individuals:

the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are conducting thorough discussions of living options and putting plans into place to address obstacles to referral. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	51	118	206	447	603	109			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	50% 1/2	N/A	1/1	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	50% 1/2	N/A	1/1	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	50% 1/2	0/1	N/A	1/1	N/A	N/A	N/A			
Comments: 19. Two of six ISPs (for Individual #118 and Individual #206) included a description of the individual's preference for where to live and											

how that was determined. Examples of those that did not included:

- The IDT did not provide a clear description for Individual #603. It did not describe where Individual #603 would like to live or how that preference was determined. The ISP indicated it was her vision to live at Denton SSLC, while the personal goal was described as living in a group home near her family. The action plans appeared to be focused on living at Denton SSLC. Her preference was never defined, but the narrative indicated her LAR wished her to remain at Richmond SSLC and that most disciplines concurred.
- For Individual #447, the IDT determined he would like to live in an environment less restrictive than his current environmentally-managed home (for pica), but otherwise did not describe how his preference had been determined. Individual #447 had no knowledge of community living options.

20. The Monitoring Team observed Individual #118 and Individual #125's annual ISP meetings. The IDT provided a description of where he wanted to live based on his stated preferences for his desire to live in an apartment by himself. This was not the case for Individual #125.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members.

- Current assessments by key staff members were sometimes not available at the time of the ISP. Those that were present generally provided a statement of the opinion and recommendation of the respective team member. This was an indication of progress, but it was not yet consistent across all disciplines. The annual medical assessments (AMA) did not consistently make clear statements and recommendations. For example, the AMA for Individual #447 needed to provide a specific statement or recommendation. Instead, it stated that he may not be able to move to a group home in the community due to his need for close supervision due to occasional aggressive behaviors to self and others and due to his bipolar disorder.
- All ISPs did not include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For some ISPs, the IRIS format listed a series of identical statements stating a professional recommendation, but they were not attributed to any specific discipline. The Monitoring Team could not determine whether all disciplines had contributed or what specific recommendations they made: For example:
    - For Individual #447's ISP, the only disciplines listed were behavioral health, nursing, OT/PT, SLP, and nutrition.
    - Individual #206's ISP did not provide specific recommendations nursing, vocational, dental, nutrition, FSA, behavioral health, or psychiatry.

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for two of six individuals (Individual #603, Individual #109.)

23. One of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. This positive determination for Individual #206 was based on his referral meeting at which time the ISP was appropriately updated. Implementation of the referral had been delayed, at least in part, by the absence of the primary care provider (PCP) from the ISP meeting. The PCP was the only member of the team who did not recommend transition, due to undefined medical issues. As a result, the IDT deferred the referral. Other ISPs did not provide discussion of possible living options or needs in a community setting, although some did list preferences that supported community living.

24. One of six ISPs (for Individual #206) identified a thorough and comprehensive list of obstacles to referral in a manner that should allow for the development of relevant and measurable goals to address the obstacle. Examples of those that did not meet criterion included:

- Individual #118's IDT indicated LAR Choice and Behavior/Psychiatric needs as barriers. They did not indicate individual awareness as a barrier, but the earlier narrative indicated he needed help to identify the supports he would need as well as assistance to identify a group home with the proper supports.
- For Individual #447, the IDT did not identify any barriers, but the narrative suggested behavioral needs, LAR choice, and Individual awareness should all have been considered.

25. The Monitoring Team observed Individual #118 and Individual #125's ISP annual meetings while onsite. The IDT identified behavioral/psychiatric needs and individual choice as barriers for Individual #118. This was not the case for Individual #125.

26. Individual #206 had an active community referral. None of the remaining five individuals had individualized, measurable action plans to address obstacles to referral. The action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes.

27. The Monitoring Team observed Individual #118 and Individual #125's annual ISP meetings. The IDT did not articulate a clear set of plans to address/overcome the barriers for either individual, but did have some detailed discussion about how Individual #118 could be exposed to possible living options.

28. One of six ISPs had individualized and measurable plans for education. This was for Individual #206, based on his referral ISPA. Otherwise, IDTs did not develop specific, individualized learning outcomes, or plan for specific data collection or methodology to support learning or evaluate individuals' responses.

29. Four of six individuals had obstacles identified at the time of the ISP. Individual #51 no longer wished to live at another SSLC, which the IDT had acknowledged, but they had not met to reconsider the overall determination or obstacles. The sixth person (Individual #206) had been referred.

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

Summary: ISPs were revised annually. This has been the case for some time at Richmond SSLC, therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	118	206	447	603	109			
30	The ISP was revised at least annually.	100%	1/1	N/A	1/1	1/1	1/1	1/1			

		5/5									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were developed on a timely basis. One of these individuals had been newly admitted.

32. ISPs were not implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals. Two of six ISPs, for Individual #51 and Individual #447, had been filed within 30 days. Individual #447's did not include action plans for most personal goals.

33. Five of six individuals participated in their ISP meetings. Both individuals who could participate in interview (Individual #51, Individual #118) were knowledgeable of the personal goals, preferences, strengths, and needs articulated in their individualized ISPs. The remaining individuals were not able to participate in this kind of interview.

34. One of six individuals (Individual #603) had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. However, other aspects of the criteria for this indicator were not met for her, such as LAR participation and direct support professional knowledge of the individual. Examples of those that did not included:

- No psychiatry staff, vocational staff, PCP, or dietitian participated in Individual #118's initial ISP. The former two were significant absences based on his needs.
- The PCP and psychiatrist did not attend Individual #447's ISP, despite significant needs.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: IDTs were not considering and, thereby, not obtaining needed assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	118	206	447	603	109			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	0% 0/5	0/1	N/A	0/1	0/1	0/1	0/1			

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

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for none of five individuals. The ISP reviewed for Individual #118 was his initial plan, so no ISP preparation meeting was held.

The Monitoring Team considers whether the requested assessment fields of the ISP preparation Meeting documentation are completed as one factor, but also evaluates whether the IDT actually requested all the assessments an individual needed and would be relevant to the development of an individualized ISP. For these individuals, the Monitoring Team found the IDT did not request all needed and relevant assessments, based on the individuals' needs. For example, two individuals had repeated falls over the year, but the IDT did not request that a falls assessment be completed.

36. IDTs did not arrange for and obtain needed, all relevant assessments prior to the IDT meeting. Examples included falls assessments for Individual #206 and Individual #109 and an updated speech assessment for Individual #109, as described above.

Even when the IDTs identified a needed assessment at the time of the ISP preparation meeting, they were not yet using the period between that time and the ISP annual meeting to ensure assessments were completed as needed. For example, some individuals needed assessments for tentative goals, but these were not completed during the interim period. Instead, they became the initial action plan for the annual ISP. This meant the IDT did not know whether the tentative goal would be feasible. This could also result in a several-month gap before any actual implementation could begin. For example, the IDT for Individual #447 did not request pre-meeting evaluations for the use of microwave/snack preparation or for social work to assess family willingness for visit, even though these needs were identified at the time of the ISP preparation meeting.

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

Summary: The need for conduct of monthly reviews was evident. These indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	51	118	206	447	603	109			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. Some QIDPs were not completing monthly reviews consistently, although improvement was noted. It was also positive to see improvement in the areas of QIDP knowledge and the scheduling of needed ISPA meetings overall.

37-38. IDTs did not review and revise the ISPs as needed, which reflected the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports Examples included:

- Both Individual #109 and Individual #206 had frequent falls and these had not been assertively addressed by the respective IDTs, as detailed above.
- The ISP action plans for Individual #118 and Individual #51 had been minimally implemented.
- While the Monitoring Team commended Individual #51's QIDP for her notable efforts to improve her professional practices and for holding frequent ISPAs regarding weight issues, she had not raised the issue of the lack of treatment for H. Pylori to the needed level of attention. QIDPs must continue to follow-up on all outstanding issues, including seeking the assistance of managers and supervisors if needed, and should document all follow-up efforts through resolution.

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 modify the IRRF, as needed, within no more than five days. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	The individual's risk rating is accurate.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	44% 8/18	0/2	0/2	1/2	1/2	1/2	1/2	1/2	1/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 17 IRRFs addressing specific risk areas (i.e., Individual #206 – falls, and weight; Individual #447 – constipation/bowel obstruction, and other: dementia/safety related to aggressive behavior; Individual #663 – infections, and cardiac disease; Individual #570 – falls, and infections; Individual #640 – infections, and weight; Individual #352 – constipation/bowel obstruction, and fractures; Individual #404 – weight, and aspiration; Individual #109 – constipation/bowel obstruction, and falls; and Individual #603 – choking, and skin integrity).

a. The IDT that effectively used supporting clinical data, and used the risk guidelines when determining a risk level was for Individual #352 – fractures.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual

#663 –cardiac disease, Individual #570 – infections, Individual #640 – infections, Individual #352 – constipation/bowel obstruction, Individual #404 – aspiration, Individual #109 – constipation/bowel obstruction, and Individual #603 – choking, and skin integrity.

Psychiatry

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

Summary: Some progress was demonstrated during discussions with the psychiatrists, however, the ISPs and other psychiatry documents did not yet show individualized psychiatry goals/objectives. Richmond SSLC and its behavioral health services department demonstrated the ability to obtain reliable and valid data. This bodes well for the collection of reliable and valid data on psychiatric indicators once the goals/objectives are developed. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4. The primary psychiatric indicators for the individuals were overt problematic behaviors, such as physical aggression, verbal aggression, and or self-injury.

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

5-6. These indicators were potentially measurable, but were not considered to be appropriate goals due to the lack of the definition of the relationship between the psychiatric indicators and the underlying psychiatric disorder. Accordingly, they could not be considered to have been based on an assessment.

7. There had been progress in improving the reliability of the behavioral data that could be used to monitor the progress of appropriate psychiatry goals and objectives when they are developed. As noted in psychology/behavioral health indicator 5, reliable and valid data

were being collected. This sets the occasion for the collection of data on psychiatric indicators that are also in the PBSP and those that are only in the PSP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance was almost identical to the last review. All individuals had a CPE, therefore, indicator 12 will be moved to the category of requiring less oversight. With sustained high performance, indicators 13 and 15 might be moved to the category of requiring less oversight after the next review. Some attention to content of the CPEs was needed, especially for older CPEs that were not formatted as per Appendix B. With full psychiatry department staffing (psychiatrists and support staff), it is possible that indicator 16, regarding consistent diagnoses, might also improve. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 5/5	N/A	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1

Comments:

12. Each individual had a completed CPE.

13. All of these were formatted as specified with the exception of Individual #346 whose 2010 CPE did not contain several sections.

14. Individual #346's CPE was, thus, missing important information as was that of Individual #54, for whom the formulation was deficient as well as was the section on non-pharmacological interventions.

15. Five individuals (Individual #67, Individual #682, Individual #118, Individual #206, Individual #54) were all admitted after 1/1/14. Their CPEs were performed in a timely manner and there was an IPN from the medical department within the first business day.

16. The psychiatric diagnoses were consistent in the record for five of the individuals, that is, all except Individual #51, Individual #346, Individual #447, and Individual #54. The psychiatric diagnoses were consistent in the psychiatric and behavioral sections of the record for all of the individuals, the discrepancies for these four were in the Annual Medical Assessment.

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

Summary: CPE annual updates were done for all individuals for this review and for the past two reviews, too (with one exception in December 2015). Therefore, indicator 17 will be moved to the category of requiring less oversight. The other four indicators are about psychiatry's participation in the ISP process, from preparation planning to the annual meeting. These four indicators require some attention from the psychiatry department. With the full staffing of the department being in place for a number of months, it is possible for these indicators to show progress at the time of the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	67% 6/9	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. All of the individuals had a CPE update within the prior year.

18. The information was adequate for all of these, except those of Individual #682, Individual #118, and Individual #206. A consistent deficit in the CPE updates for these individuals was the lack of a combined psychiatric and behavioral health formulation.

19. The information was submitted to the ISP team at least 10 days prior to the ISP for two of the nine individuals (Individual #67, Individual #118).

20. The attendance sheets for the ISPs indicated that the psychiatrist attended one of the nine ISPs. This was the ISP for Individual #118 that occurred during the onsite review. During the onsite review, the psychiatrist indicated that a member of the department had only been attending the ISP of the individuals prescribed psychotropic medication if they were requested to do so by the IDT at the time of the ISP preparation meeting (which occurs three months prior to the annual ISP meeting). During the onsite review, the psychiatric team presented documentation from the ISP preparation meeting that it had been determined that a member of the psychiatric team did not need to attend the ISP for six of the individuals (i.e., all except for Individual #682 and Individual #447). However, there was no indication in the documentation that was presented which would indicate how this decision was made and/or that there was any psychiatrist participation in making any of these other six decisions.

21. The information contained in the IRRF section of the ISPs for all of the individuals was insufficient. When there were references to the treatment being the least intrusive and most positive, there was no explanation as to how that determination had been made. A comprehensive summary of the combined behavioral/psychiatric treatment plan was also missing as well as the signs, symptoms, and related data that were measured to monitor progress.

During the onsite review, the Monitoring Team attended the ISP for Individual #118 that occurred on 6/13/17. The content of the IRRF was projected on a screen as part of the new electronic format. During the meeting, it was confirmed that the information projected on the screen was the same as that which would appear in the final ISP. The information that was contained in these sections (i.e., the IRRF) would not have met the criteria identified in the monitoring requirements. This information was conveyed to the facility's psychiatrist at the conclusion of the onsite review. The possibility of having a licensed member of the psychiatric team attend the ISP preparation meeting was also discussed, as well as increasing the number of ISP meetings attended by a member of the psychiatric team.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary:			Individuals:								
#	Indicator	Overall Score									
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

22. Twenty-nine of the 136 individuals (21%) who were prescribed psychotropic medication had a PSP rather than a PBSP. This compared to 16 % at the time of the prior review. At Richmond SSLC, the behavioral health services director said that she recently instituted a requirement for a complete functional assessment to be completed as a part of the PSP development/determination protocol. This will help to ensure that the determination of whether the individual should have a PSP or PBSP was appropriate for each individual (cf. Individual #118 as noted in ISP indicator 12 comments). The Monitoring Team was not concerned about the number of individuals at Richmond SSLC who had a PSP.

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

Summary: There was a signed consent form for each medication and HRC review was obtained as required. With sustained high performance, these indicators (28, 32) might be moved to the category of less oversight after the next review. Some additional attention is needed to ensure that the risk versus benefit discussion is complete for all individuals (indicator 30). These three indicators will remain in active monitoring. The content of the documentation regarding what was presented to the guardian and referencing alternate/non-pharmacological intervention options, however, met criteria for all individuals for this review and the last two reviews, too, with one exception in December 2015. Therefore, these two indicators (29, 31) will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

28. There was a signed consent form for all of the medications that each individual was prescribed that had been signed by the LAR or Facility Director within the prior year.

29. The consents for the psychotropic medications were specific for each medication. The information regarding side effects was adequate and understandable.

30. The consents included a separate risk benefit discussion for each individual. However, this was not adequate for Individual #67 and Individual #447 because they were prescribed multiple psychotropic medications with the potential for clinical interactions and there was no discussion of this added risk for these individuals.

31. There was a reference to potential alternative non-pharmacological interventions.

32. The consents were accompanied by HRC reviews and approvals.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Richmond SSLC maintained good performance on these important foundational aspects of providing behavioral health services. The two indicators that were not in the category of less oversight may move to this category after the next review, with sustained high performance. This review and the last review showed much improvement compared with the December 2015 review. Indicator 5 is pivotal for the determination of many other indicators in behavioral health services. It was very good to see that criteria for this indicator were met for all (but one) of the individuals. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	88% 7/8	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1

Comments:

1. At the time of the onsite review, Individual #118 had a psychiatric support plan, however, he recently began to engage in behaviors that placed both him and others at risk for injury. Therefore, he required a PBSP. It was encouraging to see that Richmond SSLC had begun the development of a PBSP for Individual #118 during the onsite review.

5. Seven individuals had evidence of interobserver agreement (IOA) and data collection timeliness (DCT) assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. Individual #787 did not have an IOA assessment in the last six months.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Richmond SSLC met criteria with the currency, content, and completeness of behavioral assessments and functional assessments for all individuals for this review and for the last two reviews too, with one exception in December 2015 and September 2016, respectively. Due to this sustained high performance, indicators 10 and 12 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
10	The individual has a current, and complete annual behavioral health update.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	The functional assessment is complete.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
Comments: 10. All eight individuals had current and complete annual behavioral health assessments. 11-12. All eight functional assessments were current and complete. The Monitoring Team was impressed with the overall quality of the functional assessments. For example, Individual #447's functional assessment contained, in addition to the components required to meet criteria with this indicator, a systematic preference assessment, and a functional analysis of his pica.											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Completeness of PBSPs continued to meet criteria, showing sustained improvement from the last review. With continued sustained high performance, indicator 15 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
Comments:											

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Seven of the eight PBSPs were complete. Individual #54's functional assessment indicated that escape from demands/environmental events likely maintain his SIB and property destruction, however, interventions addressing this function were not found in his PBSP.

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

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	56% 5/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
Comments: c. On 2/7/17, Individual #404 died, so this indicator was not calculated for him. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not											

define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Efforts were needed to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

b. Although Indicator b was moved to the category requiring less oversight, in reviewing individuals' annual medical assessments, the Monitoring Team noted that at times PCPs had not justified individuals' diagnoses. For example, for Individual #404, justification was not present for the diagnosis of iron deficiency anemia. For Individual #206, the term latent tuberculosis infection would have been the correct terminology, but PPD converter was used instead.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #206 – infections, and osteoporosis; Individual #447 – diabetes, and cardiac disease; Individual #663 – cardiac disease, and diabetes; Individual #570 – diabetes, and gastrointestinal (GI) problems; Individual #640 – diabetes, and osteoporosis; Individual #352 – GI problems, and seizures; Individual #404 – respiratory compromise, and cardiac disease; Individual #109 – osteoporosis, and constipation/bowel obstruction; and Individual #603 – urinary tract infections (UTIs), and diabetes].

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.	
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.	Individuals:

#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	22% 4/18	0/2	0/2	0/2	0/2	1/2	2/2	0/2	1/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	Comments: a. The IHCPs that sufficiently addressed the chronic or at-risk conditions in accordance with current standards of practice consistent with risk-benefit considerations were those for: osteoporosis for Individual #640; GI problems, and seizures for Individual #352; and constipation/bowel obstruction for Individual #109. b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Based on the Monitoring Team's review of the dental exams for other indicators, many of them did not meet criteria for timeliness, particularly the requirement that the dentist complete exams no earlier than 90 days prior to the ISP meeting. As a result, Indicator a.ii will return to active oversight. The Center should continue its focus on improving the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, based on the Monitoring Team's review of the dental exams for other indicators, many of them did not meet criteria for timeliness, particularly the requirement that the dentist complete exams no earlier than 90 days prior to the ISP meeting. As a result, Indicator a.ii will return to active oversight.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.										
	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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1

Comments: a. Six of nine dental exams reviewed did not meet criteria. It is important that IDTs have current dental exam information to develop the individuals' ISPs. Those that met criteria were for Individual #206, Individual #663, and Individual #570.

b. It was positive that for Individual #352, the dental exam included all of the required components. Individual #447 did not have an up-to-date dental exam. Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting; and
- A summary of the number of teeth present/missing.

c. It was positive that four individuals' dental summaries included all of the required components to meet their needs. Individual #447, and Individual #404 did not have dental summaries with up-to-date information. Moving forward the Center should focus on ensuring dental summaries include the following, as applicable:

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

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Due to previous high performance with regard to the completion of annual nursing reviews and physical assessments, Indicators a.i and a.ii moved to the category requiring less oversight. However, based on the annual nursing assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. As a result, Indicators a.i and a.ii will move back to active monitoring. The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603

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.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, due to regression in the completion of complete physical assessments, these indicators will move back to active monitoring.									
	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.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/10	0/1	0/2	0/1	0/2	0/1	0/1	0/2	N/A	N/A

Comments: a. Based on the Monitoring Team's use of annual nursing assessments and physicals for other elements of its review, problems were noted for all nine individuals with regard to completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. As a result, Indicators a.i and a.ii will move back to active monitoring. Similarly, quarterly physicals were missing these critical components.

This largely appeared to be due to issues with IRIS. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead. If this issue is corrected by the time of the next review, these indicators might move back to the category requiring less oversight.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #206 – falls, and weight; Individual #447 – constipation/bowel obstruction, and other: dementia/safety related to aggressive behavior; Individual #663 – infections, and cardiac disease; Individual #570 – falls, and infections; Individual #640 – infections, and weight; Individual #352 – constipation/bowel obstruction, and fractures; Individual #404 – weight, and aspiration; Individual #109 – constipation/bowel obstruction, and falls; and Individual #603 – choking, and skin integrity).

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

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

- In an IPN, dated 2/6/17, the Nurse Practitioner noted Individual #447 had three emesis the previous day and a suppository was given, but had not had any results yet. No nursing IPN was found for 2/5/17 noting the three emesis episodes or that a suppository was given for a fecal impaction. In addition, the data the Center provided for the Tier II document request IV.1-20 indicated the individual had no episodes of emesis in the past six months. However, it was noted that on 5/1/17, a KUB (i.e., abdominal x-ray) indicated mild constipation after staff reported emesis to the PCP. The lack of documentation of a nursing assessment for the emesis was of significant concern, since emesis had been a symptom that Individual #447 was constipated or impacted.
- Individual #447 took medication for dementia. However, nursing staff did not document any assessments to address dementia symptoms. As a result, information was not available to determine if his status changed.
- According to an IPN, dated 4/11/17, a direct support professional notified the Licensed Vocational Nurse (LVN) that Individual #663's right lower jaw was swollen. The nurse did not conduct a thorough assessment. Specifically, the assessment did not include a description of the area where the swelling was; a description of the inside of the individual's mouth, teeth, tongue, and gums, comparing the right side to the left side of the individual's mouth; any odor; the individual's ability to open and close his mouth; the individual's ability to breathe through both nostrils; the temperature of the skin; sensitivity to hot or cold; and/or if an injury was sustained recently. Individual #663 was allowed to go home with his family. An IPN, dated 4/15/17, indicated that the family called the Center to let them know the individual was in the hospital "fighting for his life." A nursing IPN, dated 4/16/17, indicated that the individual was on leave with no mention that he had been admitted to the hospital. In addition, on 5/17/17, nursing staff did not document an assessment or write an IPN noting when the individual returned from the hospital.
- An IPN, dated 3/29/17, from Habilitation Therapy noted Individual #352 refused to participate in the weight-bearing program due to right foot pain and redness. The note indicated that direct support professionals reported to nursing staff that the individual had been complaining of pain and redness over the lateral aspect of her heel, and nursing staff told the staff to use heel protectors instead of her tennis shoes. The Habilitation Therapy note indicated that: "PT did not find any notation in IRIS about this issue," and that Individual #352 needed to wear the tennis shoes during weight bearing to support her ankles. The PT assessed her right and concluded it was slightly red with mild tenderness. No nursing assessments of the individual's foot were found prior to or after this Habilitation Therapy IPN.
- Individual #404's weight graph clearly showed a weight loss of 12 pounds in one month (i.e., in February 2016, he weighed 164 pounds, and in March 2016, he weighed 152 pounds). On 2/15/16, he was admitted to the Infirmary for an oxygen saturation of 92 percent, and then was admitted to the hospital, where he was diagnosed with chronic obstructive pulmonary disease (COPD) and Congestive Heart Failure. On 3/19/16, he again was admitted to the hospital for pneumonia after an episode of vomiting. On 3/22/16, a percutaneous endoscopic gastrostomy tube (PEG-tube) was placed after a modified barium swallow study (MBSS) demonstrated aspiration. However, on 3/31/16, a MBSS was repeated and only showed a mild delay in swallowing. It is of major concern that nursing staff did not note the significant weight loss clearly demonstrated on the weight graph, conduct relevant assessments, and recommend that the IDT convene to reconsider the risk rating and develop an IHCP to address weight. Moreover, a brief note in the QIDP review, dated 12/28/16, indicated that: "since May (no year provided, but the Monitoring Team assumed it is 2016) [Individual #404] has lost 14.6 pounds, which [sic] his DWR

[desired weight range] is 150-170 and his current weight is 138.5" (no date of current weight provided). The nursing quarterly, dated 10/7/16 to 1/23/17, indicated that the IDT met on 11/3/16 to review Individual #404's's weight loss. However, no ISPA was found for this date. In addition, the nursing quarterly indicated that on 11/10/16, the PCP ordered labs to evaluate weight loss, and on 1/6/17, Individual #404 was seen at the Infirmary due to abnormal weight loss. ISPAs regarding Individual #404's health status, dated 1/13/17, 1/18/17, 1/26/17, and 2/15/17, never mentioned weight. The response to the document request for the last three months of weight records only included one weight for 11/1/16 (i.e., 135.2 pounds). The lack of specific values for weights by month, the reporting of weight values only every one to two months, and discrepancies in weights found in the documentation indicated there was no consistent and accurate tracking system in place to address weight.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Given that over the last four 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: 206	447	663	570	640	352	404	109	603
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. through f. Generally, IHCPs included no nursing interventions. The few that were included were to "administer medications," or to react when the individual was showing symptoms. The couple promising proactive interventions included:

- Individual #352's IHCP for constipation/bowel obstruction included an intervention for staff to evaluate the individual for abdominal distention, tenderness, and bowel motility. Unfortunately, the IHCP did not define all of the assessment criteria (e.g. bowel sounds, daily intake), did not assign responsibility, and did not include frequency of the assessments, or where

documentation would be maintained.

- For Individual #206, the only nursing intervention was to assess him if he fell. However, an intervention that was promising was for direct support professionals to clear items in the room and hallway that might contribute to falls/injuries. However, the IDT had not included a frequency. Staff were to document in the Observation notes, but it was unclear who, if anyone was to review the data, and address any concerns identified.

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: Although some improvement was noted with regard to the timely referral of individuals to the PNMT and completion of the PNMT reviews, these areas still needed focus. The Center also should concentrate on completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5	1/1	N/A	N/A	1/1	N/A	N/A	0/1	0/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5	1/1			1/1			0/1	0/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3	1/1			N/A			N/A	0/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	40% 2/5	1/1			1/1			0/1	0/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	33% 1/3	0/1			N/A			0/1	N/A	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	20% 1/5	0/1			1/1			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;	0% 0/3	N/A			0/1			0/1	0/1	N/A

	• Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	0/1			N/A			N/A	0/1	0/1

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 10/17/16, Individual #206 was hospitalized for a bowel obstruction. On 10/27/16, after his discharge from the hospital, the IDT referred him to the PNMT. On 11/1/16, the PNMT reviewed him, and on 11/29/16, the PNMT completed an assessment. The Core PNMT Team and Behavioral Health Services staff were listed as participants in the assessment, but based on the assessment, it was not clear that BHS staff assisted the PNMT in the problem-solving role (i.e., a recommendation indicated that PT and BHS staff would collaborate to increase ambulation in the home, but this did not reflect integrated assessment as part of the PNMT process, and another issue that required BHS input was noncompliance with taking medication).
- On 1/13/17, Individual #570's physician referred her to the PNMT in relation to skin integrity at the stoma site due to "moderate leaking." On 1/18/17, the PNMT initiated a review. The PNMT RN checked the stoma site, and saw redness and irritation, but no leaking. The PNMT recommended that staff change the stoma site dressing every shift, and if needed, the PCP make a referral to the gastroenterologist. The review did not address risk ratings. The IHCP was not modified as a result of the PNMT review, and it was unclear that the PNMT review was of the depth necessary to address the reason for the referral.
- On 12/30/16, Individual #404 was hospitalized for pneumonia, and returned to the Center on 1/3/17. The 1/4/17 RN post-hospitalization review indicated that the last PNMT assessment was dated 3/28/16, and addressed his new g-tube placement. In an IPN, the PCP indicated that the individual's diet was changed in the hospital due the diagnosis of aspiration pneumonia. On 1/6/17, the PCP saw him again, and noted diagnoses of abnormal weight loss (i.e., 29 pounds), acquired thrombocytopenia, COPD, diastolic dysfunction, and GERD. In January 2017, despite these diagnoses, the PNMT did not recommend referral because Individual #404 had not had pneumonia in over a year, but recommended a head-of-bed elevation (HOBE) evaluation to reassess this aspect of care. Of note, at the time of his last PNMT assessment, the PNMT identified concerns with regard to staff not intervening when he was overfilling his spoon and staff not consistently filling out trigger sheets. At that time, little was documented as having been done to address these issues. Given these circumstances and the new diagnosis of pneumonia, a referral was warranted for at least a PNMT review, and given that he also experienced significant weight loss, a comprehensive assessment likely should have been initiated. On 1/4/17, the PNMT attempted to conduct the recommended HOBE evaluation. Individual #404 refused to cooperate. The recommendation was to defer to the existing guideline of 30 degrees. It did not appear that additional attempts were made to complete a HOBE evaluation. On 1/11/17, Individual #404 went to the ED, and was admitted to the hospital. On 1/15/17, documentation indicated he was unresponsive and on ventilator. On 1/22/17, he was extubated and taking ice chips and ice cream. He reportedly was stable on 1/28/17 and 2/5/17. On 2/7/17, Individual #404 died with causes of death listed as cardiac arrest, pneumonia, and aspiration. Given that he was on a pureed diet texture with nectar thick liquids, it was unclear why staff were giving him ice chips and ice cream in hospital.

- Individual #109 experienced numerous falls. The data on falls did not appear complete. However, the IDT should have referred him or the PNMT should have made a self-referral when he met the following criteria: "Unresolved fall episodes (greater than three per month for two consecutive months)." At a minimum, in December 2016 and again in January 2017, he met criteria, but was not referred. Rather, the PNMT notified the QIDP that the IDT should meet to address the falls. The IDT did meet on several occasions, but clearly the interventions and plan the IDT developed were not working.
- On 7/5/16, based on an RN post-hospitalization review and meeting minutes, Individual #603 was referred to the PNMT, but then minutes indicated she did not meet criteria for assessment. On 10/5/16, according to the RN post-hospitalization review, she was referred to PNMT for a HOBE evaluation. There was no evidence of further review or assessment. On 11/18/16, Individual #603 experienced respiratory failure with also diagnoses of septic shock, fungemia, and pneumonia. She was placed on a ventilator. On 11/30/16, Individual #603 was transferred to an LTAC. On 12/12/16, she underwent a tracheostomy and had a sacral pressure ulcer. On 1/11/17, after her discharge on 1/10/17, the PNMT RN completed a post-hospitalization assessment and recommended referral, but then documentation stated that there were no PNM issues found, which was confusing given the numerous PNM issues Individual #603 had. On 2/16/17, she transferred back to the hospital with another diagnosis of aspiration pneumonia (i.e., other diagnoses were on 11/31/11, 11/3/15, and 11/16/16). On 2/22/17, she returned to the Center. On 3/1/17, Individual #603 was transferred to the ED due to recurrent emesis. She was hospitalized again for aspiration pneumonia, fungemia, bacterial sepsis, and C difficile colitis. The PNMT stated they could not complete an assessment at that time, because she returned to hospital. On 4/5/17, she returned to Center with a diagnosis of aspiration pneumonia and sepsis. As of 4/10/17, the PNMT assessment was in process of completion with target date of 5/4/17. On 5/9/17, the PNMT completed it. The assessment did not include the involvement of respiratory therapy or medical staff.

e. For Individual #206, although the PNMT discussed the results of the RN post-hospitalization review, the discussion and/or the documentation of the discussion was not thorough.

For Individual #404, it was not clear from the documentation submitted that the PNMT discussed the results of the post-hospitalization review.

h. As noted above, one individual who should have had comprehensive PNMT assessments did not (i.e., Individual #109). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- Individual #206's assessment did not address the relevance of medications and their side effects on his PNM issues. In addition, the PNMT assessment did not offer recommendations for clinically relevant, achievable, and measurable goals/objectives. As a result, Individual #206's IHCP was not modified to address his identified needs. The PNMT identified an etiology as his Ogilvie syndrome, but contributing factors included issues with hydration and his preference for wheelchair mobility and sitting in a sling-seat wheelchair. They offered some strategies related to improving fluid intake, but nothing to measure the effectiveness of these interventions. The PNMT also did not identify specific outcomes related to PT for ambulation and collaboration with BHS for compliance. With regard to the concern with him sitting in a sling-seat wheelchair, the PNMT did not offer recommendations to address their finding.
- Individual #603's PNMT assessment included numerous observations and findings in the main sections of assessment, which was good to see. However, these findings were not carried through to recommendations. The PNMT did not offer recommendations for clinically relevant, achievable, and measurable goals/objectives. As a result, Individual #603's IHCP was

not modified to address her identified needs.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/18	0/2	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: falls, and constipation/bowel obstruction for Individual #206; falls, and choking for Individual #447; choking, and fractures for Individual #663; falls, and skin integrity for Individual #570; falls, and weight for Individual #640; aspiration, and fractures for Individual #352; weight, and aspiration for Individual #404; choking, and falls for Individual #109; and fractures, and aspiration for Individual #603.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. Individual #663's IHCP on fractures included preventative interventions to minimize the condition of risk.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs/Dining Plans for Individual #447, Individual #570, and Individual #603 included all of the necessary components to meet their needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, four PNMPs referred to oral health care plans, but provided no instructions; three did not provide details

regarding the type of assistance the individuals required with toileting, as well as bathing; one had no pictures; and two had missing risks.

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

f. The IHCPs reviewed did not identify triggers and actions to take should they occur.

g. The IHCPs reviewed did not include the frequency of PNMP monitoring.

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	206	447	663	570	640	352	404	109	603
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% 0/4	N/A	N/A	N/A	0/1	N/A	0/1	0/1	N/A	0/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/4				0/1		0/1	0/1		0/1

Comments: a. and b. Individual #570 currently received oral intake, and enteral nutrition for refusals. The IRRF provided no clear data to show how often this occurred. The IRRF also stated that nurses administered medications through the G-tube, even though the PNMP provided instructions if given orally. The IHCP referenced hydration through the tube, although one part stated this was discontinued on 11/1/16. The more current IHCP entry, dated 2/1/17, referred to the Dining Plan and that the tube was not used at all. Ultimately, it was not clear how much intake she received orally versus through the tube and there was no plan to clearly address this issue.

Individual #352 and Individual #404's IDTs indicated that oral intake was not indicated and the tube was medically necessary. However, no findings regarding oral motor control status were included in these individuals' IRRFs.

Individual #603's IRRF included a detailed medical status over the last year, including a new tracheostomy. While the return to oral intake might not be possible for Individual #603, there was no statement or discussion to support the IDT's conclusion.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. The quality of OT/PT assessments continues to be an area on which Center staff should focus as numerous problems were noted. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	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; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

	• 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% 0/6	0/1	0/1	N/A	0/1	0/1	N/A	N/A	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A

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

- The ISPs for Individual #447, Individual #570, Individual #640, Individual #352, and Individual #603 that the Center submitted to the Monitoring Team were not dated correctly (i.e., it was impossible to determine the actual date the meeting was held from the documents the Center submitted). After obtaining an explanation from State Office as well as description of the State's actions to correct this moving forward, the Monitoring Team modified the scores for these six individuals. However, in the future, it is essential that when providing comments to draft reports, Center and State staff review the documents the Center submitted and tailor its comments accordingly.
- For Individual #663, the final OT/PT assessment was not completed until 2/2/17, which was after the ISP meeting on 1/25/17.
- On 1/5/17, based on brief observations on 1/3/17 and 1/5/17, the PT wrote a limited progress note for Individual #404 to evaluate his gait after a readmission to the hospital due to pneumonia. Individual #404 was refusing to walk, but he was observed walking independently outside of his room, and quickly returned to bed when he saw the PT. Individual #404 also was uncooperative when the RN tried to complete a HOBE. Based on the documentation provided, the PT drew conclusions about Individual #404's functional status based on very limited information, which did not constitute a valid assessment. The PT made no additional attempts to complete a change of status screening or evaluation.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for six individuals. Overall, many problems were noted with the assessments reviewed. The following summarizes some of the problems noted:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: For four of the six individuals, the assessments merely listed diagnoses and identified health issues in last year, but provided limited to no discussion of their relevance to functional performance or support needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services: Half of the individuals' preferences were not reflected in the development of skills;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #206's assessment did not identify risk levels 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: For two individuals, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard

components do not require a rationale): For Individual #206 and Individual #640, discussion of wheelchair condition was not included in the assessments. For Individual #640, fit also was not discussed, nor was a rationale for components provided. For Individual #206, the assessor did not discuss the rationale for his current wheelchair or for the trial with a Power Assist wheelchair;

- 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: Four of the assessments reviewed did not provide a comparative analysis;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: Most of the assessments did not meet this criterion. Problems included a lack of monitoring findings, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: A number of assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. Similarly, some assessments recommended services, but did not provide the rationale. The only assessment that met criterion was the one for Individual #447; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

e. The following summaries some examples of concerns noted with regard to the required components of OT/PT updates:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: Individual #663's assessment provided limited discussion of the impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services: It was good to see that the OT/PT incorporated Individual #352's preference to visit the coffee shop into a recommended SAP. For Individual #663, the preferences were listed, but not incorporated into recommended supports and services;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): The condition and effectiveness of Individual #663's adaptive equipment was not sufficiently discussed in the update;
- 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: For Individual #663, the assessment did not present data to show a comparison of his left elbow extension to previous assessments. No baseline data was reported prior to Botox injections and application of the dyna-splint;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Either no monitoring was reported, or monitoring was reported, but the findings were unclear;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Data was not collected and/or reported to provide clinical justification related to the effectiveness of

supports and services and/or the need for more or less services; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Neither assessment included a full set of recommendations, including recommendations for clinically relevant, measurable goals/objectives.

On a positive note, as applicable, all of the updates reviewed provided:

- 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; and
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day.

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: These indicators need attention and will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	13% 1/8	0/1	0/1	0/1	0/1	0/1	1/1	N/A	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.	13% 1/8	0/1	N/A	0/1	0/2	0/1	1/2	N/A	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments: d. Examples of concerns noted included:

- An ISPA for Individual #352, dated 12/13/16, identified the need for upper extremity exercises, but no evidence was found of implementation.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Numerous concerns were noted with the comprehensive communication assessments and the update reviewed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	N/A								N/A	
	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.	N/A									
	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.	71% 5/7	0/1	1/1	1/1	0/1	1/1	1/1	N/A		1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	1/1		1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	0/1		N/A

	augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1	N/A	0/1	0/1	N/A	N/A		0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A		N/A

Comments: a. The ISPs for Individual #447, Individual #640, Individual #352, and Individual #603 that the Center submitted to the Monitoring Team were not dated correctly (i.e., it was impossible to determine the actual date the meeting was held from the documents the Center submitted). After obtaining an explanation from State Office as well as description of the State's actions to correct this moving forward, the Monitoring Team modified the scores for these four individuals. However, in the future, it is essential that when providing comments to draft reports, Center and State staff review the documents the Center submitted and tailor its comments accordingly. Center staff need to take into consideration holidays in calculating timeliness (e.g., Individual #206).

c. Some of the concerns noted included:

- Individual #663's communication screening did not discuss if he would benefit from amplification to address a moderate hearing loss that resulted in poor speech discrimination and interference with functional communication due to background noise. In 2013, his comprehensive communication assessment indicated that a trial with bilateral amplification was indicated. The recent screening did not report the outcome of such a trial.
- Individual #404's communication screening did not thoroughly describe his functional expressive and receptive communication skills. It also did not address medications and relevant side effects. Rather, it merely listed side effects, and it was not clear whether or not he was prescribed medications that had these potential side effects. The Speech Language Pathologist (SLP) did not provide a sufficient rationale for a screening versus an assessment or a clear rationale for his not needing supports.

d. Numerous concerns were noted with the five comprehensive communication assessments reviewed. Some of these concerns included:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Individual #447's assessment referred to "medical changes" in the last year that could impact his communication skills, but did not discuss these changes;
- The individual's preferences and strengths are used in the development of communication supports and services: Three of the five assessments merely listed the individuals' preferences and strengths, but did not incorporate them into recommendations;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Most of the assessments listed the individuals' medications and potential side effects, but they lacked discussion of whether such side effects had been noted for the individual being assessed and/or whether they impacted communication. In one instance, side effects were listed, but it was unclear to which medications they related;
- 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: Assessments did not provide specifics about

individuals' communication skills, which is not helpful to individuals' IDTs;

- A comparative analysis of current communication function with previous assessments: For Individual #640, no comparative analysis from previous assessments was noted;
- The effectiveness of current supports, including monitoring findings: This was not applicable to one individual. For the remaining four individuals, results of monitoring/observations over the previous year were not cited, and/or the assessors concluded that supports were effective, but provided no data to support this conclusion. For one individual, no information was provided regarding his progress on goals/objectives;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: This is a component of assessment that requires significant improvement. None of the assessments reviewed met this criterion;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services (BHS) as indicated: Evidence to show compliance with this sub-indicator was present for Individual #206. However, for Individual #447, the assessment indicated the SLP planned to collaborate with BHS staff, but did not do so for the purpose of the assessment; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs. In addition, identified needs often were not addressed through recommendations.

e. Numerous problems were noted with regard to Individual #352's update. Some examples included that the update listed the individual's strengths and preferences, but did not apply them in a meaningful way; offered only generic discussion of medications and their impact on communication; provided no reference to monitoring in order to analyze the effectiveness of current supports and services; did not provide justification for not pursing the option of a tablet; and did not offer recommendations to improve or expand the use of her communication book.

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	38% 3/8	0/1	1/1	0/1	0/1	0/1	1/1	N/A	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate,	0%	N/A	0/1	N/A	0/1	0/1	0/1	N/A	N/A	0/1

	and it comprehensively addresses the individual's non-verbal communication.	0/5									
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	8% 1/13	0/2	0/6	N/A	0/2	1/1	0/1	N/A	N/A	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. For five individuals, their ISPs included incomplete descriptions of their communication skills, and/or how others should communicate with the individual. d. No evidence was found that the IDT held an ISPA meeting to approve a goal/objective and modify the ISP related to direct therapy initiated for Individual #447.											

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: Performance was about the same as last time. Even though indicator 1 is scored at 100%, about half of the individuals had less than three SAPs. These were individuals who had many skill deficits and could benefit from a better set of SAPs. This same problem was noted in the last report, too. A renewed focus on SAPs was described by the facility, including assignment of behavior analyst from the behavioral health services department to oversee this. These five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	86% 19/22	2/2	3/3	1/1	1/3	2/2	2/3	3/3	3/3	2/2
3	The individual's SAPs were based on assessment results.	68% 15/22	2/2	1/3	0/1	2/3	2/2	1/3	2/3	3/3	2/2
4	SAPs are practical, functional, and meaningful.	45% 10/22	0/2	0/3	0/1	2/3	0/2	1/3	2/3	3/3	2/2
5	Reliable and valid data are available that report/summarize the	5%	0/2	0/3	1/1	0/3	0/2	0/3	0/3	0/3	0/2

	individual's status and progress.	1/22										

Comments:
1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There was only one SAP to review for Individual #787, and two SAPs available to review for Individual #54, Individual #682, and Individual #51, for a total of 22 SAPs for this review.

2. Eighty-six percent of the SAPs were judged to be measurable (e.g., Individual #206's operate his TV SAP). Some SAPs, however, were judged not be measurable because they did not have a specific number of prompts necessary to achieve the objective (e.g., Individual #346's clean his room SAP), or the prompt level was not identified (Individual #118's budgeting SAP).

3. Sixty-eight percent of the SAPs were based on assessment results. The remaining seven SAPs were inconsistent with assessment results (e.g., Individual #206's operate a phone SAP).

4. Ten SAPs were practical and functional (e.g., Individual #118's download songs SAP). The SAPs that were judged not to be practical or functional typically represented a compliance issue rather than a new skill (e.g., Individual #51's complete her vocational task SAP), or assessment data indicated the individual already possessed the skill (e.g., Individual #67's operate a radio SAP).

5. Only Individual #787's follow directions SAP had interobserver agreement (IOA) demonstrating that the data were reliable. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). It was encouraging to learn that Richmond SSLC recently established a plan to conduct IOA on every SAP at least every six months.

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: All three indicators were met for one individual (same as last time), however, overall, these indicators required more attention and will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9	0/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1

Comments:
10. Eight individuals had current FSAs, PSIs, and vocational assessments (if appropriate). The exception was Individual #54, who did not have a vocational assessment.

11. Individual #118, Individual #682, and Individual #67 had documentation that FSAs, PSIs, and vocational assessments were available to the IDT at least 10 days prior to the ISP.

12. Individual #67, Individual #346, Individual #118, and Individual #447's vocational assessments did not include recommendations for SAPs.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 20 of these indicators were moved to the category of requiring less oversight. For this review, 10 other indicators were added to this category, in restraints, psychiatry, psychology/behavioral health, and pharmacy, including one full outcome: psychiatry outcome 7. On the other hand, one indicator was returned to active monitoring due to poor performance. This was in 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

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

Content of the psychiatry quarterly review documentation was now at 100% scoring. Attendance at quarterly reviews by all relevant team members continued to be an area of improvement for Richmond SSLC. Psychotropic medication side effect assessments were usually completed, but an area for improvement is completing prescriber review. Continued improvement was shown in the management of polypharmacy. One individual's need for blood draws for lab value determination is highlighted below in psychiatry outcome 11, indicator 36.

Acute Illnesses/Occurrences

Regarding use of crisis intervention restraint more than three times in any rolling 30-day period, all of the indicators were met the one case to which this applied, except for the indicators regarding the crisis intervention plan. At this point, seven of the 12 indicators have been moved to the category of requiring less oversight.

Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

Numerous problems were noted with regard to the Medical Department's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations.

For the dental emergency reviewed, based on documentation provided, Medical Department and Dental Department staff did not conduct necessary follow-up despite worsening symptoms. The individual's family took him to the Emergency Department during a home visit, and he required extraction of four teeth, had a neck infection, and required additional surgical intervention, including debridement of muscle and fascia, tracheostomy, and skin grafting.

In psychiatry, without measurable goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Implementation of Plans

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

Significant work was needed to ensure that individuals received the medical assessments, tests, and evaluations consistent with current standards of care to address their chronic or at-risk conditions, and that PCPs 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, and often, for those action steps assigned to the PCPs in IHCPs, documentation was not available to show PCPs implemented them.

For the consultations reviewed, it was good to see improvement with regard to PCPs writing IPNs that were consistent with the requirements of the related policy. The timeliness of reviews of consultations is an area on which the Center should focus.

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

A number of individuals reviewed had not had needed dental treatment. Based on the Monitoring Team's review of dental documentation for review of other indicators, a number of individuals had not had tooth-brushing instruction at each preventive visit. As a result, the related indicator will move from the category requiring less oversight to active monitoring. In addition, the Dental Department should provide individuals with timely prophylactic care, and x-rays, and ensure that individuals with periodontal disease have treatment plans that meet their needs and are implemented.

Based on the individuals reviewed and positive findings from the previous two reviews, the Clinical Pharmacist completed timely Quarterly Drug Regimen Reviews (QDRRs). As a result, one indicator will be placed in the category requiring less oversight. The quality of QDRRs and timely provider review of the QDRRs are areas in which the Center needs to improve its performance.

Psychiatry worked well with other departments. For instance, there was good coordination and work going on between psychiatry and behavioral health services. This should set the occasion for the development and obtaining of reliable and valid data on psychiatric indicators. In addition, treatment was coordinated between psychiatry and neurology.

In behavioral health services, there was good reliable data for eight of the individuals. This was good to see and two of the individuals were rated as making progress. Goals/objectives were not always updated when met. When goals were not met, however, actions were taken and, when actions were identified, Richmond SSLC implemented them.

There were many positive aspects of the provision of behavioral health services at Richmond SSLC. For instance, staff training maintained at 100%. Summaries for float staff existed for all. Graphs of targeted and replacement behaviors continued to be well made and useful for making treatment decisions. Data collection systems were flexible to individual need and adequately measured PBSP and replacement behaviors.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: All of the indicators were met for this one individual, except for the indicators regarding the crisis intervention plan. The CIP was developed, but the individual's LAR did not approve it. Given the sustained high performance on many of the indicators for this review and the previous two reviews, too, four additional indicators will be moved to the category of requiring less oversight (19, 20, 22, 28). The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	787								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors	100% 1/1	1/1								

	that provoke restraint, a plan to address them.										
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	100% 1/1	1/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 1/1	1/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	0%	0/1								
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 1/1	1/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 1/1	1/1								

Comments:
18-29. This outcome and its indicators applied to Individual #787.

19. Individual #787 had an ISPA to address her restraints within 10 business days of her fourth restraint. Additionally, a sufficient number of ISPAs existed for developing and evaluating their plan to address each individual's restraints.

20. Individual #787's ISPA following more than three restraints in 30 days included a discussion of potential adaptive skills, and biological, medical, and/or psychosocial issues, and actions to address them in the future.

21. Individual #787's ISPA following more than three restraints in 30 days reflected a discussion of several potential contributing environmental variables (e.g., cluttered room) and actions (e.g., teach her to clean and maintain her room) to address the variables hypothesized to contribute to her restraints.

22. Individual #787's ISPA included a discussion of potential antecedent events that affected her restraints, and a plan to address them.

23. Individual #787's ISPA indicated that her IDT concluded that consequences did not affect her restraints.

25. Individual #787 did not have a CIP. Richmond SSLC did develop a CIP, however, Individual #787's guardian refused to sign it.

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: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
8-9. The lack of goals that were derived from the underlying psychiatric diagnosis made it impossible to assess for meaningful progress. Thus, the first two indicators are scored at 0%.

10. However, it was clear from the psychiatric quarterlies and the integrated progress notes that the psychiatrists intervened when there was a concern about emerging side effects or a deterioration in an individual's psychiatric status. Evidence of these interventions was found in the records of all of individuals, except Individual #682 for whom there was no indication that urgent interim interventions were required.

11. The interventions that were recommended were implemented.

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

Summary: There was good coordination and work going on between psychiatry and behavioral health services. As noted in psychiatry outcome 2, this should set the occasion for the development and obtaining of reliable and valid data on psychiatric indicators. Due to sustained high scores for all individuals for this review and the last two reviews (with one exception in December 2015), both indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
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.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1

Comments:
23. The quarterly psychiatric documents routinely referenced the behavioral data and the behavioral contributions to the individual's presentation. The Behavioral Health Assessment (BHA) contained a specific section for the discussion of the individual's psychiatric disorder and the contributions of the symptoms of the disorder to their behavioral presentation.

24. The section of the BHA that discussed the role of the psychiatric disorder also provided a notation of consultation between the behavioral health specialist and the psychiatrist concerning the development of the plan, including the date that this discussion

occurred. In addition, the psychiatrist reviewed and signed the PBSP. Individual #118 did not have a PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.												
Summary: Treatment was coordinated between psychiatry and neurology and documented as such. With sustained high performance, indicator 27 might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
27. There were two individuals for whom anticonvulsant medications were used both for treatment of a seizure disorder and for treatment of a psychiatric disorder (Individual #67, Individual #54). The neurology notes were referenced by psychiatry in IPNs when the clinic occurred, and in the subsequent quarterly review. The neurology consultations were also attended by the psychiatrist and the PCP. This method ensured that there was direct communication between the three disciplines regarding the content of the consult and the plans for future treatment. An onsite request for the attendance sheet for these meetings confirmed that these meetings occurred for these two individuals.

The facility had difficulty in obtaining blood levels for Individual #54's medication. See comments in this report below in psychiatry outcome 11, indicator 36.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: There was improvement in the content of the quarterly review documentation, resulting in 100% scoring for this review. Quarterly reviews were held every quarter for most individuals for most of the time. The handful of exceptions were due to late occurrences rather than the absence of a quarterly review. Attendance at quarterly reviews by all relevant team members continued to be an area of improvement for Richmond SSLC. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54

33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1

Comments:
33. The quarterly reviews were completed every three months for seven of the individuals. The exceptions were Individual #346 for whom there was a gap of greater than three months between the 8/16/16 and the 12/19/16 reviews as well as Individual #447 for whom there was a gap of greater than three months between the 7/28/16 and the 11/9/16 reviews.

34. The documentation related to the psychiatric quarterlies was adequate for all of the individuals.

35. The psychiatric clinics for Individual #118 and Individual #54 were observed during the onsite review. These meetings were attended by the psychiatrist, the psychiatry assistant, the nurse case manger, the behavioral assistant, and the QIDP. The various criteria in the sub-indicators were met, except that a member of the direct care staff was not present for either of these individuals and, thus, there was no direct input from a DSP.

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

Summary: These side effect assessments were usually (though not always) completed for all individuals as required. The main area for improvement is obtaining prescriber review and signature. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
36. The requirements for this outcome involve the timely completion of the MOSES every six months and the AIMs every three months. This outcome also required that the prescriber review and sign these evaluations, which were performed by members of the nursing staff, within 15 days.

These requirements were completely met for none of the individuals.

Even so, it should be noted that the assessments were completed for most of the individuals most of the time. The primary deficit was related to the requirement that the prescriber review the forms within 15 days of completion. The MOSES was completed as required for all the individuals, except Individual #67 and Individual #682. The AIMS was completed as required for all of the individuals, except

Individual #67, Individual #682 and Individual #51.

At the last review (September 2016), Individual #54 was in need of labs due to high VPA and prolactin levels. The staff were having a hard time getting his cooperation with getting his blood drawn. Since then, multiple attempts to draw blood were unsuccessful. The psychiatry and behavioral health services department worked together and tried various procedures, such as using preferred staff and preferred reinforcers (e.g., Coke, vehicle rides), but these were not successful. Therefore, a blood draw was done while he was sedated during TIVA for dental work, on 6/8/17. Fortunately, both levels were within normal parameters and Individual #54 had not been showing any symptoms to indicate otherwise. The facility planned to continue to try procedures for blood draws, with draws during already-scheduled TIVA as a last resort. The Monitoring Team suggests that side effects for these two medications, in particular, be monitored and that a written plan (formal or informal) be developed to teach Individual #54 to allow blood draws to be done. Blood draws are likely going to be a lifelong part of his care.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary:			Individuals:								
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators continued at a high level of performance. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	administration (PEMA), the administration of the medication followed policy.										

Comments:

40. The dosages of the prescribed medications were reasonable and did not suggest that the goal was to sedate the individual.

41. There was no indication that the psychotropic medications were used for the convenience of staff, punishment, or for sedation.

42. The record of each individual contained either a PBSP or a PSP.

43. The facility did not utilize PEMA.

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: Continued improvement was shown in the management of polypharmacy as per the many requirements of these indicators. They will remain in active monitoring. With sustained high performance, they might be moved to the category of less oversight after the next review.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A
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.	100% 6/6	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A

Comments:

44. There were six individuals in the review group whose psychotropic medications met the criteria for polypharmacy (Individual #51, Individual #67, Individual #787, Individual #118, Individual #206, Individual #447). There was clinical justification for the medications for all of these individuals.

45. For all of these individuals, there was either a plan to taper the medications if they were stable or it had been determined that the current dose was the minimum effective dose.

46. The frequency of review in the Polypharmacy Committee met the criteria for all of the individuals. .

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: Richmond SSLC had good reliable data for eight of the individuals. This was good to see and two of the individuals were rated as making progress. Goals/objectives were not always updated when met. When not met, actions were taken in most cases and when actions were identified, Richmond SSLC implemented them. This was the case for all examples during this review and the last two reviews, too. Therefore, indicator 9 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
6	The individual is making expected progress	25% 2/8	0/1	0/1	0/1	1/1	0/1	N/A	1/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	33% 1/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	1/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	83% 5/6	1/1	1/1	1/1	N/A	1/1	N/A	N/A	0/1	1/1
9	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	1/1	1/1	N/A	1/1	N/A	N/A	N/A	1/1

Comments:
6. Individual #206 and Individual #346 were scored as making progress toward their target behavior objectives. The remaining individuals were judged to not be making progress.

7. Individual #447 achieved his objective of 0 incidents of pica in 12 months, and the IDT decided to maintain that objective another year due the potential danger of this behavior. Individual #206 achieved his aggression objective in February 2017, his property destruction objective in July 2016, and his SIB objective in November 2016, however, no new objectives (or rationale why the objective would be maintained) were presented. Similarly, Individual #346 achieved his property destruction objective in September 2016 and no new objectives were established.

8-9. Individual #51, Individual #67, Individual #787, Individual #682, and Individual #54 were not making progress, however, their progress notes included actions to address the absence of progress. Individual #447 demonstrated increases in property destruction and stealing, however, no actions to address the lack of progress in these target behaviors were suggested.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: Staff training maintained at 100% and with sustained high performance	Individuals:

might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. Summaries for float staff have existed for all individuals for this review and the past two reviews, too. Therefore, this indicator (17) will be moved to the category of requiring less oversight.											
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
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% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 16. The Monitoring Team was encouraged to find that all individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs. 17. Summaries were available for float staff for all individuals.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Graphs continued to be well made and useful for making treatment decisions. This has been the case for all individuals for this review and the previous two reviews, too. Therefore, indicator 20 will be moved to the category of requiring less oversight. Peer review met criteria for this review and with sustained high performance, this indicator might also be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
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% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of										

	recommendations made in peer review.		
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%	

Comments:
20. All individuals had progress notes and graphed PBSP data that lent themselves to visual interpretation, and included indications of the occurrence of important environmental changes (e.g., medication changes).

23. Individual #118 was reviewed in the peer review meeting during the onsite review. He was reviewed because the team decided that he needed a PBSP. His peer review included the review of his history, functional assessment, PSP, and progress notes. There was participation and discussion by the behavioral health services team to address his recent increase in target behaviors. Additionally, Richmond SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

Summary: Richmond SSLC maintained data collection systems that met the many varied criteria across the set of indicators in this outcome. This was very good to see. As a result of sustained high performance, three of these indicators (26, 27, 29) will be moved to the category of requiring less oversight. With sustained high performance, indicator 28 might be moved to the category of requiring less oversight after the next review. Achievement of the set goals regarding data collection was improving from review to review, but was not yet at criteria. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	50% 4/8	0/1	1/1	0/1	1/1	0/1	N/A	0/1	1/1	1/1

Comments:
26-27. The data collection system was flexible to individual need and adequately measured PBSP and replacement behaviors.

29. Individualized frequency and minimal levels of treatment integrity, IOA, and DCT were established for all individuals.

30. All individuals had treatment integrity, IOA, and DCT. Established frequencies were not achieved for Individual #51 (DCT), Individual #787 (IOA), Individual #682 (treatment integrity), or Individual #206 (treatment integrity and IOA).

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #206 – infections, and osteoporosis; Individual #447 – diabetes, and cardiac disease; Individual #663 – cardiac disease, and diabetes; Individual #570 – diabetes, and GI problems; Individual #640 – diabetes, and osteoporosis; Individual #352 – GI problems, and seizures; Individual #404 – respiratory compromise, and cardiac disease; Individual #109 – osteoporosis, and constipation/bowel obstruction; and Individual #603 – UTIs, and diabetes).

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

of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
Summary: Three of the nine individuals reviewed received the preventative care they needed. Some declines were noted in the overall scores for the various types of preventative care. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual receives timely preventative care:										
	i. Immunizations	33% 3/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1
	ii. Colorectal cancer screening	57% 4/7	0/1	1/1	1/1	N/A	0/1	N/A	0/1	1/1	1/1
	iii. Breast cancer screening	50% 1/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	0/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	vii. Cervical cancer screening	100% 4/4	N/A	N/A	N/A	1/1	1/1	1/1	N/A	N/A	1/1
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	1/1	0/1	0/1	0/1
Comments: a. The following problems were noted:											

- No zoster status was in the record for Individual #206. According to Individual #206's AMA, on 2/25/16, the gastroenterologist (GI) recommended a repeat colonoscopy due to chronic pseudo-obstruction and a family history of colon cancer (i.e., his sister). The documentation included multiple notes about a colonoscopy being scheduled and cancelled until the PCP could review the individual's medical records. Per the AMA, it was rescheduled for 9/27/16, but documentation was not found to show the colonoscopy occurred. A GI consult, dated 12/14/16, noted problems with preparation. However, in the May 2017 AMA, the PCP documented that there was no record of a bowel preparation being ordered.
- For Individual #447, the administration of Tdap was not clear, due to different dates being in different documents (e.g., the AMA and the immunization record).
- Individual #640's immunization record did not include her zoster status. According to the AMA, on 7/22/11, Individual #640 had a colonoscopy, and the recommendation was to repeat it in five years. Documentation of a follow-up colonoscopy was not submitted. The Center submitted an esophagogastroduodenoscopy (EGD) report in response to the Monitoring Team's request for colonoscopy documentation.
- For Individual #352, the AMA and official immunization record were not consistent. For example, the AMA documented the pneumococcal vaccination, but the immunization record did not. The AMA included varicella status, but the vaccine record did not. It was unclear which was correct.
- Again, for Individual #404, the immunization record and AMA included inconsistent information. Individual #404 went through preparation for a colonoscopy scheduled for 5/15/12, but then ate. The Preventive Care Flow Sheet documented that the individual refused to complete a bowel preparation. Therefore, an air contrast barium enema was obtained on 9/6/12. The Center should have submitted the report for this study, but did not. On 6/20/11, he had a DEXA scan. Given his continued risk, it should have been repeated in five years, but was not.
- Individual #603 never received the Zostovax vaccine. In 2015 and 2016, she was treated for Herpes Zoster. In addition, the status of her PPD was not clear. The reason Center staff provided for no mammogram was "handicap and feeding tube." This is not sufficient justification for not completing a mammogram.

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 its comments on the draft report, the State copied excerpts from the medication side effects sections of the AMAs that the Monitoring Team had reviewed, and argued that several of them met criteria. It is essential when reviewing these sections to also take into consideration other data and information in other sections of the AMAs, lab reports, etc. The following provide some examples of problems noted:

- Even though Individual #603 was recently diagnosed with diabetes mellitus, the PCP rated her at low risk on the risk chart. In addition, there was no substantive discussion of risk mitigation.
- For Individual #570, the PCP commented in the AMA, dated 1/13/17, that she did not have a diagnosis of diabetes or metabolic syndrome. In fact, on 12/8/16, the glucose was 123, and had consistently been 120 or greater since that time. Furthermore, the validity of these elevated glucose levels was affirmed with the A1c level of 5.8 on 4/6/17. The failure to acknowledge the elevated blood glucose levels resulted in the PCP rating the diabetes risk as low in the January AMA. The individual meets the American Diabetes Association criteria for prediabetes.
- Individual #640 met three of the five criteria for metabolic syndrome: triglycerides of 230, high-density lipoprotein of 39, and fasting blood glucose of 104. This was sufficient to make the diagnosis. It was unclear why the PCP assessment in the AMA,

	dated 2/3/17, was "may present with borderline metabolic syndrome." The AMA risk assessment for diabetes/metabolic syndrome was medium. It was unclear why the PCP rated this as medium when the individual met the criteria for the diagnosis of metabolic syndrome. At the time of the Monitoring Team's review, the individual now met the criteria for diabetes mellitus, based on an A1c of 6.6 on 4/5/17. The PCP acknowledged this in the interim medical review, dated 5/10/17. The individual was started on metformin for control of diabetes mellitus. Hyperglycemia and elevated HbA1cs were documented several months prior to April 2017. The failure to address this in the risk assessment delayed implementation of treatment.

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: The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
	Comments: None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed had DNR Orders in place at the time of the review.										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Numerous problems were noted with regard to the Center's handling of acute issues addressed at the Center, as well as for acute issues requiring ED visits or hospitalizations. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	42% 5/12	1/2	0/2	0/1	1/2	0/2	1/1	1/1	1/1	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.	27% 3/11	1/2	0/2	0/1	1/2	0/2	N/A	0/1	1/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an	50% 3/6	N/A	1/1	N/A	N/A	0/1	N/A	2/2	N/A	0/2

	IPN with a summary of events leading up to the acute event and the disposition.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 2/4		N/A	N/A		0/1		2/2		0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	60% 3/5		1/1	N/A		0/1		2/2		0/1
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 with this indicator, it has moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	75% 3/4		N/A	N/A		1/1		0/1		2/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	17% 1/6		0/1	0/1		0/1		0/1		1/2

Comments: The Monitoring Team specifically requested: "IPNs for last six months - This should include all disciplines' IPNs (e.g., medical, nursing, dental, habilitation therapies, etc.) in chronological order (i.e., Center staff should collate the entire set of IPNs so that they are in chronological order)." Based on the State's comments to the draft report, the Center did not follow these instructions, and included notes that should have been included as IPNs in response to numerous other document requests. In the future, Center staff should provide the documents the Monitoring Team requests in the format requested. The IPNs need to tell the entire clinical story.

a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 12 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #206 (subconjunctival hemorrhage on 2/9/17, and abdominal pain on 1/18/17), Individual #447 (emesis on 11/30/16, and emesis/constipation on 2/6/17), Individual #663 (fall/abrasion on 1/6/17), Individual #570 [cellulitis/abscess on 12/29/16, and gastrostomy tube (g-tube) leakage on 3/11/17], Individual #640 (acute rhinosinusitis on 5/4/17, and left arm assessment on 11/2/16), Individual #352 (allergic rhinitis on 12/2/16), Individual #404 (chronic obstructive pulmonary disease on 12/14/16), and Individual #109 (neck pain on 3/13/17).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #206 (abdominal pain on 1/18/17), Individual #570 (cellulitis/abscess on 12/29/16), Individual #352 (allergic rhinitis on 12/2/16), Individual #404 (chronic obstructive pulmonary disease on 12/14/16), and Individual #109 (neck pain on 3/13/17).

The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the

acute problem resolved or stabilized were for Individual #206 (abdominal pain on 1/18/17), Individual #570 (cellulitis/abscess on 12/29/16), and Individual #109 (neck pain on 3/13/17).

The following describe some of the problems noted:

- On 12/14/16, the PCP evaluated Individual #404 for reports of coughing. The PCP noted that the individual was not receiving scheduled bronchodilator and steroid nebulizer treatments. This was attributed to behavioral issues. The individual did not allow a physical exam. The PCP concluded that the "cough is more likely due to missing his COPD breathing treatment." The treatments were rescheduled for the afternoon. The PCP did not document follow-up or re-attempts at assessing the individual. Individual #404 continued to have an intermittent cough for several days. Since behavioral issues were cited as the reason that he did not receive his scheduled treatments, it would have been appropriate for the PCP to refer this to the IDT. On 12/30/16, Individual #404 was hospitalized with pneumonia.
- According to an IPN, on 11/2/16, "This nurse assessed [Individual #640] per request of [name of nurse practitioner], NP," and noted: "Attention paid particularly to left arm. Left arm assessed… nothing abnormal noted." (In its comments on the draft report, the State questioned the order of these activities in the following comment: "Should it be the other way around, that the nurse informed the Nurse Practitioner?" The Monitoring Team agrees that what was documented is not standard practice.) The provider ordered a STAT ultrasound. On 11/4/16, nursing staff documented that the individual was on medical monitoring that the nurse initiated on 11/2/16. On 11/3/16, an ultrasound was obtained to rule out a deep vein thrombosis. The PCP did not document an evaluation or the ultrasound findings. It was not clear why the study was obtained, since there was no documentation of a PCP evaluation. In its comments on the draft report, the State indicated that the Center failed to provide documentation that might have clarified this issue.
- On 5/4/17, the PCP assessed Individual #640 for a report of a runny nose. The assessment was seasonal allergies, acute rhinosinusitis, and anorexia. The PCP requested a complete blood count (CBC) and basic metabolic panel (BMP) and prescribed loratadine along with oral hydration. The PCP did not document follow-up, or the lab results. In its comments on the draft report, the State argued that because the lab results were included in the interim review, the Center should receive a positive score. Again, there was no follow-up assessment documented for this acute issue. The interim medical review is not a follow-up evaluation. The Monitor did not revise the score.
- On 3/10/17, Individual #570 underwent dental treatment (not specified) in the hospital. On 3/11/17, the PCP assessed the individual for G-tube leakage. The assessment was g-button leakage. Nursing staff changed the button. Orders were given for a KUB (abdominal x-ray) with Gastrografin, hold enteral feedings, and routine checking of gastric residual. The PCP made no comments related to the hospital treatment that occurred on 3/10/17. There was no acknowledgment that the individual received sedation and/or general anesthesia. On 3/12/17, the PCP documented that the g-tube was in the stomach, and a moderate amount of rectal stool was present. The PCP did not document that this was addressed (i.e., bowel management plan). The provider noted that the above findings would be discussed with the individual's primary doctor the next day. Nursing staff subsequently documented that the PCP ordered a bisacodyl suppository based on the KUB findings and the individual had a large bowel movement. The PCP did not include this intervention in the note. Medical staff made no additional IPN entries even though nursing and dental staff were documenting medical/dental problems for this individual. On 5/9/17, nursing staff noted that the gastric button was displaced and nursing staff replaced it, and a KUB verified placement. On 5/15/17, nursing staff documented that the individual was attending a GI appointment.
- In its comments on the draft report, the State erroneously referenced Individual #663's dental infection as the issue addressed

for Indicators a and b. As noted above, the acute issue addressed at the Center that was scored for Individual #663 was a fall/abrasion.

c. through h. For five of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #447 (ED visit for jaw contusion on 1/14/17), Individual #663 (admission for Ludwig's angina on 4/11/17), Individual #640 (admission for UTI on 1/13/17), Individual #404 (admission for pneumonia on 12/30/16, and septic shock on 1/11/17), and Individual #603 (acute respiratory failure and pneumonia on 11/16/16, and pneumonia and UTI on 2/16/17).

Of note, the Center provided incomplete hospital information. Hospital liaison notes were submitted. However, for each hospitalization, the response to the records request should provide the transfer record, the ED notes, the admitting history and physical, and the discharge summary. The transfer record was not submitted for any of the individuals reviewed and the admitting history and physical, and discharge summary were not consistently provided.

The following provide examples of concerns noted:

- On 3/10/17, Individual #663 was seen in the dental clinic. It was noted that the individual "still has bleeding in areas of #11. Get consent for filling and local gingival therapy." On 4/11/17, the PCP saw the individual for swelling to the right lower jaw. The physical exam showed: "mild swelling to right lower mandibular area, no parotid gland swelling, no redness or induration, soft to touch, non-tender to palpation." The PCP referred the individual to the dental clinic. The PCP's plan was to follow-up with the PCP if the swelling did not improve or redness/pain developed.

  The dentist evaluated the individual the same day. The only abnormality was right submandibular swelling. One non-diagnostic quality x-ray was done. The recommendation was: "treatment with antibiotics first, then use sedation of 3mg Ativan if we need to get an x-ray to confirm a tooth problem." There was no definitive follow-up plan, such as return in 24 or 48 hours.

  On 4/12/17, the PCP wrote an addendum. At that time, the physical exam revealed: "moderate swelling to the right submandibular area, mild erythema, mild induration of adjacent soft tissue, no salivary gland stone/calculi palpated or seen on limited oral exam, no pus on oral cavity, no tenderness on palpation, no trismus." Based on the findings of the two exams, there was a progression with increasing swelling and erythema, which indicated a worsening of the infection. The plan was to apply warm compresses and give Keflex for seven days. Cephalosporins are not a first line treatment in the management of odontogenic infections due to the lack of coverage of anaerobic organisms. On 4/13/17 at 12:50 p.m., a nursing entry was made. The next nursing entry was on 4/15/17 stating that the individual's sister called to inform the Center that the individual was admitted to the hospital "fighting for his life from the infection he has."

  The Oral Maxillofacial Surgery History and Physical documented that the individual was admitted early on the morning of 4/15/17, with a one- to two-week history of jaw swelling that was treated with Keflex. He was visiting with family for Easter who found the swelling concerning and took him to the hospital. The individual was taken to the operating room for incision and draining of deep neck infection and extraction of four teeth. He was found to have necrotic muscle and tissue. He required additional surgical intervention, including additional debridement of muscle and fascia, tracheostomy, and skin grafting.

On 5/17/17, the dentist documented that the individual had four teeth extracted during a hospitalization. In the IPNs the Center submitted, there was no documentation from the PCP. In its comments on the draft report, the State pointed to documentation provided in response to hospitalizations in which the PCP documented Individual #663's hospital course.

- On 1/13/17, nursing documented that the NP reviewed Individual #640's labs, and "decision made for individual to be admitted" to the hospital for antibiotic therapy. This nursing note did not indicate the type of labs reviewed, the results, or the diagnosis. The physician did not write an IPN related to the medical assessment or transfer. In its comments on the draft report, the State referenced a consultation note, dated 1/11/17 and signed on 1/13/17, and requested that the Monitor revise the rating based on this note. The note the State referenced was a consult note, and not a transfer note. It did not meet the requirements of a transfer note, including documentation such as vital signs, and communication with the accepting physician. Furthermore, it was not clear if this was a direct admission or if the individual was transferred to the ED. A transfer note would have included this information.

  On 1/25/17 at around 7:00 p.m., the individual returned to the Center. On 1/26/17, the on-call PCP was notified of a positive Influenza B test, and started the individual on Tamiflu. The first documentation of a medical assessment related to this illness occurred on 1/27/17 at around 4:30 p.m. The PCP noted that the individual was treated for a multi-drug resistant UTI and renal stones. The PCP referenced extracorporeal shock wave lithotripsy (ESWL) used for the management of the renal stones. The PCP also indicated that the individual was started on Tamiflu the previous day due to a low-grade temperature. It was documented that the individual had mild wheezing for which nebulizer treatments were ordered. The assessment was UTI, poor oral intake, and influenza with wheezing. The plan was to continue antibiotics, check for fecal impaction, and continue Tamiflu and nebulizer treatments. The next post-hospital follow-up occurred on 1/30/17. It was noted that the individual's oral intake had improved, and treatment for the UTI, influenza, and bronchospasm would continue. On 2/1/17, the PCP saw the individual again and persistent bronchospasm was noted. The next follow-up was not until 2/6/17, at which time Individual #640 was transferred back to her home on campus. In summary, a provider did not assess Individual #640 within 24 hours of discharge, and/or for a minimum of two consecutive days.
- On 12/30/16, the PCP assessed Individual #404 for one episode of emesis that occurred after eating breakfast. The assessment was possible GI irritation from Fergon started on 12/29/16 for iron deficiency anemia, or emesis due to GERD. A urinalysis (UA) was ordered. A CBC and BMP were also requested due to his overall decrease in activity. Shortly after the initial assessment, the PCP documented that the individual did not look like himself. The individual was hypoxic with an oxygen saturation of 70% on room air. He was transferred to the hospital and admitted with pneumonia.

  On 1/3/17, Individual #404 returned to the Center, and on 1/4/17, the PCP saw him. He had rhonchi in his lower lung fields, but was noted to be in stable condition. The PCP also indicated that the individual's diet was changed in the hospital due the diagnosis of aspiration pneumonia. On 1/6/17, the PCP saw him again, and noted diagnoses of abnormal weight loss, acquired thrombocytopenia, COPD, diastolic dysfunction, and GERD. The plan was to continue nebulizer treatments, proton pump inhibitors, and complete a workup for the weight loss of 29 pounds. The PCP also noted that the diagnosis of iron deficiency anemia was not clear and needed further workup. Moreover, it was documented that further evaluation was needed for a history of pulmonary lung nodules seen on a chest CT in March 2016, because there was no documentation of the follow-up CT scan being done.

In its comments on the draft report, the State referenced the corresponding order on 1/6/17 for a CT scan. However, this order was overdue. The AMA, dated 4/28/16, did not provide any information on the number of nodules or the size of the nodules. There was also no plan for follow-up of the pulmonary nodules. The Center did not submit any interim medical reviews or pulmonary consultations. The IPN, dated 1/6/17, noted lung nodules were seen on the CT scan done in March 2016. In the setting of newly diagnosed multiple pulmonary nodules, a repeat CT scan is typically done at the three- or six-month interval. It is, therefore, likely that follow-up was not timely.

Again on 1/9/17 and 1/10/17, the PCP saw him and elaborated on multiple chronic medical issues. On 1/10/17, it was reported that the individual had eight stools of liquid consistency, a temperature of 99, and a heart rate of 101. He also had an elevated white blood count of 13.6. A Clostridium difficile (C-Diff) toxin was requested and labs. On 1/11/17, the individual was transferred to the hospital due to continued diarrhea and hypotension with a blood pressure of 85/53, heart rate of 117 to 119, and hypoxia. He was admitted with septic shock, C. difficile colitis, aspiration pneumonia, and acute kidney failure. Individual #404 was admitted into the Intensive Care Unit (ICU), where he required vasopressors, intubation with mechanical ventilation, and emergent hemodialysis. He also was diagnosed with fungemia. It is important to note that, as discussed below, Individual #603, another individual in the group the Monitoring Team reviewed, had blood cultures positive for yeasts, which is an unusual and serious diagnosis. Individual #404 was placed on DNR status, and on 1/24/17, he transferred to a Long-term Acute Care (LTAC) facility. On 2/7/17, he died with causes of death listed as cardiac arrest, pneumonia, and aspiration.

- Little information was available about the events leading up to Individual #603's hospitalization on 11/16/16. On 11/2/16, the PCP saw the individual for follow-up of pneumonia that was diagnosed in October. The individual was also started on antibiotics for left eye conjunctivitis. On 11/14/16, the PCP saw the individual for follow-up of left eye conjunctivitis after completion of treatment. The infection had not resolved, so additional treatment was prescribed. There were two notes prior to hospitalization. On 11/14/16, nursing staff indicated that the eye specimen was not collected. On 11/16/16, nursing staff wrote that: "individual has not returned to home, and also had medical problems on the way back to unit, per case manager's report." On 11/17/16, nursing staff documented that the individual was en route to a pulmonary appointment by EMS, but was transported to the hospital ED due to low oxygen saturations. The individual was admitted to ICU with respiratory failure. The PCP did not provide documentation within 24 hours.

  The Center did not submit the admission history and physical, so it was difficult to determine the circumstances surrounding the transfer and admission. On 11/30/16, Individual #603 was transferred to an LTAC. The progress note documented the individual was admitted with septic shock, pneumonia with Pseudomonas, Methicillin-resistant Staphylococcus Aureus (MRSA), and fungemia. She also had respiratory failure requiring endotracheal intubation and mechanical ventilation.

  On 1/10/17, Individual #603 returned to the Center and on 1/11/17, the PCP saw her. This note indicated she was admitted to hospital on 11/18/16, and was diagnosed septic shock, fungemia, and pneumonia. On 12/12/16, she underwent a tracheostomy and had a sacral pressure ulcer. On 1/12/17, and 1/13/17, the PCP saw her again. She continued to have a number of issues including "new hyperglycemia." On 1/17/17, the PCP conducted the next follow-up, and it was noted that she had abdominal distention and diarrhea and was awaiting follow-up with a wound specialist.

On 2/16/17, Individual #603 was hospitalized again. The first documentation regarding this hospitalization was on 2/17/17, at which time nursing staff noted that there was a phone call update and the individual had been admitted with sepsis. It was not clear exactly when the individual was transferred to the hospital. Neither nursing nor the PCP documented this (i.e., no note from the PCP), and no transfer record was provided. In its comments on the draft report, the State indicated that the Center failed to provide documentation that might have clarified this issue.

On 2/23/17, the PCP documented that Individual #603 returned on 2/22/17 after a hospitalization for pneumonia and UTI. There was no additional follow-up. On 3/1/17, the PCP documented that the individual was transferred to the ED due to recurrent emesis. She was hospitalized again for aspiration pneumonia, fungemia, bacterial sepsis, and C difficile colitis.

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

Summary: For the consultations reviewed, it was good to see improvement with regard to PCPs writing IPNs that were consistent with the requirements of the related policy. The timeliness of reviews of consultations is an area on which the Center should focus. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	85% 11/13	2/2	2/2	1/1	2/2	2/2	2/2	N/A	N/A	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	62% 8/13	1/2	1/2	1/1	2/2	1/2	2/2			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.	85% 11/13	2/2	2/2	1/1	2/2	2/2	2/2			0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 9/9	N/A	2/2	1/1	2/2	2/2	2/2			N/A
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A									

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #206 for podiatry on 1/31/17, and gastroenterology (GI) on 12/13/16; Individual #447 for podiatry on 4/18/17, and neurology on 3/7/17; Individual #663 for Physical Medicine and Rehabilitation (PMR) on 1/30/17; Individual #570 for cardiology on 4/11/17, and podiatry on 2/21/17; Individual #640 for rheumatology on 12/5/16, and urology on 2/10/17; Individual #352 for gynecology on 3/28/17, and orthopedics on 3/27/17; and Individual #603 for pulmonary on 11/7/16, and urology on 11/14/16.

Of note, for Individual #603, the physician on the Monitoring Team found reference to the consultations listed above in the AMA and/or IPNs. Center staff did not submit the actual consultation forms. The consultation for urology, dated 11/14/16, was related to a very significant issue of bilateral renal stones, one of which was a staghorn calculus. The urologist made a recommendation for intervention. The presence of these continued to present an ongoing and serious risk for urinary tract infections, sepsis, etc.

In addition, it is important to note that the neurology consultation for Individual #447 on 3/7/17, did not appear to meet the individual's needs. It did not resolve the many questions about his neurological status.

Finally, the Center did not include IPNs related to consultations with the overall set of IPNs (i.e., Document Request #12). The Medical Director indicated that they are maintained in a separate tab in IRIS, and they do not collate with the rest of the IPNs. Although it is unclear whether or not this is just a printing issue or an issue that prevents other IDT members from reviewing these IPNs, it is an issue that should be investigated, and addressed, as appropriate.

a. It was positive that PCPs generally reviewed the consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were the consultations for Individual #603 for pulmonary on 11/7/16, and urology on 11/14/16.

b. The reviews that did not occur timely were for: Individual #206 for podiatry on 1/31/17, Individual #447 for podiatry on 4/18/17, Individual #640 for urology on 2/10/17, and Individual #603 for pulmonary on 11/7/16, and urology on 11/14/16.

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

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

Summary: Significant work was needed to ensure that individuals received the medical assessments, tests, and evaluations consistent with current standards of care to address their chronic or at-risk conditions, and that PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
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.	33% 6/18	0/2	1/2	0/2	0/2	1/2	2/2	0/2	2/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #206 – infections, and osteoporosis; Individual #447 – diabetes, and cardiac disease; Individual #663 – cardiac disease, and diabetes; Individual #570 – diabetes, and GI problems; Individual #640 – diabetes, and osteoporosis; Individual #352 – GI problems, and seizures; Individual #404 – respiratory compromise, and cardiac disease; Individual #109 – osteoporosis, and constipation/bowel

obstruction; and Individual #603 – UTIs, and diabetes).

a. It was positive that for the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #447 – cardiac disease; Individual #640 – osteoporosis; Individual #352 – GI problems, and seizures; and Individual #109 – osteoporosis, and constipation/bowel obstruction. The following summarizes some of the concerns noted:

- The PCP noted that Individual #206 was a purified protein derivative (PPD) converter who was treated with Isoniazid (INH) in 1993. Per the AMA, "he is currently monitored with annual chest films." The completion of the annual TB questionnaire was not mentioned in the medical plan, but should have been according to the Centers for Disease Control (CDC) guidelines. Per the CDC guidelines: "Regardless of whether the patient completed treatment for LTBI, serial or repeat chest radiographs are not indicated unless the patient develops signs or symptoms suggestive of TB disease."
- Per the AMA, Individual #447 was at low risk for development of metabolic syndrome. However, the individual was at increased risk and met two of the three criteria for the development of metabolic syndrome, including treatment of hypertension and treatment of hyperlipidemia. Additionally, the individual's body mass index (BMI) was high.
- Although the Center had a clinical pathway for the management of dyslipidemia that thoroughly discussed the American Heart Association (AHA) 2015 guidelines and the diagnoses of metabolic syndrome, Individual #663's PCP did not document an atherosclerotic cardiovascular disease (ASCVD) risk score or indicate the intensity of statin therapy based on the ASCVD risk score. The individual was treated with Atorvastatin 20 milligrams (mg).
- In Individual #633's AMA, dated 12/16/17, the PCP documented in the risk assessment section that the risk for diabetes was "low." The PCP further stated: "Records shows that individual does not have history of diabetes." In terms of risk for the metabolic syndrome/diabetes mellitus, the same PCP noted in the AMA that the individual had the diagnoses of hyperlipidemia and hypertension. Moreover, the AMA documented an abdominal girth of 40.5 inches. Based on data included in the AMA, the individual met the criteria for diagnosis of the metabolic syndrome. Assessing a risk status of low was, therefore, not accurate.

  The National Cholesterol Education Program's Adult Treatment Panel III (NCEP ATP III) uses five criteria for diagnosing metabolic syndrome. The PCPs could simplify this discussion and make an accurate determination by scoring one point for the presence of each criteria. If the individual scores three or more points, the diagnosis of metabolic syndrome is made. It is possible for an individual to have increased risk for metabolic syndrome or diabetes mellitus (e.g., inactivity, use of SGAs, etc.) and still score 0. It is also important for the PCPs to address the underlying risks, such as obesity, hyperglycemia, hyperlipidemia, and hypertension. Center staff frequently documented that an individual exhibited no signs or symptoms of diabetes or metabolic syndrome. It also should be noted that metabolic syndrome, like diabetes mellitus, may not result immediately in any signs or symptoms of disease.
- Individual #570's AMA documented a history of abnormal liver function tests with hepatomegaly and fatty liver. On 11/14/16, a gastroenterology (GI) consult was obtained. The gastroenterologist noted that the liver enzyme elevations could be drug-induced and further evaluation was necessary. The PCP did not document in the record any of the results of the extensive work-up the gastroenterologist requested. Moreover, the AMA and Active Problem List did not include hepatomegaly, fatty liver, and abnormal liver enzymes as diagnoses. The individual was scheduled for follow-up in six months.
- According to the AMA, Individual #640: "may present with borderline metabolic syndrome." The individual met two criteria for metabolic syndrome and had documentation of several elevated fasting blood glucose levels. The PCP did not acknowledge

or document in the IPNs the multiple elevated serum glucoses that occurred over a period of several months. On 4/5/17, the hemoglobin (HB) A1c was 6.6, which met the criteria for the diagnosis of diabetes mellitus. Again, there was no IPN entry reflecting this finding. On 5/10/17, the PCP noted that the individual was newly diagnosed with diabetes mellitus and would be started on metformin. There was a substantial delay in addressing hyperglycemia and implementing appropriate medical management. Moreover, the IDT did not appear to recognize the significant new diagnosis of diabetes mellitus as a change in status, and/or modify the IHCP.

- Individual #404's AMA documented that the diagnosis of COPD was made following two hospitalizations and was confirmed with a computerized tomography (CT) of the chest. The Medical Department had developed a clinical pathway for the management of COPD. The pathway was based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD). However, for Individual #404, there was no mention of pulmonary function testing, which might have been difficult to obtain with this individual, so the disease was not staged. However, based on the treatment regimen, it appeared that the individual had advanced COPD, but there was no documentation of recent pulmonary evaluation.

  On 1/6/17, the PCP documented that further evaluation was needed for a history of pulmonary lung nodules seen on a chest CT in March 2016. There was no documentation of the follow-up CT scan being done. Moreover, the AMA, dated 4/28/16, did not document the pulmonary nodules. The individual also had bronchiectasis and there was no assessment related to the need for aggressive pulmonary hygiene.
- On 11/7/16, Individual #603's PCP documented that the urologist recommended lithotripsy for "bladder stones," but medical clearance was needed. That same day, pulmonary saw the individual, and requested a CT scan prior to completing a pre-surgical evaluation. Multiple diagnostic studies revealed bilateral staghorn calculi, including a CT on 12/16/16, and a CT on 2/25/17. On 2/15/17, the PCP documented in the AMA that: "Pt is more at risk for UTIs with the stones and will need to monitor closely. The recommendation to the IDT is ensure that patient has follow-up with urology for the renal calculi, and continue imaging as recommend by them." The Center submitted incomplete information from the multiple hospitalizations. However, it was noted that the assessments never mentioned the presence of the staghorn renal calculi even though the individual's admission diagnosis included UTI. Additionally, the Center post-hospital assessments never mentioned the renal calculi and there was no documentation of urology follow-up. Of note, the hospital records included a CT report, dated 3/30/17, that showed normal kidneys. This report belonged to another individual and was included in error.
- In a post hospital follow-up on 1/12/17, the PCP noted that the hospital records revealed Individual #603 had a glucose of 163. The PCP documented there was "no prior DM [diabetes mellitus]." However, this was not an accurate statement. The lab reports documented elevated fasting blood glucose levels dating back to May 2016. On 5/11/16, an abnormal HbA1c of 6.3 also was documented. There appeared to be a significant delay in implementing an appropriate plan for the management of diabetes.

  In its comments on the draft report, the State indicated: "The monitor cited a glucose of 163. It is uncertain if the hospital lab value is a fasting or a random glucose to determine a diagnosis of diabetes. The labs submitted to the monitor performed at RSSLC on 5/17/2017, shows a fasting glucose of 108 (TX-RI-1706-II.063…, pg. 6) and an A1c of 6.4 on 4/27/2017 (TX-RI-1706-II.063, pg.7) which does not indicate a diagnosis of diabetes. Individual #603 may have signs of prediabetes which is why she has an order for HgbA1c every 3 months for close monitoring. The orders were provided to the monitors in the records request, TX-RI-1706-II.021…, pg.22."

On 5/4/16, Individual #603 had a glucose of 130. On 5/11/16, the HbA1c was 6.3. On 1/11/17, the HbA1c was 6.5. The American Diabetes Association's Standards of Medical Care – 2017 defines diabetes as: fasting blood sugar (FBS) >126, two-hour post prandial glucose >200, HbA1c >6.5, or a random blood glucose > 200 with classic signs and symptoms of hyperglycemia. Additionally, per the ADA, "prediabetes" is the term used for individuals with an A1C between 5.7 and 6.4. The documents providing these important standards in medical care may be found at: https://professional.diabetes.org/content/clinical-practice-recommendations. Based on ADA standards, Individual #603 met criteria for prediabetes in May 2016 and diabetes in January 2017.

Moreover, the State should review the PCP's documentation in the AMA. In the AMA, dated 2/15/17, the PCP stated that the individual was recently diagnosed with diabetes and was started on metformin. The State's comments on the draft report are in direct contradiction to the PCP's documentation in the AMA. In addition, the medical records provide factual data related to the diagnosis of diabetes. The Monitoring Team's concern continues to be that there was a delay in implementing appropriate interventions for prediabetes.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. 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	206	447	663	570	640	352	404	109	603
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	39% 7/18	0/2	1/2	0/2	0/2	1/2	2/2	0/2	2/2	1/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. In addition, often, those action steps assigned to the PCPs that were identified for the individuals reviewed were not implemented.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.	
Summary: N/R	Individuals:

#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
	Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.										

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given the Clinical Pharmacist generally completed timely QDRRs during this review and the past two reviews (Round 10 – 89%, Round 11 – 94%, and Round 12 - 94%), indicator a will be placed in the category requiring less oversight. Improvement is needed with regard to the quality of the QDRRs. In addition, work is needed to ensure PCPs review the QDRRs timely and indicate agreement or disagreement with rationale for each recommendation. All of the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	QDRRs are completed quarterly by the pharmacist.	94% 17/18	1/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	28% 5/18	2/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	0% 0/6	0/2	0/2	N/A	N/A	N/A	N/A	0/2	N/A	N/A
	v. Anticholinergic burden.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2

c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	50% 9/18	1/2	1/2	2/2	1/2	1/2	1/2	1/2	1/2	0/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 6/6	2/2	2/2	N/A	N/A	N/A	N/A	2/2	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 12/12	1/1	2/2	2/2	1/1	1/1	1/1	2/2	2/2	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.	N/R									

Comments: b. Some of the problems noted included:

- For a number of individuals, the Clinical Pharmacist noted abnormal lab values, but did not follow-up with recommendations, and/or indicate whether or not they could be medication-induced.
- In a number of QDRRs, the Clinical Pharmacist documented that labs were within normal limits or abnormal. Recommendations were linked to these values, but the reference dates were not specified.
- For Individual #570, Individual #640, and Individual #352, the Clinical Pharmacist made comments such as: "the UA [urinalysis] came back positive for UTI [urinary tract infection]," and made a recommendation to consider starting UTI stat. This was a vague comment and did not specify the exact abnormality that resulted in determining the individual had a UTI. The clinical diagnosis of uncomplicated cystitis or pyelonephritis is made in an individual who has signs and symptoms consistent with a UTI and should be supported by laboratory evidence of pyuria and/or bacteriuria.
- For Individual #404, the Clinical Pharmacist commented that the complete blood count (CBC) revealed a depression in the values for the major blood components. It was further noted that the individual was placed on ferrous sulfate due to low iron scores. The Clinical Pharmacist did not provide any information on specific lab values. Specific criteria are required to make the diagnosis of iron deficiency and the Clinical Pharmacist provided no documentation of these criteria.
- For a few individuals, the Clinical Pharmacist commented on the use of lipids, but did not reference an ASCVD risk score.
- For Individual #109, the Clinical Pharmacist noted that the comprehensive metabolic panel (CMP) revealed an elevation in the carbon dioxide (CO2) and there were no reports of respiratory depression. As noted in previous reviews, an elevated C02 may reflect a number of clinical problems.
- For individuals with metabolic syndrome or at risk for metabolic syndrome, the individual's waist circumference should be specifically included, but was not in number of cases. At times, the Clinical Pharmacist indicated in the comment section that nursing staff needed to provide this information, but then did not make a formal recommendation that nursing staff provide it.
- Some individuals who were not on next generation antipsychotics were at risk for or had metabolic syndrome. The Clinical Pharmacist appeared to ignore these lab values or diagnoses, and simply stated that the individual was not on psychotropic medications. The discussion of metabolic syndrome should be clearly labeled.

- Metabolic syndrome is a cluster of conditions (hypertension, hyperglycemia, dyslipidemia, and increased abdominal girth) that occur together and increase the risk of heart disease, stroke, and diabetes. For individuals with the syndrome, the Clinical Pharmacist should address the management of each condition rather than focus on the risk of metabolic syndrome. This was not the case for some of the individuals reviewed (e.g., Individual #663, Individual #640, Individual #404, Individual #603).
- For Individual #570, the Clinical Pharmacist stated that monitoring and evaluation of drug effectiveness, side effects, toxicity, or adverse effects was not appropriate, but provided no specific details or rationale.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them. However, due to issues with printing responses to QDRRs, the Monitoring Team had difficulty following all of the recommendations the Clinical Pharmacist made.

Dental

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

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

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #109 was edentulous, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals, including data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and

services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individuals have no diagnosed or untreated dental caries.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	63% 5/8	0/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A	0/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									
Comments: a. and b. Individual #109 was edentulous. It is important to point out that these findings indicate that except for the one individual who was edentulous, all individuals reviewed had periodontal disease, and for three of them, the disease had worsened. c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.										

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Based on the Monitoring Team's review of dental documentation for review of other indicators, a number of individuals had not had tooth-brushing instruction at each preventive visit. As a result, Indicator b will move back to active monitoring. A number of individuals reviewed had not had needed dental treatment. The remaining indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
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.	50% 4/8	1/1	1/1	0/1	0/1	0/1	1/1	0/1	N/A	1/1

b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. However, based on the Monitoring Team's review of dental documentation for review of other indicators, a number of individuals had not had tooth-brushing instruction at each preventive visit. As a result, Indicator b will move back to active monitoring.									
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.	38% 3/8	1/1	1/1	0/1	0/1	0/1	1/1	0/1		0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	1/1		N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	63% 5/8	1/1	1/1	0/1	0/1	1/1	1/1	0/1		1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A		N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
Comments: a. through f. Individual #109 was edentulous. A number of individuals reviewed had not had needed dental treatment. Only two of eight individuals or their staff had tooth brushing instruction at the time of each preventive visit, so Indicator b will return to active monitoring.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	0% 0/1			0/1						
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A			N/A						
Comments: a. through c. On 3/10/17, Individual #663 was seen in the dental clinic. It was noted that the individual "still has bleeding in areas of #11. Get consent for filling and local gingival therapy."											

On 4/11/17, the PCP saw the individual for swelling to the right lower jaw. The physical exam showed: "mild swelling to right lower mandibular area, no parotid gland swelling, no redness or induration, soft to touch, non-tender to palpation." The PCP referred the individual to the dental clinic. The PCP's plan was to follow-up with the PCP if the swelling did not improve or redness/pain developed.

The dentist evaluated the individual the same day. The only abnormality was right submandibular swelling. One non-diagnostic quality x-ray was done. The recommendation was: "treatment with antibiotics first, then use sedation of 3mg Ativan if we need to get an x-ray to confirm a tooth problem." There was no definitive follow-up plan, such as return in 24 or 48 hours.

On 4/12/17, the PCP wrote an addendum. At that time, the physical exam revealed: "moderate swelling to the right submandibular area, mild erythema, mild induration of adjacent soft tissue, no salivary gland stone/calculi palpated or seen on limited oral exam, no pus on oral cavity, no tenderness on palpation, no trismus." Based on the findings of the two exams, there was a progression with increasing swelling and erythema. The plan was to apply warm compresses and give Keflex for seven days. On 4/13/17 at 12:50 p.m., a nursing entry was made. The next nursing entry was on 4/15/17 stating that the individual's sister called to inform the Center that the individual was admitted to the hospital "fighting for his life from the infection he has."

The Oral Maxillofacial Surgery History and Physical documented that the individual was admitted early on the morning of 4/15/17, "with a one- to two-week history of jaw swelling" that was treated with Keflex. He was visiting with family for Easter who found the swelling concerning and took him to the hospital. The individual was taken to the operating room for incision and draining of deep neck infection and extraction of four teeth. He was found to have necrotic muscle and tissue. He required additional surgical intervention, including additional debridement of muscle and fascia, tracheostomy, and skin grafting.

The documentation submitted did not indicate when the individual returned to the Center. On 5/17/17, the dentist documented that the individual had four teeth extracted during a hospitalization. There was no documentation from the PCP.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Monitoring Team will continue to review all of these indicators.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	33% 1/3	N/A	N/A	N/A	1/1	N/A	0/1	N/A	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3				0/1		0/1			0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3				0/1		0/1			0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction	0% 0/3				0/1		0/1			0/1

	tooth brushing.										
Comments: a. and b. For Individual #352 and Individual #603, the dentist recommended use of the suction tooth brushing protocol in the annual dental summary. However, the IDTs had not included measurable action steps in the individuals' ISPs or IHCPs. Moreover, data was not presented to show that staff completed suction tooth brushing for individuals who needed it on a consistent basis.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Over this review and the last one, improvements were noted with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. If the Center sustains this progress, Indicator a might move to the category requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department often provided recommendations regarding dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of	0%									

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

Comments: a. through f. Based on interview with the Chief Nurse Executive (CNE), nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist in the documentation provided. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work with State Office to correct this issue.

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

Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e.,

Individual #206 – falls, and weight; Individual #447 – constipation/bowel obstruction, and other: dementia/safety related to aggressive behavior; Individual #663 – infections, and cardiac disease; Individual #570 – falls, and infections; Individual #640 – infections, and weight; Individual #352 – constipation/bowel obstruction, and fractures; Individual #404 – weight, and aspiration; Individual #109 – constipation/bowel obstruction, and falls; and Individual #603 – choking, and skin integrity). None of the goals/objectives reviewed were clinically relevant, achievable, and measurable.

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

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

Summary: Given that over the last four 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: 206	447	663	570	640	352	404	109	603
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/15	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/1	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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

The following provide some examples of problems noted:

- Although Individual #206's IDT held ISPA meetings to discuss his ongoing falls, the IDT had not defined the various types of

falls (e.g., behavioral versus gait issues), and the IDT had not conducted an analysis of his falls. Direct support staff indicated that he was using his wheelchair more, which could account for a decrease in falls. However, data was not available to confirm this anecdotal information, in that the IDT had not collected data indicating how often he walked with his walker versus using the wheelchair. Data regarding the number of falls was unreliable. For example, the annual nursing assessment indicated Individual #206 fell 10 times, but the IRRF indicated he had 43 falls. In addition, the Center's response for Tier II request IV.1-20 noted that Individual #206 had no falls. Throughout the documentation provided, no comprehensive list of dates of falls was found. The etiology(ies) of his falls was still unknown. Moreover, the IDT had not developed a plan to prevent the individual from future falls. Given that Individual #206 was on the referral list for community transition, this lack of planning was very concerning.

- For Individual #447, the IDT had not held ISPA meetings to address the "dementia" symptoms, and/or more specifically rule in or out causes for the symptoms. The IDT had not clearly outlined what changes the individual exhibited that led them to the conclusion he had dementia symptoms, and put no plan in place to regularly assess Individual #447 to determine if symptoms were better or worse. Individual #447 was placed on a medication for dementia (i.e., Aricept), but there was no objective data found to indicate the effectiveness of the medication. Given that "dementia" is not a diagnosis, but a set of symptoms, it was unclear what the IDT had done to provide justification for the medication, and/or to identify his specific diagnosis.
- For Individual #570, the IDT increased the risk rating from low to medium regarding falls. However, they did not develop and/or implement any assessments or proactive strategies to prevent falls in the IHCP.
- Although Individual #640's IDT held ISPA meetings on 11/28/16, 1/24/17, and 2/17/17, to discuss her hospitalizations for urinary tract infections (UTIs) and renal stones, it did not appear her IDT reviewed her IHCP to find that it did not include regular nursing assessments for intake monitoring, pain, abdominal guarding, increases in vital signs, and/or changes in mental status.
- Of critical concern was that after Individual #404's decline in health began in January 2016, none of his IDT members identified that weight was not included as a risk area in his IHCPs, and the IDT did not develop a plan to address his weight loss. Between February and March 2016, he had a significant weight loss of 12 pounds according to the nursing annual assessment, and 18 pounds according to the Dietician's report, dated 4/25/16. In March 2016, the nursing annual assessment noted he weighted 152 pounds. However, for 3/24/16, the Dietician's report noted he weighed 146 pounds. This discrepancy in itself was concerning. In addition, after the ISP meeting on 6/10/16, none of the nursing quarterlies, the dietary report noted above, and/or ISPAs provided a list of weights. A brief note in the QIDP review, dated 12/28/16, indicated that: "since May (no year provided, but the Monitoring Team assumed it is 2016) [Individual #404] has lost 14.6 pounds, which [sic] his DWR [desired weight range] is 150-170 and his current weight is 138.5" (no date of current weight provided). The nursing quarterly, dated 10/7/16 to 1/23/17, indicated that the IDT met on 11/3/16 to review Individual #404's's weight loss. However, no ISPA was found for this date. In addition, the nursing quarterly indicated that on 11/10/16, the PCP ordered labs to evaluate weight loss, and on 1/6/17, Individual #404 was seen at the Infirmary due to abnormal weight loss. ISPAs regarding Individual #404's health status, dated 1/13/17, 1/18/17, 1/26/17, and 2/15/17, never mentioned weight. The Center's response to the document request for the last three months of weight records only included one weight for 11/1/16 (i.e., 135.2 pounds). The lack of specific values for weights by month, the reporting of weight values only every one to two months, and discrepancies in weights found in the documentation indicated there was no consistent and accurate tracking system in place to address weight.
- For Individual #109, the IDT held ISPA meetings to address falls on the following dates; 11/1/16, 12/22/16, 1/18/17, 1/31/17, 4/10/17, and 4/28/17. None of the notes for these meetings included a total number of falls with dates and the

specific circumstances explained, and none provided a thorough analysis of his falls. Based on a review of the ISPAs, nursing documentation, IRRF, the IHCP for falls, and QIDP reviews, the IDT appeared to minimize the seriousness of his falls, because he thus far had not had a serious injury as a result. The IDT had not identified the etiology(ies) of this high-risk area, and/or developed plans to address the etiology or suspected etiology.

- Of significant concern, an IPN, dated 5/4/17 at 10:49 a.m., from Habilitation Therapy staff noted that one of Individual #603's newly replaced oxygen tanks that was on the back of her wheelchair was empty. In a Habilitation Therapy IPN, dated 5/8/17 at 11:55 a.m., it was noted that both of the portable oxygen tanks for Individual #603 were just above the "red zone" with 500 pounds per square inch (PSI) left in both. In addition, a Habilitation Therapy IPN, dated 5/4/17 at 5:44 p.m., indicated that the tracheostomy collar mask was rotated to the right side of Individual #603's neck, and the medication vapors from a scheduled breathing treatment were escaping into the atmosphere and not into the tracheostomy to treat her lungs. When the Respiratory Therapist (RT) documented that the trach collar had been in place the whole time, the OT noted in the IPN that the OT showed the RT a picture of the rotated trach collar and recommended the RT stay in the room during the entire breathing treatment to ensure the treatments are fully delivered. No ISPA meeting documentation was found addressing these critical issues, nor was a plan implemented to ensure that nursing staff regularly check personal portable oxygen tanks and document the results, and that RTs monitor breathing treatments until they are completed.
- Even after Individual #603 developed Stage II decubiti, nursing staff did not initiate regular, proactive skin assessments.

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

Summary: For the two previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. During this review, nurses also consistently adhered to infection control procedures while administering medications. Given the importance of all of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement.

#	Indicator	Overall Score	Individuals: 206	447	663	570	640	352	404	109	603
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										

	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	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% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1
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.	38% 3/8	0/1	1/1	1/1	0/1	0/1	0/1		1/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #206, Individual #447, Individual #663, Individual #570, Individual #640, Individual #352, Individual #109, and Individual #603.

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

d. The CNE reported that nursing staff completed training regarding lung sounds during medication administration in alignment with the indicators. The following concerns were noted:

- The medication nurse attempted to listen to Individual #570's lung sounds before and after medication administration, but did not correctly place the stethoscope to accurately assess the lungs.
- When crackles were heard on the initial lung sound assessment before medication administration, the medication nurse had to be prompted to listen to lung sounds after Individual #603 was suctioned.

f. Often, medication nurses did not use the individuals' PNMPs and check the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/13	0/1	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/13	0/1	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data	0%	0/1	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1

	reflective of the measurable goal/objective;	0/13									
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/1	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/1	0/2	0/2	0/1	0/2	0/2	0/1	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	40% 2/5	1/1	N/A	N/A	1/1	N/A	N/A	0/1	0/1	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1			0/1			0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/4	0/1			0/1			0/1	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5	0/1			0/1			0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/5	0/1			0/1			0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1			0/1			0/1	0/1	0/1

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls for Individual #206; falls, and choking for Individual #447; choking, and fractures for Individual #663; falls for Individual #570; falls, and weight for Individual #640; aspiration, and fractures for Individual #352; weight for Individual #404; choking for Individual #109; and fractures for Individual #603.

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

b.i. The Monitoring Team reviewed five areas of need for four individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: constipation/bowel obstruction for Individual #206, skin integrity for Individual #570, aspiration for Individual #404, falls for Individual #109; and aspiration for Individual #603.

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

- On 12/30/16, Individual #404 was hospitalized for pneumonia. The 1/4/17 post-hospitalization review indicated that the last PNMT assessment was dated 3/28/16, and addressed his new g-tube placement. In January 2017, the PNMT did not recommend referral because he had not had pneumonia in over a year, but recommended a head-of-bed elevation (HOBE)

evaluation to reassess this aspect of care. However, at the time of his last PNMT assessment, the PNMT identified concerns with regard to staff not intervening when he was overfilling his spoon and staff not consistently filling out trigger sheets. At that time, little was documented as having been done to address these issues. Given these circumstances and the new diagnosis of pneumonia, a referral was warranted for at least a PNMT review.

- Individual #109 experienced numerous falls. The data on falls did not appear complete. However, the IDT should have referred him or the PNMT should have made a self-referral when he met the following criteria: "Unresolved fall episodes (greater than three per month for two consecutive months)." At a minimum, in December 2016 and again in January 2017, he met criteria, but was not referred. Rather, the PNMT notified the QIDP that the IDT should meet to address the falls. The IDT did meet on several occasions, but clearly the interventions and plan the IDT developed were not working.
- On 7/5/16, based on an RN post-hospitalization review and meeting minutes, Individual #603 was referred to the PNMT, but then minutes indicated she did not meet criteria for assessment. On 10/5/16, according to the RN post-hospitalization review, she was referred to PNMT for a HOBE evaluation. There was no evidence of further review or assessment. On 11/18/16, Individual #603 experienced respiratory failure with also diagnoses of septic shock, fungemia, and pneumonia. She was placed on a ventilator. On 11/30/16, Individual #603 was transferred to an LTAC. On 12/12/16, she underwent a tracheostomy and had a sacral pressure ulcer. On 1/11/17, after her discharge on 1/10/17, the PNMT RN completed a post-hospitalization assessment and recommended referral, but then documentation stated that there were no PNM issues found, which was confusing given the numerous PNM issues Individual #603 had. On 2/16/17, she transferred back to the hospital with another diagnosis of aspiration pneumonia. On 2/22/17, she returned to the Center. On 3/1/17, Individual #603 was transferred to the ED due to recurrent emesis. She was hospitalized again for aspiration pneumonia, fungemia, bacterial sepsis, and C difficile colitis. The PNMT stated they could not complete an assessment at that time, because she returned to hospital. On 4/5/17, she returned to Center with a diagnosis of aspiration pneumonia and sepsis. As of 4/10/17, the PNMT assessment was in process of completion with target date of 5/4/17. On 5/9/17, the PNMT completed it.

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

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports that included data and analysis of the data were generally not available to IDTs. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	ISP progress reports provide an explanation for any delays and a plan for completing the action steps.										
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/10	0/2	0/1	N/A	0/1	0/1	0/1	0/2	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

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

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

- Individual #206's IDT did not provide evidence that they addressed the underlying cause of his falls. Even when the PT recommended adding weight to his walker to slow him down, it did not appear that this occurred for months. Similarly, in October 2016, after his hospitalization for bowel obstruction, the IDT did not update his IHCP.
- Individual #447's IDT did not revise his IHCP to address the etiology(ies) of his numerous falls.
- In March 2017, according to the IHCP, Individual #352's PCP was supposed to make a referral to the OT/PT. No evidence was found that this occurred in March or April 2017.
- Despite numerous falls, Individual #109's IDT did not refer him to the PNMT. In addition, the IDT did not modify his IHCP to put interventions in place to address the etiology(ies) of the falls.

c. For Individual #206, on 1/18/17, the IDT held a discharge ISPA meeting with the PNMT. The PNMT made nine recommendations, and the IDT only agreed to six of them. However, none were discussed in any detail. In addition, no discussion was documented of revision to the IHCP.

Individual #404's PNMT review resulted in no revision of his IHCP, no establishment of goals, and no description of a plan for monitoring, or definition of the need for reassessment.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: N/A			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	N/R	
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: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations to determine if staff

implemented PNMPs as written. The Monitor has offered the State the option of having the Monitoring Team member return mid-cycle to conduct observations, and provide Center staff with feedback.

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	206	447	663	570	640	352	404	109	603
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.	0% 0/1				0/1		N/A	N/A		N/A
Comments: a. As noted above, it was not clear how much intake Individual #570 received orally versus through the tube and there was no plan to clearly address this issue.											

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: For the individuals reviewed, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	N/A	0/1	0/2	0/1	0/3	N/A	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1		0/1	0/2	0/1	0/3		0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1		0/1	0/2	0/1	0/3		0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1		0/1	0/2	0/1	0/3		0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1		0/1	0/2	0/1	0/3		0/1	
Comments: a. and b. Individual #447 and Individual #404 did not have a need for formal OT/PT supports or services. Individual #603's assessment did not identify areas in which functional gains were likely.											

None of the individuals' IDTs developed goals/objectives that were clinically relevant and achievable, as well as measurable.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports that included data and analysis of the data were generally not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Individual #447, Individual #404, and Individual #603 were part of the core group, so full reviews were conducted for them. The Monitoring Team also conducted full reviews for the remaining six individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	N/A	N/A	N/A	N/A	0/3	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	N/A									
Comments: a. Many individual who should have had measurable strategies and action plans in their ISPs did not. Overall, for those that were included in ISPs/IHCPs, there was a lack of evidence in integrated ISP reviews that supports were implemented.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score									
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 requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	N/R									
Comments: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations to determine if adaptive equipment was clean and appeared to fit the individual. The Monitor has offered the State the option of having the Monitoring Team member return mid-cycle to conduct observations, and provide Center staff with feedback.											

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. At the last review, no indicators were moved to the category of requiring less oversight. At this review, no indicators were 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.

Given that ISP goals were not yet individualized progress could not be determined. Furthermore, action steps were not consistently implemented for any individuals. It was positive, however, that many staff knew the preferences of individuals.

Richmond SSLC recently began to develop a new SAP training procedure and updated SAP format. Two of these met criteria for content. Furthermore, some progress was seen in IDTs taking action when a SAP goal/objective was met. A higher percentage of SAPs were observed to be implemented correctly when compared to the last review. SAPs, however, were not being reviewed in a meaningful way, though most SAPs were graphed, which was good to see.

Richmond SSLC now regularly measured engagement and set goals. Focus now needs to be on individual engagement in activities, and achieving of the goals for each site.

The Center did not have a way to measure communication outcomes for the individuals reviewed.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The goal that met criteria with these indicators was progressing, which was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	118	206	447	603	109			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

Comments: As Richmond SSLC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators. Examples of how this might be accomplished are provided above.

4-7. A personal goal that meets criterion for indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. One of the personal goals, the living options goal for Individual #206, met criterion for indicators 1 through 3 as described above, and was progressing toward the identification of potential new homes in the community. There was no basis for assessing progress for the other goals because the IDTs failed to develop personal goals that were also measurable. The Monitoring Team found the lack of implementation, monitoring, and reliable and valid data to be significant concerns.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	118	206	447	603	109			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

39. It was positive that many staff knew the preferences of individuals. The Monitoring Team found Individual #447's and Individual #206's day program staff to be particularly well-informed. Even so, staff knowledge regarding individuals' ISPs was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation. Examples included:

- Day program staff could not state the respective work/day program personal goals for Individual #51, Individual #603, or Individual #109.
- Day program staff did not observe that Individual #109's shoes were on the wrong feet until the Monitoring Team pointed it out. This was of concern because Individual #109 was at a high risk for falls and needed to be monitored for appropriately fitting clothing.

40. Action steps were not regularly implemented for any individuals, as documented elsewhere in this section and throughout this report.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Some progress was seen in IDTs taking action when a goal/objective was met (indicator 7). The other three indicators scored about the same as last time. All four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
6	The individual is progressing on his/her SAPS	0% 0/22	0/2	0/3	0/1	0/3	0/2	0/3	0/3	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 3/3	2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	22% 2/9	N/A	0/3	0/1	0/2	N/A	0/1	2/2	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	53% 8/15	2/2	0/3	0/1	1/3	2/2	0/1	3/3	N/A	N/A

Comments:

6. None of the SAPs were rated as progressing. Some (e.g., Individual #118's laundry SAP) were not making progress. Some SAPs did not have sufficient data to determine progress (e.g., Individual #54's operate a bubble machine SAP), and some were scored as not making progress because they did not have reliable data. Finally, some SAP data did indicate progress (e.g., Individual #206's operate a MP3 player SAP), but were scored as not making progress because they did not have reliable data.

7. Individual #51's complete her vocational task and line dancing SAPs, and Individual #682's begin her vocational task SAP were achieved, and all three SAPs were moved to the next step.

8-9. Similarly, in Individual #206's operate a TV and operate a phone SAPs, he was not progressing, however, actions (i.e., retraining of staff) were documented to address the lack of progress. In none of the other seven SAPs that were judged to not be progressing (e.g., Individual #787's follow direction SAP), however, were there actions to address the lack of progress. Overall, there were data based decisions to continue, discontinue, or modify SAPs in 53% of the SAPs.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Two SAPs met the criteria for this indicator and they were the only two SAPs in the new format. This was encouraging and indicates that as SAPs are developed over the next year, the content and completeness of many more SAPs should be seen. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall	51	67	787	346	682	118	206	447	54

		Score									
13	The individual's SAPs are complete.	9% 2/22	0/2	0/3	0/1	0/3	0/2	0/3	0/3	2/3	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Individual #447's brush his teeth and cut his food SAPs were found to be complete. A common missing component among the remaining 20 SAPs was the lack of specific instructions to teach the skill. The majority of the SAP training sheets indicated that forward chaining or total task methodologies should be used for training the SAP. None of the SAP training sheets, however, contained explanations of these two training methodologies. Several SAPs stated one methodology, however, completed data sheets indicated that the other methodology was used (e.g., Individual #118's download songs SAP).

Additionally, instructions were not consistently clear for the use of training prompts or staff actions following incorrect responses (e.g., Individual #682's begin her vocational task).

Finally, the majority of SAPs (e.g., Individual #54's operate a bubble machine SAP) did not contain a documentation methodology.

Richmond SSLC recently began to develop a new SAP training procedure. Three of the new format SAPs were reviewed. It was encouraging that the two complete SAPs were in the new SAP format (for Individual #447).

Outcome 5- SAPs are implemented with integrity.

Summary: A higher percentage of SAPs were observed by the Monitoring Team to be implemented correctly when compared to the last review, which was at 0%. SAP integrity was not being addressed, but new protocols were being implemented that might have a positive effect. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	67	787	346	682	118	206	447	54
14	SAPs are implemented as written.	50% 2/4	N/A	0/1	1/1	N/A	N/A	N/A	N/A	1/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	5% 1/22	0/2	0/3	1/1	0/3	0/2	0/3	0/3	0/3	0/2

Comments:
14. The Monitoring Team observed the implementation of four SAPs. Individual #447's cut his food, and Individual #787's following instructions SAPs were judged to be implemented and documented as written. Individual #67's organize his wardrobe and Individual #54's operate his bubble machine were not judged to be implemented as written.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. One SAP integrity

measure was documented (Individual #787's follow instructions SAP). It was encouraging, however, to learn that Richmond SSLC recently developed a tool to measure SAP integrity, and established a schedule of SAP integrity that would ensure that each SAP was observed at least once every six months.

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

Summary: SAPs were not reviewed in a meaningful way as to meet criteria with indicator 16. SAPs were graphed, which was good to see. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
16	There is evidence that SAPs are reviewed monthly.	5% 1/22	0/2	0/3	0/1	1/3	0/2	0/3	0/3	0/3	0/2
17	SAP outcomes are graphed.	100% 22/22	2/2	3/3	1/1	3/3	2/2	3/3	3/3	3/3	2/2

Comments:
16. Individual #346's clean his room SAP had a data based review in the QIDP monthly report. The majority of SAPs were reviewed in QIDP monthly reports, however, in the majority of those reviews, only one month of SAP data was presented, which did not allow data based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #206's operate his TV SAP).

17. SAP data were consistently graphed.

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

Summary: Richmond SSLC now regularly measured engagement and set goals. This was good to see (indicators 19 and 20). Focus now needs to be on individual engagement in activities and achieving of the goals for each site. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	1/1

Comments:
18. The Monitoring Team directly observed nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found two (Individual #206, Individual #787) of the nine individuals to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Richmond SSLC tracked engagement in all residential and treatment sites. Their established engagement goal was individualized to each residence and day program site. The facility's engagement data indicated that 33% of the residential and day treatment sites of the individuals (i.e., Individual #54, Individual #118, Individual #787) achieved their goal level of engagement.

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

Summary: Individuals participated in community outings, however, the various criteria to ensure frequency, individualization, and training were not occurring. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	67	787	346	682	118	206	447	54
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:
22-24. There was evidence that all nine of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. Richmond SSLC did not provide data concerning the implementation of SAPs in the community. SAP training data and a goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

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

Summary: Some, but not all, of the components required for this indicator were met. With additional attention, they likely can be. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 795								
25	The student receives educational services that are integrated with	0%	0/1								

	the ISP.	0/1									
Comments: 25. None of the individuals selected for review attended school, therefore, Individual #795 was reviewed to score this indicator. Individual #795 was receiving educational services from the local independent school, and the IDT worked with the school district to provide appropriate educational services. Her IEP and school related action plans, however, were not integrated into her 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.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. to e. Based on documentation the Center provided, none of the individuals the Monitoring Team responsible for physical health reviewed had refused dental services in the year prior to this review.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center did not have a way to measure communication outcomes for the individuals reviewed. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	N/A	0/6	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including	0%		0/6	0/1	0/1	0/1	0/1	0/1		0/1

	timeframes for completion	0/12									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/12		0/6	0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/12		0/6	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/12		0/6	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #206 had functional communication skills using the Spanish language. Individual #109 also had functional communication skills.

Individual #447's Speech Language Pathologist recommended six goals that appeared to be clinically relevant in the communication assessment and the direct therapy treatment notes. However, they were not included in ISP action plans, and the QIDP integrated reviews did not comment on progress. As a result, regardless of whether or not they were clinically relevant and/or measurable, these indicators are scored negatively.

c. As noted above, Individual #206 and Individual #109 had functional communication skills. They were part of the core group, so full reviews were conducted for them. For the remaining seven individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	206	447	663	570	640	352	404	109	603
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/7	N/A	0/6	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. No evidence was found that individuals' communication supports were implemented.

b. In addition, no evidence was found of an ISPA meeting to terminate Individual #447's direct therapy.

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: N/A			Individuals:								
#	Indicator	Overall Score									
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	N/R									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	N/R									
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: Due to unexpected circumstances, the Monitoring Team member was unable to conduct observations of individuals with AAC devices. The Monitor has offered the State the option of having the Monitoring Team member return mid-cycle to conduct observations, and provide Center staff with feedback.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. Even so, some progress was seen compared with the last review on a number of indicators. The transition activities at Richmond SSLC were hampered by the absence of an Admissions Placement Coordinator (APC) and Transition QIDP over the past few months. State office personnel had stepped in to provide support and were present during the onsite review to receive feedback from the Monitoring Team and engage in conversation about how to move the Center forward towards improved transition planning (and the meeting of criteria with the outcomes and indicators in this domain). It was very positive that, during one of these conversations, the State office and Facility transition staff self-identified the same needs for improvement as did the Monitoring Team.

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.

Improvements were seen in the wording and comprehensiveness of many of the pre- and post-move supports in the CLDPs. This was encouraging to see and this progress should be built upon because even though progress was seen, much more progress is needed in order to meet criteria with indicators 1 and 2.

Post move monitoring quality and documentation had also improved. Similar to the CLDP supports, much more progress is needed, however, with feedback and direction, it is very likely that this will occur. The Post Move Monitor was an experienced QIDP and was actively engaged in the post move monitoring process, with providers, and with individuals.

IDTs were involved in transitions, which was good to see. Lots of attention is needed to improve the transition assessments, so that they are focused upon recommendations in the individual's new living, working, and community settings.

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: There was some improvement in the wording of the supports in measurable terminology, and there was some improvement in the comprehensiveness of the list of pre- and post-move supports. This was good to see, however, much more improvement is needed for the CLDP content (i.e., the quality and comprehensiveness of the list of supports) to meet the various criteria required by these two indicators and their sub-indicators. These two indicators will	Individuals:

remain in active monitoring.											
#	Indicator	Overall Score	734	391							
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:

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications.

For these two CLDPs, many supports were not yet written in measurable terms and, therefore, did not provide the Post Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed. That being said, the Monitoring Team recognized that the Center had made some progress to make supports more measurable compare with those found in previously reviewed CLDPs, particularly in describing what should be included in pre-move inservice training (as described in more detail below). In addition, the APC's office had identified this as a focus for improvement efforts.

- The IDT developed 24 pre-move supports for Individual #734, which also included six sub-indicators for side effects to specific medications.
  - The pre-move supports focused largely on pre-move training requirements. These supports typically included substantial detail about the required content of the training. Behavioral and psychiatric training supports included specific sections describing "What you Need to Know," "What You Need to Do," and "What You Need to Document." Overall, this was a logical and straightforward organizational approach, which was positive, and the Center may wish to consider whether this would be a useful model for developing both supports and training. As a part of this consideration, it will be important for the IDT to think about how to prioritize what needs to be included and how to convey that in a succinct and clear manner that will be useful to provider staff. For example, the behavioral treatment history inservice requirements were found in four separate supports, many of which were repeated in the inservice requirements for the Psychiatric Support Plan (PSP.) It may be more effective to develop one comprehensive support for behavioral and psychiatric needs, particularly when they are very similar as these were.
  - It was also difficult to ascertain whether the IDT expected competency demonstration to be contingent upon knowledge of all the content included in the supports. All training supports called for a written competency test, with an 85% score required. This inferred provider staff should be able to demonstrate knowledge of at least 85% of the content in each of the training supports, however, the competency tests did not typically cover 100% of the information included in the supports. The test for the Psychiatric Support Plan was the best example of a comprehensive approach to the material included in the training, while the testing materials for residential, behavioral, and nursing/health needs were far less so. For example:
    - Supports for nursing and health care needs called for provider staff to be inserviced on Individual #734's

dining plan, nutrition requirements, level of supervision, and oral care needs. None of the testing materials addressed these needs in any meaningful way. The only one of these supports represented in the testing materials was a true/false question that stated "I will encourage and assist the individual with healthy snacks to prevent weight gain."

- Side effects of medications were addressed extensively in the pre-move training supports, including specific information about numerous possible symptoms that might occur for each of six medications. The only reference in testing was a true/false question stating staff would report to the nurse immediately if any repetitive involuntary body movements, such as grimacing and eye-blinking, were observed.
- Individual #734 had a history of frequent ingrown toenails and a resulting episode of Methicillin-resistant Staphylococcus aureus (MRSA) infection. In addition to a support calling for staff to be knowledgeable of this information, another required staff to be inserviced on the need to monitor both great toes weekly for redness/possible inflammation and ingrown toenails. The testing asked staff to answer a true/false question if they should report signs of infection to the nurse, especially to toenails. This did not test staff knowledge as to the requirements for regular and ongoing weekly monitoring or their knowledge of why this was important for Individual #734.
- No testing materials were provided for Individual #734's behavioral treatment history, despite an extensive set of supports. This included, for example, her history of sexual exploitation and the requirement that she not be transported by male staff alone.

- Individual #391's 11 pre-move supports were very similar in approach and structure, and focused largely on pre-move training requirements. Most of these supports, such as those for nursing health needs, the positive behavior support plan (PBSP,) medication side effects, and quality of life preferences, included substantial detail about the required content of the training. The IDT did not clearly prioritize what staff would be expected to know and the competency testing reviewed covered a very small number of the items included in the respective supports. For example:
  - The supports for behavioral pre-move training were extensive, listing the relationship of the PBSP to Individual #391's fundamental outcomes, restrictions, behaviors for increase, behaviors for decrease/psychiatric indicators, function of behavior, materials needed for the plan, what you need to do for alternative behavior (six steps), prevention (eight steps), management (three steps), suicide threats (nine steps), and physical aggression (six steps). The pre-move competency test was comprised of six multiple choice questions. The first two asked staff to select his psychiatric diagnosis and his level of intellectual disability. The questions did not address prevention and management techniques. The testing also did not address how to respond to suicide threats, which included conducting an immediate check for and removing items he might use to harm himself, keeping him in eyesight, and contacting behavioral staff immediately to assess whether a crisis one-to-one level of supervision was needed. The IDT needed to confirm that all provider staff were aware of these essential precautions.

- The IDT developed 29 post-move supports for Individual #734. Examples of post-move supports that did not meet criterion for measurability included:
  - A support called for Individual #734 to attend day programming to "increase recreational, leisure, independence and pre-vocational skills," but provided no detail as to what skills she may have possessed in these categories or what

baseline could be used to determine if such skills were increasing.
    - Another support indicated the provider would develop an Intervention and Prevention plan to put measures in place to intervene should problem behaviors arise between Individual #734 and other individuals. The support did not define how problem behaviors would be defined. This made it difficult for the Post-Move Monitor (PMM) to assess whether an Intervention and Prevention plan should have been developed.
    - The behavioral and PSP supports indicated only that any new staff were to be inserviced, but did not call for testing knowledge, or retention of that knowledge, for existing staff. This was particularly concerning because staff knowledge had not been meaningfully assessed at the time of the pre-move training, as described above.

- The IDT developed 37 post-move supports for Individual #391. These supports were also structured much like those described for Individual #734, with similar issues impacting measurability. For example:
    - Individual #391 had a support to attend day programming that was identical to Individual #734's. It called for attendance to "increase recreational, leisure, independence and pre-vocational skills," but provided no detail as to what skills he may have possessed in these categories or what baseline could be used to determine if such skills were increasing.
    - A support indicated Individual #391's diet should be strictly monitored by staff. The support provided no indication how "strict monitoring" would be accomplished or evaluated.
    - A support indicated Individual #391 will apply fluoride gel, but did not state when/how often this should occur or whether it needed to be documented.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. The IDT had identified many supports for Individual #734 and Individual #391 and it was positive to see that they had made a diligent effort to address their needs. In interview, the APC noted that the Center was part of a DADS pilot for a new 14-Day meeting process and template they hoped would improve the identification of needed supports. The Monitoring Team looks forward to reviewing the results of this pilot. Despite these efforts, these two CLDPs did not yet comprehensively address support needs and did not meet criterion. In addition to those identified above under indicator 1, other examples included:

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
    - For both Individual #734 and Individual #391, the IDT extensively addressed behavioral needs in pre-move training supports, but did not provide a training methodology that ensured staff demonstration of competence, as described above.
    - The behavioral assessment for Individual #734 indicated Post Traumatic Stress Disorder (PTSD) had not been ruled out as a diagnosis. The IDT did not include a support to make this determination, which could have been significant given her history of abuse.
    - Individual #734 attended counseling at the Center, although no detail regarding the counseling plan was included in the CLDP. The IDT developed a support including a statement the provider should consult with the counselor "as needed" to address past trauma and current life issues. No indication was provided as to what might make counseling necessary.

- The CLDP did not fully address Individual #391's behavioral and psychiatric history, such as his history of fire starting in community residential settings.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Examples included:
   - Individual #734 was a relatively healthy young woman, but she did have some health risks that the provider needed to be aware of and address. For example, the IRRF rated her at medium risk for constipation because she received multiple medications that may cause constipation, including Vitamin D, Zyprexa, and Valproic Acid. She had not required any intervention at the Center, but it was notable her risk had increased from low to medium over the past year. The Integrated Health Care Plan (IHCP) required direct support staff to report any complaint of bloating, stomach upset, or abdominal pain, to follow-up with any complaint or report of straining during defecation, and to encourage fluid intake during meal. The CLDP did not address this risk with any support or staff knowledge.
   - Individual #734 also was at medium risk for fracture, having sustained a fractured clavicle in 2014. The IHCP included a restrictive checklist due to this history, but the IDT did not develop any support for staff knowledge of this history or any related restrictions.
   - The CLDP did not provide the specificity needed about Individual #391's level of supervision. The CLDP support indicated his level of supervision was to be routine and defined that as "day-to-day treatment, training, independence and safety needs are met with minimal staff supervision and/or assistance." Another support described his possible needs for enhanced supervision when he made a suicide threat, but this support was couched in terms of Center procedures that were not applicable to the community home. The CLDP also did not address supervision needs related to inappropriate sexual behavior, except in terms of how this was handled at the Center. The IDT needed to describe a process for supervision that addressed all these needs in the new settings.
   - Individual #391's habilitation therapy assessment indicated he had a new order for a back brace, due to intermittent back pain, to wear as needed, especially during lifting tasks. The CLDP did not include any support related to this need.

c. What was important to the individual: Neither of the CLDPs met criterion. For example, the ISPs, assessments and CLDPs for both individuals identified family contact as very important. The CLDPs included minimal supports in this area. Individual #734's supports included assisting her to contact her guardian within the first seven days and noted that all contact with her family must be approved by the guardian. No support addressed how or when family contact would actually be facilitated. Individual #391's CLDP included a single support to be assisted with calling his mother within the first seven days after transition. No support addressed how or when ongoing family contact would be supported.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings:
   - Individual #734 was employed in an on-campus job at the Center prior to transition and had indicated on many occasions that she wished to work at McDonald's. Her CLDP included a support for quality of life preferences that acknowledged she liked working, but did not address any paid work or any assistance with exploring opportunities to be employed at McDonalds. Instead, a support indicated she would attend day programming to, very broadly, "increase recreational, leisure, independence and pre-vocational skills." The IDT also did not include any specific supports for meaningful day activities in integrated community settings.
   - Individual #391's ISP included a personal goal to obtain secured employment as a security officer at the community

mall and a housekeeping job on-campus. It also noted he liked to work as a security assistant, at the laundromat, or in housekeeping. A vocational assessment was not submitted, but the Vocational narrative indicated a recommendation for Individual #391 to have a job in the community. The IDT discussed and agreed he should become stable in his new home before being assessed for employment. The narrative noted he had always asked to be assessed to be a security guard and would be assessed. The CLDP did not include any supports for employment or paid work, or to be assessed for employment once stabilized in his new home. The IDT also did not include any specific supports for meaningful day activities in integrated community settings.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success:
   - The CLDP included pre-move and post-move supports that included positive reinforcement and motivating components for both Individual #734 and Individual #391. The pre-move support described training content that included various prevention strategies that focused on reinforcing and motivating strategies. The post-move support called for training of any new staff in these same components. It was unfortunate that pre-move training did not test whether staff were knowledgeable of these supports. IDTs need to include a requirement that staff know how to provide reinforcement and motivating strategies for these supports to meet criterion.

f. Teaching, maintenance, participation, and acquisition of specific skills:
   - The IDT did no develop specific any supports that addressed teaching, maintenance, participation, and/or acquisition of specific skills for Individual #734.
   - For Individual #391, the CLDP did include staff instruction to provide verbal prompting and hand over hand assistance with toothbrushing, as needed, but otherwise did not address skill acquisition or maintenance. Individual #391's ISP included a personal goal for learning to cook, which would have been a very appropriate goal to continue in a community setting, and the CLDP should have offered more opportunity to engage in that activity.

g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center had a process for reviewing CLDP assessments, documenting discussion, and making final recommendations. As described in more detail under indicator 12 below, transition assessments often did not provide many recommendations for the IDT to consider. Examples of recommendations made, but not addressed in the CLDP included:
   - For Individual #734, the CLDP narrative noted a vocational assessment recommendation that she should be employed in a sheltered workshop or an off-campus job. The CLDP documented the final recommendation only as that she would be assessed for community employment at a later date. Neither recommendation was included in the CLDP supports.
   - For Individual #391, the audiological assessment indicated he had bilateral mild sensory-neural hearing loss and sometimes needed to read lips in noisy settings. Recommendations included an annual audiology exam in one year (due in February 2018) and a hearing aid evaluation to determine candidacy as well as the type of device. The IDT determined the community audiologist would follow-up on this, but did not reference the possible need for a hearing aid evaluation in the final recommendation.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: A new post move monitor was in place since right after the last onsite	Individuals:

review (i.e., nine months prior). Due to her work, performance was improved since the last review, thought not yet at criteria most of these indicators. With further feedback and direction from State office and from the new APC (not yet identified), it is likely that the quality and thoroughness of post move monitoring at Richmond SSLC will continue to improve. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	734	391							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	0/1	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	1/1	N/A							

Comments:

3. Post-move monitoring had been completed for the seven-day, 45-day, and 90-day PMM periods for Individual #734. Each of these post-move monitoring visits was within the required timeframes and was done in the proper format. The 90-day PMM visit included a visit that took place at the hospital where Individual #734 was a patient and at the home, but did not include the day habilitation program, per the documentation provided. The PMM provided comments regarding the provision of most supports, but improvements to this documentation process were needed, as described below.

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in some instances, but there were issues that compromised reliability and validity. For example, some supports for Individual #734 did not have any data or comments for the 90-day PMM visit. For both individuals, it was not always possible to ascertain whether reliable and

valid data were present, due in part to a lack of specificity and measurability of some supports as described in indicator #1. Other examples are described below. The Monitoring Team spoke with the transition staff while onsite about the facility creating a support checklist to be used by the provider to document the provision of various supports that community providers do not typical document. Many other Centers have had good success with these checklists being welcomed by the community provider.

5. Based on information the Post Move Monitor collected, neither individual had consistently received supports as needed.
- Individual #734 had not consistently received supports as listed and/or described in the CLDP. Examples included:
  - Due the lack of entries for some supports at the 90-day PMM visit, it could not be confirmed whether those supports were being received as needed.
  - A support called for provider staff to monitor both of her great toes weekly. Neither the seven- or 45-day PMM comment documented whether such monitoring was occurring.
- Individual #391 had not consistently received supports as listed and/or described in the CLDP. Examples included:
  - The PMM provided no evidence that his purchases at the vending machines or stores were being documented on his dining plan as required.
  - At the time of the 90-day PMM visit, the PMM documented that staff were not exactly sure what a 1500 calorie diet should look like.

6. Based on the supports defined in the CLDP, some scoring was not accurate based upon the available evidence. Examples included:
- For Individual #734, the PMM scored as present the support for staff monitoring of her great toes, but provided no evidence this was occurring.
- For Individual #391, the PMM scored a support for staff to strictly monitor his diet as present, despite documenting staff were not sure what a 1500 calorie diet looked like.
- For Individual #391, the PMM provided no evidence his purchases at the vending machines or stores were being documented on his dining plan as required. For example, at the 45-day visit, the PMM indicated Individual #391 went shopping on Fridays or the weekend with his peers and that he was trying not to buy so many sodas. The notation did not indicate whether any of these purchases were documented on the dining plan, or even that the PMM had observed the dining plan. The support was scored as not applicable, without any rationale.

7-8. The PMM did not accurately and consistently identify supports that were not being provided. Thus, follow-up needs were not identified as needed. For example, the concerns noted in indicators 5-6 should have prompted the PMM to identify needed follow-up. These included"
- The PMM should have identified whether monitoring of Individual #734's toes was occurring and taken action as needed.
- The PMM should have identified the lack of staff knowledge regarding Individual #391's 1500-calorie diet as an issue that required follow-up.

9. The Monitoring Team accompanied the PMM and the acting APC (from state office) on the six-month post move monitoring review for Individual #734. The group visited, observed, and interacted with Individual #734 at her day program and at her home. Overall, she was in a happy mood, pleased to meet new people, and eager to show her day program and home to the visitors. She was satisfied with her day program and home (though she wanted to go shopping more often). Moreover, her health issues were stable.

In both settings, the PMM asked lots of questions of direct support staff, such as around behavioral issues, responses, and documentation. Thorough post move monitoring, however, was hampered by the way the CLDP was written, in that many supports were not written in measurable terms, did not clearly indicate what the PMM should look for to verify provision of supports, and did not focus on the three aspects of support verification: observation, interview, and documentation. Much of the verification of supports was limited to staff interview (i.e., verbal response). Given the PMM's gregarious and slow-paced style, it is likely that with better CLDPs and with support from the new APC, that this indicator will meet criteria in the near future.

10. The post move monitoring report for the visit accurately reflected what was observed by the Monitoring Team. Furthermore, this report was an improvement from previous reports. This was likely the result of the PMM immediately implementing some of the recommendations presented by the Monitoring Team during the onsite week. For instance, there was much more detail provided regarding the status of each support. This was especially good to see and, because post move monitoring was now in the quarterly stage for Individual #734, this report can provide a lot of guidance to the PMM when the nine-month post move monitoring is conducted.

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

Summary: Negative events occurred for both individuals and, in both cases, there were some absences in the transition planning process related to these events that, if done, would have reduced the likelihood of the events occurring. It was good to see that IDTs reviewed these events after they occurred. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	734	391							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/2	0/1	0/1							

Comments:

11. Both individuals had experienced a PDCT event within the first 90 days after transition. In both instances, pre-move training deficiencies may have played a part in these events, but the IDT did not take this into consideration.

- Individual #734 had experienced a negative Potentially Disrupted Community Transition (PDCT) event. She went to the emergency room and was subsequently hospitalized for an infected great toe and cellulitis. She had gone to the podiatrist on 2/3/17 and an ingrown toenail on her right great toenail was removed. At a follow-up appointment, approximately two weeks later, on 2/22/17, the great right toe was reported to be fine, but the podiatrist removed another ingrown nail on another toe of the same foot. Medications were prescribed for both instances. On 2/28/17, staff noted redness and pain on the great toe. The provider took her to the emergency room (ER) and she was hospitalized. Individual #734 was discharged on 3/8/17. Per

the PMM, she had also been diagnosed with osteomyelitis, a bone infection that may have been result of infection at another site. At that time, she had a PCP appointment for follow-up bloodwork on 3/16/17 and a follow-up podiatry appointment on 3/17/17.

In the PDCT ISPA documentation, the IDT indicated the tendency towards infected and ingrown toenails was a known medical issue that had been identified and covered in inservice training on 12/14/16.

- The CLDP did include a pre-move support for staff to be inserviced on health care needs that listed MRSA infection of the great left toe. The pre-move supports did not, however, include a specific training support for the need for staff to monitor her toes, how that should be completed and documented, or the reporting requirements.
- The CLDP did include a post-move support to follow-up with a community podiatrist and monitor both great toes weekly for redness/possible inflammation and ingrown toenails, but it did not define any reporting or documentation expectations.
- The pre-move competency testing included one related question. It asked staff to answer a true/false question if they should report and signs of infection to the nurse, especially to toenails. This did not test staff knowledge as to the requirements for regular and ongoing weekly monitoring or their knowledge of why this was important for Individual #734.
- At the seven-day PMM visit, comments did not reflect that staff were interviewed for knowledge of the support; instead, the PMM noted only that inservice had been provided on 12/14/16 and that testing materials had been provided to the Transition QIDP.
- At the time of the 45-day PMM visit, the PMM documented Individual #734 told her she had new medication for her toes, but no additional information was provided and the PMM did not document interviewing staff for knowledge in this area.
- At the time of 90-day PMM visit, the PMM visit took place at the hospital. The home was visited the next day, but the PMM did not provide any comments and there was no indication staff had ever been interviewed about this need.

- Individual #391 experienced both law enforcement contact within 90 days and a psychiatric hospitalization. On 3/7/17, Individual #391 called police. He stated he was going to kill himself and had a cut on his inner arm, which appeared to be healing. Law enforcement personnel took him to the hospital, per their protocol. He was released to the provider the next day, who reported developing a special needs sheet for the staff to follow. It included various instructions, including behavioral needs.

  The IDT met on 3/27/17 to discuss the event and concluded the event was both negative and preventable.
  - The ISPA stated efforts prior to the event included having addressed that Individual #391 sometimes called the police when he was lonely or depressed and that the provider was instructed to have staff talk and build a relationship with him. The IDT further determined the behavior plan was in place prior to the move and that it had been inserviced, but the ISPA documented the behavior plan was not being followed or referenced by provider staff.
  - In response to whether anything could have been done differently, the ISPA stated he could have spoken to staff about what he was feeling and that provider staff should refer to the behavior plan for information on how he deals with his feelings.

- The IDT did not examine whether pre-move training was sufficient to ensure staff had knowledge of, and competence to implement, the many requirements of his PBSP. As described under indicator 1 above, pre-move testing did not address staff knowledge of prevention and management techniques. It also did not address staff knowledge about how to respond to suicide threats, which included instructions, such as to conduct an immediate check for and remove items he might use to harm himself, to keep him in eyesight, and to contact behavioral staff immediately to assess whether a crisis one-to-one level of supervision was needed. The IDT should have confirmed that all provider staff were aware of these essential precautions.
- The IDT did not consider, or take, any action to provide any additional training for provider staff to ensure their current knowledge and competence once their lack of knowledge was identified.

Overall, for both individuals, the IDTs should have considered and identified the deficits in the specificity of the related supports, the pre-move training and confirmation of staff knowledge, both at the time of the training and during PMM visits, as factors that may have played a part in these events. One of the important purposes of the PDCT process is to critically analyze the Center's actions during and after transition and use this information for process improvement in future transitions.

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: Two of these indicators met criteria, which was an improvement from the last review. That being said, transition assessments need improvement to be useful for the IDT and transition staff. Various other transition activities (indicators 14-17) also need attention to make sure that they occur, occur with quality, and are documented. All the indicators of this outcome will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	734	391							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be	0% 0/2	0/1	0/1							

	trained and method of training required.										
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments did not yet consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance, as described below. It was encouraging and positive to see that the APC and transition staff had identified needs in this area and had been meeting with Center disciplines to discuss how to improve. They reported behavioral, habilitation, and medical assessments had shown recent progress.

- Assessments updated with 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for these individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. For Individual #734, the Center did not provide the following assessments for review: Functional Skills Assessment (FSA), psychiatry and pharmacy. For Individual #391, assessments not made available included psychiatry and pharmacy.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Many assessments provided a good summary of relevant facts, but assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments did not consistently meet criterion for this indicator. Again, missing assessments factored into this determination, but even assessments that had been updated did not consistently provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not typically address/focus on the new community home and day/work settings.

13. The CLDPs met criterion for this indicator. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) there was documentation to show IDT members

actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.

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: The Monitoring Team requested and reviewed the training documentation, including the training and testing materials. As described elsewhere in this section, pre-move training did not assertively address the testing of staff competence and knowledge. In addition, the Monitoring Team noted that the scoring of tests administered was not rigorous, with some staff written tests being scored as achieving 100% even when there were obvious errors or missing answers.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting its consideration of the need for any such collaboration, and a develop a corresponding support as appropriate. Neither of the CLDPs met criterion.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. Neither of the CLDPs met criterion.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. The CLDPs did not meet criterion in this regard.

18. LIDDA participation: This indicator met criterion. The LIDDA Service Coordinator participated in both CLDPs. For Individual #734, the LIDDA also participated in the PDCT ISPA.

19. The Pre-Move Site Reviews (PMSR) were completed in a timely manner and indicated all supports were in place. For both individuals, due to the lack of comprehensive competency testing, the PMSR failed to document that provider staff had knowledge of important health and safety needs that should have been clearly in place at the time of transition. Other issues included:

- For Individual #734, the PMSR provided for review did not include all her pre-move supports.
- For Individual #391, the PMSR was dated 2/27/17 and indicated the in-service supports were in place, but the comments indicated those in-services had not yet been held and were scheduled for 3/4/17.

Outcome 5 – Individuals have timely transition planning and implementation.	
Summary: One individual moved in a timely manner. The other did not and, moreover, delays in IDT activity resulted in opportunities being missed. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	734	391							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	50% 1/2	1/1	0/1							

Comments:
20. Individual #734 was referred on 4/29/16 and transitioned on 12/9/16. The Transition Log provided substantial detail about the transition process, which was helpful. The Center put the transition process on hold between 8/3/16 and 9/30/16 due to an investigation of an allegation of physical abuse.

Individual #391 was referred at the time of his last ISP on 5/26/16 and transitioned on 3/6/17. ISPAs documented that vacancies in homes Individual #391 chose to visit were no longer available due to lack of timeliness on the part of his IDT.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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