United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: March 12-16, 2018

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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, 16 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 restraint management. Two other indicators, in abuse/neglect/incident management, did not maintain performance and will be returned to active monitoring.

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

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

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

<u>Restraint</u>
Richmond SSLC continued to have a strong system for managing crisis intervention and medical/dental restraint. The assigned restraint manager was knowledgeable of restraint requirements and was diligent in following-up whenever something wasn't documented or reported correctly. Moreover, the Center made continued improvements since the last review, such as now trending the usage of non-chemical, pretreatment sedation, and TIVA usage for medical and dental procedures.

Richmond SSLC changed their reporting to a straight frequency count since the last review. The census-adjusted comparison since that time puts the Center at the fourth lowest in the state. Average duration of a physical restraint was under three minutes.

One particularly noteworthy practice is the Restraint Review Committee's review of video of restraints. We again sat in on the committee's meeting during the onsite week. It was a review of video of restraints with good interdisciplinary and problem

solving discussion. Attendance included a PMAB instructor who commented on aspects of the restraint in the video, as well as attendance by specific IDT members.

More training and/or oversight are needed when the Facility uses medical restraint. It doesn't happen very often at Richmond SSLC, but when it does, the required protocols and documentation need to be, but weren't, implemented.

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

Abuse, Neglect, and Incident Management

Since the last review, the Incident Management department had undergone significant staff changes and seemed to be, at the time of this onsite review, starting to stabilize.

Some of the deficient practices noted in this review can be attributed to these staffing changes, most notably:

- The absence of serious injury audits for most of this review period.
- Not all discovered non-serious injuries were being subjected to a non-serious injury investigation (NSI) when required by policy.
- The absence of data for trending, which also resulted in absence of any quality assurance/quality improvement analysis.
- Need for more review of circumstances surrounding any possible late or incorrect reporting.

That being said, supports were in place to have reduced the likelihood of the occurrence of the incident for all incidents, this is indicator 1, and for many of the investigations, the IDT conducted a post investigation ISPA to review results and determine if any supports needed to be modified or added. The Monitoring Team interviewed one or more direct support professionals who support each individual and they were very knowledgeable about the individuals, their PBSPs, the high-risk areas, and their communication skills.

Of note, one investigation was for an allegation of neglect regarding a medication administration error. HHSC PI referred the allegation back to the Center for clinical review and investigation. After review and discussion with a number of state office discipline coordinators, it became clear that the facility methodology for investigations of this type was not being done according to state policy requirements. According to state office, this will be addressed through policy clarification, some new procedural and documentation requirements, and training for IMCs, CNEs, and nurse investigators.

Other
In the six months prior to the review, Richmond SSLC completed four DUEs, but they either were not clinically appropriate, or were incomplete.

Restraint

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

Summary: Richmond SSLC continued to have a strong system for managing crisis intervention and medical/dental restraint. The assigned restraint manager was knowledgeable of restraint requirements and was diligent in following-up whenever something wasn't documented or reported correctly. Moreover, the Center made continued improvements since the last review, such as now trending the usage of non-chemical, pretreatment sedation, and TIVA usage for medical and dental procedures. The meeting during which videos of actual applications of crisis intervention restraint were reviewed and discussed continued to be an excellent practice. Some of the occurrences of crisis intervention restraint in the Center's data set were due to new admissions and/or the recent inclusion of escort and object release into the data set. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (May 2017 through January 2018) were reviewed. The Center changed to a frequency count of crisis intervention restraints shortly after the last review. Therefore, a long-term comparison or trend could not be made. However, over the course of the seven months of frequency data, there was a decreasing trend. The census-adjusted comparison with the other Centers placed Richmond SSLC's frequency of crisis intervention restraint at the fourth lowest in the state. A new confound to the data was the inclusion of physical escorts over active resistance (July 2017) and object removal from the individual over his or her active resistance (October 2017). The frequency of crisis intervention restraints paralleled the overall usage of crisis intervention restraints because the vast majority of crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was under three minutes, putting the Center in the middle when compared with the other 12 Centers. Even so, it was good to see a relatively low average duration.

There was one occurrence of crisis intervention chemical restraint, in September 2017 (and a second in February 2018, though that was just past the cut-off of the data set for this review). There was also infrequent use of crisis intervention mechanical restraint, mittens

with one individual, three times, in June 2017, and none since then. There were no individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB) and there were no instances identified of protective devices (e.g., helmets) being used for operant based behavior, but being categorized as medical restraint or protective devices. There was one occurrence of an injury due to application of restraint; it was deemed non-serious (however, see Outcome 1a-c below regarding nursing restraint-related activities). There was a higher number of individuals who had a crisis intervention restraint each month compared to the last review, that is, about seven per month versus about five per month, respectively. The Center reported that this was due primarily to new admissions. It might be interesting to tease this out of the data, such that a secondary data set is made that does not include the first six months of a new admission.

Few individuals had non-chemical restraints used for medical or dental procedures each month and there was a descending trend (or already low occurrence) of the use of pretreatment sedation for medical or dental procedures. TIVA usage remained relatively high and stable at about 200 individuals per year.

Thus, facility data showed low/zero usage and/or decreases in 10 of these 12 facility-wide measures (overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of physical restraint; use of PMR-SIB; restraint-related injuries; use of non-chemical and use of pretreatment sedation for medical and dental procedures).

Restraint review committee remained active. One particularly noteworthy aspect of the committee's activity was review of video of horizontal restraints. The Monitoring Team again sat in on the committee's meeting during the onsite week. It included detailed review of the video (a security video staff was present to manage the video presentation, e.g., slow, back and forth, zoom in) with good interdisciplinary and problem solving discussion. Attendance included a PMAB instructor who commented on aspects of the restraint in the video, as well as attendance by specific IDT members. For instance, at this meeting, the attendees noticed a staff member standing behind an individual who was agitated. It looked like it might have been a restraint that was never recorded or reported. After the meeting, the restraint manager explored this further and found out that it was a handhold, which should have been reported as a restraint, but wasn't. It was added to the data set and the staff was retrained on reporting requirements. Overall facility usage of restraint continued to be presented by the director of behavioral health each quarter at the Center's QAQI Council meeting. Since the last review, she had expanded her data set to include both frequencies and episodes of crisis intervention restraint. Sometimes this can present a different picture of the status of the Center's (or of an individual's) trend related to crisis intervention restraint.

2. Five of the individuals selected for review by the Monitoring Team were subject to restraint. Of these five individuals, four received crisis intervention physical restraints (Individual #15, Individual #108 Individual #263, Individual #118), one received crisis intervention chemical restraint (Individual #118), and one received medical restraint (Individual #140). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all five individuals. The other four individuals selected by the Monitoring Team had no restraints making a total of nine of the nine 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: Some attention to implementation, documentation, and review of	Individuals:

medical restraints is needed at Richmond SSLC. The sole medical restraint in this review (for Individual #140) did not have complete information (indicator 10). This should be corrected if medical restraint is used in the future for the safety of the individual as well as to maintain the placement of a number of indicators in the category of less oversight (e.g., indicator 10). Indicator 9 was not rated because criterion was met for all individuals for indicator 2. This was good to see. Also, documentation of restraint contraindications was in place for all individuals. With sustained high performance, indicator 11 might be moved to the category of requiring less oversight after the next review. The three indicators reported in this outcome (7, 9, 11) will remain in active monitoring.											
#	Indicator	Overall Score	15	108	140	263	118				
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.	75% 6/8	0/2	1/1	1/1	2/2	2/2				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	Due to the Center's sustained performance, this indicator was moved to the 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.	Not rated	Not rated	Not rated	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% 5/5	1/1	1/1	1/1	1/1	1/1				
Comments: The Monitoring Team chose to review seven restraint incidents that occurred for five different individuals (Individual #15, Individual #108, Individual #140, Individual #263, Individual #118). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a medical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.											

7. For both of Individual #15's restraints, the restraint checklist said no injury, but they also said no for whether the nurse checked for injury. The only way no injury can be validated is through a nurse assessment.

9. Because criterion for indicator #2 was met for all 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: With sustained high performance, this indicator might be moved to the category of requiring less oversight after then next review.			Individuals:								
#	Indicator	Overall Score	15	108	140	263	118				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 1/1	1/1	Not rated	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.											

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: With sustained high performance, indicator 13 might be moved to the category of requiring less oversight after the next review. As noted throughout this section of the report, attention to medical restraint is needed, as evidenced by the 0% score for indicator 14. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	108	140	263	118				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	86% 6/7	2/2	1/1	N/A	2/2	1/2				
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.	0% 0/1	N/A	N/A	0/1	N/A	N/A				
Comments: 13. For Individual #118 1/12/18, the restraint monitor arrived later than the required timeline, that is, at more than an hour. 14. For the sole medical restraint, for Individual #140, there was no information regarding how long the wristlets were in use.											

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

Summary: Overall, since the last review, nursing assessments for restrained individuals showed regression. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: for chemical restraints, monitoring individuals' mental status, and documenting the effectiveness of the restraint; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and assessing individuals for injuries and documenting the results. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	15	108	140	263	118				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	13% 1/8	0/2	0/1	0/1	0/2	1/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	38% 3/8	0/2	1/1	0/1	1/2	1/2				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	13% 1/8	0/2	0/1	0/1	0/2	1/2				

Comments: The crisis intervention restraints reviewed included those for: Individual #15 on 12/11/17 at 12:05 p.m., and 1/25/18 at 4:55 p.m.; Individual #108 on 10/25/17 at 10:05 a.m.; Individual #140 on 1/30/18 at 7:00 p.m. (medical for intravenous infusion); Individual #263 on 11/17/17 at 12:52 p.m., and 1/19/18 at 11:40 a.m.; and Individual #118 on 9/14/17 at 12:05 p.m. (chemical), and 1/12/18 at 6:25 a.m.

a. through c. For Individual #118's physical restraint on 1/12/18 at 6:25 a.m., the nurse performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individual.

The following provide examples of problems noted:

- Individual #118's chemical restraint on 9/14/17 at 12:05 p.m. (chemical) was the only other restraint for which documentation was found to show that nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint.
- For Individual #15's restraints on 12/11/17 at 12:05 p.m., and 1/25/18 at 4:55 p.m., the Center submitted a statement indicating that no IPNs, IView flowsheets, or PCP orders were available. In addition, even without nursing assessments to assess the individual for injuries, the Center indicated that the individual did not sustain injuries as the result of these restraints. This was concerning.
- Individual #108's restraint on 10/25/17 at 10:05 a.m., an IPN, dated 10/25/17 at 11:15 a.m., noted that the nurse was not notified of the restraint until 11:05 a.m. Consequently, nursing assessments and vital signs were not completed with 30

minutes of the episode. It was positive that for this individual, the nurse documented an assessment to determine whether or not the individual sustained any injuries during the restraint.

- For Individual #140's restraint for intravenous (IV) infusion on 1/30/18 at 7:00 p.m., the IPN provided, dated 1/18/18 at 9:36 p.m., did not note the use of any restraints or the use of IV for fluid administration. The PCP order noted the use of wristlets only during IV fluid administration while the individual was awake. The Center did not provide any IPNs addressing this restraint.
- Individual #263's restraint on 11/17/17 at 12:52 p.m. occurred off grounds, but the documentation provided did not indicate what time the individual returned to the Center. Therefore, the Monitoring Team could not determine the timeliness of the nurse's assessment. The documentation did not indicate if the abrasions found on the individual's left hand and fingers were related to the restraint process.
- For Individual #263's restraint on 1/19/18 at 11:40 a.m., the nurse assessed vital signs, but not within 30 minutes (i.e., at 12:25 p.m.). The IPN did not provide a detailed description of the individual's mental status. It was positive that for this individual, the nurse documented an assessment to determine whether or not the individual sustained any injuries during the restraint.
- An IPN, dated 9/14/17 at 12:23 p.m., did not indicate whether or not Individual #118 had to be held in order for the nurse to administer the chemical restraint or was cooperative for the injection. The nurse identified the site for the injection as "left upper arm," rather than left deltoid (i.e., the muscle used on the arm for an intermuscular injection). Although the nurse took vital signs appropriately, the nurse did not document mental status exams or his response to the chemical restraint, which is essential when a chemical restraint is administered.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Although in less oversight, documentation problems with three of the restraints were evident (two regarding nursing documentation, one overall regarding medical restraint). Given the long history of sustained high performance, this indicator will remain in the category of requiring less oversight, but these documentation issues need to be addressed for this indicator to remain in this category after the next review.			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: Richmond SSLC demonstrated sustained high performance on both indicators, with both indicators scoring 100% for all restraints for this review and for the previous two reviews, too (with one exception for one restraint in September 2016). Therefore, both indicators 16 and 17 will be moved to the	Individuals:

category of requiring less oversight.											
#	Indicator	Overall Score	15	108	140	263	118				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 7/7	2/2	1/1	N/A	2/2	2/2				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 7/7	2/2	1/1	N/A	2/2	2/2				
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: Criteria were met for the (infrequent at Richmond SSLC) use of crisis intervention chemical restraint. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	118								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
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 crisis intervention chemical restraint during this review period that involved an individual in the review group. Individual #118 was administered Zyprexa 10 mg by an intramuscular injection on 9/14/17. The review of the chemical restraint documentation by the Pharm.D and the psychiatrist were both completed later that day. 48. Zyprexa was the only medication that was utilized.											

Abuse, Neglect, and Incident Management

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

Summary: For most incidents, supports were in place to have reduced the likelihood of the occurrence if the behaviors/actions of the individuals were ones that had occurred before. This was good to see. During this review, however, it became apparent that some aspects of investigations conducted by the Center as an administrative/clinical review did not follow proper protocols. This should be addressed by the incident management and nursing departments. It resulted in one (out of one) administrative/clinical investigation not meeting criteria for this indicator. Also, the Monitoring Team noted that an ascending trend of fractures did not receive any review or plans for attention (also relevant for outcome 10, indicators 19-23). This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12	1/1	3/3	2/2	1/1	2/2	1/1	0/1	1/1	

Comments:

The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, eight were HHSC PI investigations of abuse-neglect allegations (five unconfirmed, three referred back to Center for clinical investigation [serious medication administration error, finger fracture, ingestion of inedible item], one was streamlined, one was abbreviated). The other four were for facility investigations of serious injuries (fracture of back, finger, femur), and a suicide threat. 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 #108, UIR 18-039, HHSC PI 45775568, unconfirmed allegation of physical abuse, 11/6/17
- Individual #140, UIR 18-034, HHSC PI 45728884, unconfirmed allegations of physical and verbal abuse, 10/29/17
- Individual #140, UIR 17-159, discovered fractures, back, chest, 7/12/17
- Individual #140, UIR 18-089, discovered fracture, hand, 1/9/18
- Individual #263, UIR 18-035, HHSC PI 45729611, unconfirmed allegation of neglect, 10/29/17
- Individual #263, UIR 17-172, witnessed ingestion, 7/31/17
- Individual #118, UIR 18-010, HHSC PI 45546039, administrative referral of allegation of verbal abuse, streamlined investigation, 9/14/17
- Individual #575, UIR 17-161, HHSC PI 45373154, unconfirmed allegation of verbal abuse, 7/13/17
- Individual #575, UIR 18-027, suicide threat, date unknown
- Individual #475, UIR 18-087, HHSC PI 46106075, unconfirmed allegation of physical abuse, 1/3/18

- Individual #268, UIR 18-086, neglect and life threatening medication error, date unknown
- Individual #372, UIR 18-052, discovered fractures, back, thigh, 11/19/17

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For all 12 investigations, sub-indicator (a) was met. Five of the investigations were of alleged staff abusive conduct; for each of these, there were no trends to identify and no relevant prior occurrences. For six of the other seven, there was a trend and/or prior occurrences and plans were in place and were being implemented. These were typically PBSPs or PNMPs. Richmond SSLC's system for doing so was evident for Individual #567 (not in the above list), during the onsite review week. The Monitoring Team observed an ISPA meeting for him that was held because he had three occurrences of peer-to-peer aggressive behavior. There was good discussion among the IDT and some reasonable actions were developed.

On the other hand, tier 1 documents sent to the Monitoring Team showed a number of occurrences of fractures, both discovered and witnessed (17 in six months). The Monitoring Team asked about this and the Center shared a graph of fractures per month from the January 2018 QAQI report. It was good to see that the Center was trending these occurrences, however, the report (which included a graph with a clearly ascending line) did not have any commentary about this trend line, possible causes, or any actions considered.

For the remaining investigation, Individual #268 UIR 18-052, a medication administration error occurred whereby he received another individual's anti-seizure medication. The case was referred back to the Center for clinical investigation. It was investigated, however, many of the required protocols were not followed (e.g., separation of incident management and nurse investigator activities). As a result, this investigation was scored 0 for this indicator. In addition, at the time of the last review, the Monitoring Team identified two systems issues that needed to be corrected. One was regarding management of outside medical-related consultations, and the other was regarding the proper reconciliation of medications after an individual's hospitalization. For three months following the last review, the Center submitted a brief report to the Monitors regarding the management and status of both issues. Both were reported to have been corrected. At the time of this review, that was the case for management of outside medical-related consultations, but was not the case for proper reconciliation of medications after an individual's hospitalization. In fact, shortly before the onsite review, one individual's psychotropic medications were halved while he was in the hospital for two days for pneumonia, but this change was not noticed by the Center for more than two weeks post-hospitalization, during a review by the psychiatrist (Individual #72).

Three individuals at Richmond SSLC were identified by HHSC PI for streamlined investigations because of their frequent self-reporting of allegations that were false. The Monitoring Team reviewed whether HHSC PI and SSLC protocols were being followed for one of these individuals (Individual #118) and found that they were (i.e., quarterly review by HHSC PI, and addressing of this behavior in a treatment plan by the SSLC). Individual #118's treatment plan, however, only recently included any commentary regarding frequent calling in of allegations. The treatment plan for an individual (e.g., PBSP) is required to talk about how this behavior is to be handled, or, if the treatment team determines that certain direct intervention is likely to be counter-therapeutic (e.g., talking about or providing

behavior specific praise), that rationale should be stated in the plan.

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

Summary: Two allegations were not reported in a timely manner and/or circumstances around what appeared to be late reporting were not adequately explained or explored in the UIR. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	83% 10/12	0/1	2/3	2/2	1/1	2/2	1/1	1/1	1/1	

Comments:

2. The Monitoring Team rated 10 of the investigations as being reported correctly. The other two 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.

- Individual #108 UIR 18-039: Per HHSC PI, the incident occurred on 11/4/17 and was reported to them on 11/6/17. The UIR stated that the individual reported it to staff on 11/6/17, however, the UIR did not have an entry regarding who made the report. Therefore, this could not be confirmed. The UIR did not have sufficient data to validate timely reporting.
- Individual #140 UIR 18-034: Per HHSC PI, the incident occurred on 10/2/17 and was reported on 10/29/17. The UIR stated that on 10/27/17 that a nurse observed the alleged perpetrator sitting with the individual and forcefully throwing the individual's legs back onto the bed, over the bedrails. The UIR stated that it was likely the hospital staff who made the call. The UIR also noted that there was no reason/excuse for the report not having been more timely.

For Individual #263 18-035, a review of the data in the UIR indicated that it was a later report. However, in the UIR, it was explained that the reporter (campus administrator) was on hold on the phone for 30 minutes when making the report. If HHSC PI had not placed the call on hold for that long it would not have been a late report. It was good to see this explanation in the UIR.

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: There was improvement in staff ability to talk about abuse and neglect identification and reporting. This was good to see. Further, problems with the placement and availability of posters with reporting phone numbers in some homes was fully corrected at the time of this review. This indicator (3) will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	1/1	Not rated	
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. For Individual #268, staff correctly answered the Monitoring Team's questions about identification of abuse and reporting of abuse. Even though not required, the Monitoring Team had the opportunity to talk with more than a half dozen staff about abuse identification reporting and all of them also correctly answered the Monitoring Team's questions.

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

Summary: With one exception, criteria were met. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	1/1	3/3	2/2	0/1	2/2	1/1	1/1	1/1	

Comments:
6. There was not immediate reassignment of alleged perpetrators for Individual #118 UIR 18-010. On the positive, however, the Center, in the UIR self-identified this issue.

Outcome 5– Staff cooperate with investigations.

Summary: Overall, there was good cooperation by facility staff with investigations. For one, however, the UIR did not explain what appeared to be Center delays in document submission, but which turned out to be a delay in HHSC PI's request for those documents. Even so, with sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	

7	Facility staff cooperated with the investigation.	92% 11/12	0/1	3/3	2/2	1/1	2/2	1/1	1/1	1/1	

Comments:
7. For Individual #108 UIR 18-039, the HHSC PI investigation was hampered/delayed by the investigator not receiving documents from the Center (as noted in the HHSC PI extension request being due to waiting for documentation from the Center). However, upon making two requests for more information about this to the Center, the Monitoring Team learned that the HHSC PI investigator requested these documents (observation notes and incident reports) on the 10th day (i.e., the same day as the extension request) and there was no delay in the Center's response to HHSC PI. This should have been explained in the UIR. The Center reported that they had this on their agenda for their upcoming regularly occurring meeting with HHSC PI in May 2018.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

Summary: Most investigations met criteria for collecting and analyzing relevant information, data, and evidence. In three cases, some aspects of the investigation were not as thorough as they might have been. Thus, a score of 83% was made for both indicators. Both indicators, however, will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	83% 10/12	0/1	2/3	2/2	1/1	2/2	1/1	1/1	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	83% 10/12	1/1	2/3	2/2	1/1	2/2	1/1	0/1	1/1	

Comments:
9. For Individual #108 UIR 18-039, the alleged incident was reported to have happened at 5:00 am in the individual's bedroom with only the alleged perpetrator and the individual present. This should have been confirmed by HHSC PI by either interviewing other staff on duty at the time, or reviewing video. As a result not all evidence was collected.

For Individual #140 UIR 18-089, for a discovered serious injury, the investigation should include an attempt to determine when the individual was last observed without the injury, and first time he or she was observed with the injury. This time-window allows the investigator to focus on a specific timeframe and, therefore, upon specific staff assigned 1:1, activities scheduled, etc.

10. For Individual #140 UIR 18-089, there wasn't any finding or conclusion despite her being on 1:1 supervision. The investigator did not determine any specific actions that could have, or may have likely, caused the fracture.

For Individual #268 UIR 18-086, HHSC PI concluded that the incident should be referred back to the Center for administrative/clinical review. Problems with the handling of some aspects of the Center's subsequent investigation (e.g., see indicator 1 regarding proper investigatory practices for clinical referrals) did not allow for the analysis of evidence as required by this indicator.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: All investigations were completed within 10 days or had proper extensions; this was a return to 100% performance after some slippage at the last review (indicator 12). In some cases, supervisory review was thorough and some issues with investigations were identified. In three cases, however, some issues with some investigations were not noted in the supervisory review. Indicator 13 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (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.	75% 9/12	0/1	2/3	2/2	1/1	2/2	1/1	0/1	1/1	

Comments:

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

For Individual #108 UIR 18-039 and Individual #140 UIR 18-089, supervisory review did not detect or comment on the issues identified by the Monitoring Team. For Individual #268 UIR 18-086, the UIR did not explore (or describe) whether the medications he incorrectly received resulted in problems for another individual who did not receive those medications. Ultimately, this was examined by the nurse investigator and found to not be the case, however, the supervisory review did not note it.

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: Due to discontinuation of audits of serious injuries and inconsistent implementation of non-serious injury investigations, both indicator 14 and indicator 15 will

Individuals:

be returned to active monitoring.											
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, due to discontinuation of audits of serious injuries and inconsistent implementation of non-serious injury investigations, both indicators will be returned to active monitoring.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										

Comments:
14. Audits of serious injuries were discontinued after March 2017. The Center planned to start doing these again in the upcoming month after the onsite review.

15. Four individuals did not have any non-serious injuries that warranted a non-serious injury investigation. One of the other four had a non-serious injury investigation implemented correctly. For the other three, non-serious injuries occurred for which a non-serious injury investigation should have been, but was not, conducted.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: These indicators will remain in active monitoring. It was noteworthy that for many of the investigations, the IDT conducted a post investigation ISPA to review results and determine if any supports needed to be modified or added.			Individuals:								
#	Indicator	Overall Score	108	140	263	118	575	475	268	372	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	90% 9/10	N/A	2/2	1/2	1/1	2/2	1/1	1/1	1/1	

Comments:
17. There were three cases in which there was a confirmation of physical abuse category 2. In all three cases, the employment of the confirmed staff member was terminated.

18. For Individual #263 UIR 17-172, documentation was not available to show that all 10 of the recommendations in the UIR were implemented.

It was noteworthy that for many of the investigations, the IDT conducted a post investigation ISPA to review results and determine if any supports needed to be modified or added.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Tracking, trending, and analysis of data were not occurring, due in large part, to staffing changes in the incident management department, including a new incident management coordinator. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No										
20	Over the past two quarters, the facility's trend analyses contained the required content.	No										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										
Comments: 19-23. The Center reported that it had not completed a quarterly trend report since early 2017. This was due to a number of staffing changes in the incident management department, including a new incident management coordinator (IMC). In addition to a new IMC, there was one new campus investigator, two new campus administrators, and a new administrative assistant for the department. The IMC recently met with the data analyst to discuss how to complete a trend report and will work closely with them to complete one by the next monitoring onsite visit.												

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.										
Summary: These indicators will remain in active oversight.			Individuals:							
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470

a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. For Individual #72's TIVA on 11/15/17, in response to the Monitoring Team's request (i.e., #49), the Center did not provide evidence of medical clearance, informed consent, or post-operative vital signs.

b. For Individual #612's two instances of oral pre-treatment sedation, the Center did not submit evidence to show input from an interdisciplinary team. On a positive note, informed consent was present, nothing-by-mouth status was confirmed, an operative note documented the procedures and assessment, and nurses documented pre- and post-operative vital signs.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/4	N/A	N/A	0/2	N/A	N/A	0/2	N/A	N/A	N/A

Comments: a. The Monitoring Team reviewed two uses of pre-treatment sedation each for Individual #612 (i.e., 10/24/17, and 1/10/18), and Individual #552 (i.e., 8/2/17, and 8/10/17). For these instances of pre-treatment sedation, informed consent was provided, and nurses completed pre- and post-procedure vital signs. However, based on the documentation provided, the PCPs did not determine the medication and dosage with input from an interdisciplinary team.

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b)										

	determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	351	737	661						
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 the three deaths. Causes of death were											

listed as:

- On 10/19/17, Individual #351 died at the age of 51 of fungal endocarditis.
- On 12/8/17, Individual #737 died at the age of 60 of gastrointestinal bleeding due to gastric ulcer.
- On 12/18/17, Individual #661 died at the age of 63 of "complications of cerebral palsy."

b. through d. Although the death reviews identified a number of important recommendations, evidence was not submitted to show the Center conducted thorough reviews of nursing or medical care, or an analysis of medical/nursing reviews to determine a full set of additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. The following provide examples of concerns noted:

- For Individual #351, the death review information stated that in March 2017, the cardiologist and cardiothoracic surgeon agreed that he was not a candidate for surgery. This was not consistent with what the PCP documented, which was that the cardiologist stated he was in need of open heart surgery, and "The IDT including the family is in agreement that they do not wish to do the open-heart surgery. They would like to continue his antifungals for now and consider hospice care at a later time." This is an important distinction.

  Also, in the physician death summary, it was documented that: "after consultations with specialists including cardiology, infectious disease, and cardiothoracic surgery, it was determined that the intervention to stop the recurrent infection would require surgical removal of the vegetations on the mitral valve, which would involve cardiac surgery. Discussion among [Individual #351's] family members and the IDT determined that they did not want to subject [him] to the rigor of cardiac surgery." Based on ISPA documentation, the Medical Director conveyed her opinion to the team that Individual #351 should not have surgery. Although it was important for the IDT to weigh the risks and benefits of surgery, the death review should have objectively reviewed the facts of the case, and recognized that the surgeons indicated they could operate.
- According to the PCP death summary, in 2011, Individual #661 was diagnosed with central and obstructive sleep apnea. There was no treatment stated for this diagnosis, so it was unclear if he required CPAP. Also, sleep apnea might worsen with age, and it was unclear what, if any, follow-up occurred, and what the plan was to manage sleep apnea following sedation. This should have been addressed in the medical clearance for sedation. The clinical death review did not address the possibility of whether the individual was hypoxic due to sleep apnea and then had an overwhelming aspiration event sufficient to cause cardiac arrest on route to the hospital.
- For these three individuals, the Center provided the Quality Improvement Death Reviews of Nursing Services that included a much-improved summary in comparison with the last review of pertinent information from the electronic record addressing nursing assessments, acute care plans, the IHCP goals and risk ratings from the IRRF, the annual comprehensive nursing assessment, and quarterly nursing assessments, as well as a narrative of the 72 hours prior to death. Although this represented some good improvement in the review of nursing documentation, the review of the provision of nursing care was limited to 72 hours prior to the individual's death and did not reflect a comprehensive review of nursing services and documentation over a period of time. In addition, the report offered no analysis of how the problems with acute care plans, goals and interventions in the IHCPs, and risk ratings impacted the individuals' overall nursing care. On a positive note, the Conclusions section of the reports identify some significant issues that generated associated recommendations.

e. For a number of the death review recommendations, the Center did not submit documentation to show staff implemented them.

In addition, as discussed in previous reports, the recommendations were not consistently written to ensure that changes made resulted in changed outcomes. For example, one recommendation read: "Within 45 days of the Clinical Death Review, Nurse Educator should retrain facility Nurses on Acute Care Plan initiation and documentation using Nursing Guidelines for acute problems and follow through to resolution. The Plan should be reviewed every 7 days by Case Managers or Designee RN." Although the curriculum for the training was appropriate, the competency-based test did not include the development of an acute care plan to ensure nurses were competent in their development.

In the Monitoring Team's last report, dated 9/6/17, concerns were raised about individuals diagnosed with fungemia. Based on review of Individual #351's records for this review, he also had this diagnosis. It is unclear whether the Center addressed the concerns the Monitoring Team raised in its last report:

> "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."

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall	17	108	612	72	481	552	351	372	470

		Score									
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

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 the six months prior to the review, Richmond SSLC completed four DUEs, but they either were not clinically appropriate, or were incomplete. These indicators will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/4
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/4

Comments: a. and b. In the six months prior to the review, Richmond SSLC completed four DUEs, but they either were not clinically appropriate, or were incomplete. More specifically:

- On 8/3/17, a DUE on fenofibrate was presented to the Pharmacy and Therapeutics (P&T) Committee, and on 10/26/17, a follow-up DUE was completed. The stated goal of the DUE was to determine the overall effectiveness of fenofibrate for dyslipidemia. The determination of the effectiveness of a treatment/therapy is accomplished not through a DUE, but through various methodologies of clinical studies. Data related to this goal is available in a number of well-known clinical guidelines. Society guideline links are readily available through sources such as UpToDate.

  The out-of-date 2001 Adult Treatment Panel (ATP) III guidelines on lipid management were attached and used as the framework for the evaluation, and one of the primary "take home points" for this DUE was: "Ensure that we are following ATPIII guidelines." The Pharmacy and Therapeutics and Committee meeting minutes did not document that any member of the medical staff raised concern or disagreed with the recommendations based on use of the ATP III guidelines. Moreover, these same guidelines were frequently cited in the QDRR recommendations. The Medical Director reported that the American College of Cardiology/American Heart Association 2013 guidelines had been implemented. Therefore, all of the recommendations from the DUE were based on a set of obsolete clinical guidelines. The Medical Director should identify clearly which guidelines are being utilized for management of hyperlipidemia, and all relevant clinical staff should be trained on the requirements.
- On 10/26/17, a DUE on fish oil was presented to the P&T Committee. The objective of the DUE was to determine the

appropriateness of fish oil use for treatment of elevated triglycerides and to make sure that staff were following the guidelines. Again, the DUE referenced the out-of-date 2001 ATP III guidelines. It is reasonable to conduct a DUE to determine if the practitioners are complying with the Center's clinical pathways and guidelines. In this case, though, the compliance was determined using obsolete guidelines.

- On 1/25/18, a follow-up DUE on anticholinergics was presented to the P&T Committee. This was in follow-up to one done in March 2016. It appears that the goal was to determine the appropriateness of anticholinergic use at the Center. The conclusion did not provide any data related to the goal. It was not clear what medications were reviewed. The DUE stated that pro re nata (PRN, or "as needed) medications were excluded from the evaluation since the prescribers monitor them closely. There was no specific conclusion other than: "the use of anticholinergics continues to remain low and appropriate."
- On 1/25/18, a DUE on benzodiazepines was presented to the P&T Committee. This evaluation provided no specific objective or goal. The Pharmacy Department should have an ongoing process to monitor the use of benzodiazepines. This data should be reported on a regular basis.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 19 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, seven other indicators were moved to this category, in psychiatry, behavioral health, and OTPT.

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

The Monitoring Team attended two annual ISP meetings and one ISP preparation meeting last week, as well as some ISPA meetings, and a variety of other meetings during which individuals' services and supports were discussed. The Monitoring Team also visited with all individuals at their homes and in their day programs.

Assessments

For some, but not all, individuals, the IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. But then, IDTs did not consistently arrange for and obtain the needed, relevant assessments prior to the IDT meeting.

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

Since the last review, it was good to see improvement in the timely completion of annual medical assessments. However, ISPs/IHCPs still generally did not define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. In addition, based on documentation provided, PCPs often had not completed them since early 2017.

Since the last review, some improvements were noted with regard to the quality of annual medical assessments. The Center should focus on ensuring medical assessments include, as applicable, family history (i.e., medical history), and childhood illnesses.

Work also is needed with regard to the timely completion, as well as the quality of dental exams. It was good to see improved dental summaries.

Full nursing physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, reproductive assessments, and Braden scores). On a positive note, for about a third of the risk areas reviewed, nurses included status updates in annual assessments, including relevant clinical data. Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year. The Center should focus on ensuring 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.

When individuals were referred to the PNMT, the PNMT generally completed timely reviews. However, a number of individuals' IDTs did not make referrals when individuals met criteria for PNMT review or assessment, and the PNMT did not make self-referrals for these individuals. The Center also should focus on the completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments.

It was positive that most individuals reviewed received the type of OT/PT assessment needed (i.e., a comprehensive assessment or an update) in a timely manner. However, the quality of OT/PT assessments was poor, and requires focused efforts.

Most individuals reviewed received timely communication assessments. The quality of communication assessments was poor, though, and requires focused efforts.

In psychiatry, for new admissions the CPE was completed within the required time frame and there was an IPN from medicine at the time of admission. The Annual Psychiatric Treatment Plan Updates were all completed on schedule and forwarded to the ISP team with the required time frame.

In behavioral health, behavioral assessments and reports were timely and complete.

Assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs were current.

Individualized Support Plans

The number of personal goals that met criterion for individuality and meaningfulness increased slightly from nine to 12 since the last review. This, however, indicates that more work is needed to create these types of goals. Moreover, they need to be written in terms that allow for the goals to be measurable (i.e., the ability to determine if the goal has been met). Then, there need to be data that can reliably show the progress (or lack of progress).

IDTs needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal.

The Monitoring Team observed a positive practice exhibited by one of the QIDPs, in the San Antonio home C. In her monthly reviews, had begun the practice of summarizing the current status and any planned next steps for each of the goal areas. This included commentary on each of the action plans within that goal area. Also, each grid box included relevant comments regarding the specific action plan.

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.

Overall, individuals' ISPs did not describe their OT/PT and communication strengths and needs, and did not include plans to address their needs.

The psychiatry department was still in the early stages of developing psychiatric goals and the necessary monitoring of progress toward meeting those goals. The

Richmond SSLC PBSPs continued to be complete in content. Six 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. This was very good to see.

Richmond SSLC was again re-visiting the way SAPs were chosen, written, and managed. This was good to see and was needed. All of the individuals could have benefited from additional SAPs because they had various skill training needs.

More programming and opportunities for employment were needed. The apprenticeship program continued to languish.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: The number of personal goals that met criterion for individuality and meaningfulness increased slightly from nine to 12 since the last review. This, however, indicates that more work is needed to create these types of goals. Moreover, they need to be written in terms that allow for the goals to be measurable (i.e., the ability to determine if the goal has been met). Then, there need to be data that can reliably show the progress (or lack of progress). These indicators will	Individuals:

remain in active monitoring.											
#	Indicator	Overall Score	17	108	140	118	372	72			
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	2/6	4/6	1/6	0/6	1/6	4/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	1/6			

Comments: The Monitoring Team chose six individuals for monitoring of the ISP process at the facility: Individual #17, Individual #108, Individual #140, Individual #118, Individual #372 and Individual #72. 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.

The IDTs continued to work toward developing personal, measurable goals. For this review period, none of the six ISPs contained individualized goals in <u>all</u> areas; therefore, none had a comprehensive set of goals that met criterion.

1. During the last monitoring visit, the Monitoring Team found nine personal goals met criterion for being individualized, reflective of the individual's preferences and strengths and based on input from the individual on what is important to him or her. During the current site visit, 12 personal goals met criterion. Findings included:

- The personal goals that met criterion were the leisure goal for Individual #72; the relationship goals for Individual #108 and Individual #72; the work goal for Individual #108; independence goals for Individual #17, Individual #108 and Individual #72; and, living options goals for Individual #17, Individual #108, Individual #140, Individual #372 and Individual #72.
- Of the remaining personal goals, many were not aspirational.
- It was positive the IDTs had made attempts to develop personal goals that addressed individual preferences in some domains, such as leisure and living options.
- Overall, however, considerable work remained to be done in this area, especially for leisure, relationships and employment goals.

2. The Monitoring Team reviewed the 12 personal goals that met criterion for Indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 12 personal goals, one met criterion for measurability. This was the living options goal for Individual #72. For the others, the IDT typically stated personal goals in broad terms without projecting a timeframe for, or a clear path toward, achievement. In such instances, the Monitoring Team also reviewed the action plans to assess whether these provided that needed measurability. Findings included:

- The IDT developed a work goal for Individual #108, to work part-time in the community as a greeter at the local Walmart Super Center, and it demonstrated some progress toward projecting a path for achievement. The underlying action steps developed by the IDT included related communication needs, referral to supported employment, assessment for working as a greeter, and for acting as a greeter on-campus to be added to his daily schedule. It was positive the IDT addressed a range of needs, but it did not project how these steps would culminate in the outcome of employment or when that might occur. Without such a clear path and an assertive timeline, personal goals cannot be met in a timely manner or action plans evaluated for progress and needed revision. For Individual #108, most of these related action plans had not been implemented with the needed frequency, if at all, in the several months since his ISP. This should have alerted the IDT to consider whether the steps in the path to achievement needed to be reconsidered.
- The IDT formulated many action plans as service objectives (SOs) or simply as descriptions of actions staff needed to complete. While some of these action plans were straightforward and indicated a single step needed with a projected timeframe for completion, many others required ongoing and successive implementation. The IDTs rarely developed service objectives with specific implementation methodologies and required data collection that would support measurability. For example:
  - Individual #17 had eight action plans in the area of independence. Two of these addressed his personal goal to make a healthy meal or snack. One was an SO for preparing a smoothie. The IDT should have considered developing a skill acquisition plan (SAP) instead of an SO for making a smoothie to facilitate its implementation and focus on learning rather than participation. The other action plan, to make a meal for others in his home, did not have a corresponding SO or specific implementation methodology.
  - Individual #72 had five leisure action plans, but only one had a SAP with a specific methodology and none of the remaining four had an SO. He also did not have SOs for four relationships action plans, for six work action plans, and one implementation plan for six independence action steps.
  - Individual #17, Individual #108, Individual #140, and Individual #372 did not have specific, individualized, and measurable living options action plans.

3. For the one personal goal that met criterion in indicator 2, it had reliable and valid data and met criterion. This was the living options goal for Individual #72, for which the transition log provided ample documentation.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: Criteria were not met for any of these indicators for any of the individuals. The aspects of the ISP that are targeted by these indicators speak directly to the overall quality of the ISPs. The Center should consider some way to ensure that these aspects get addressed in the ISPs. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	17	108	140	118	372	72			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
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. For the most part, this group of individuals did not have personal goals that met criterion, as described under Outcome 1 above. IDTs needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal. For example:

- Individual #17 had two related personal goals, to participate in a musical choir/band (leisure) and to create a friendship with

his band members (relationships). Neither set of action plans provided a measurable path to achieve these outcomes. The only related action plan for the leisure goal indicated a referral would be sent to music therapy to complete an assessment; the only related action plan for the relationships goal indicated he would have to participate in the musical choir/band before a relationships action plan could be implemented.

- IDTs often did not construct SOs with methodologies or data collection instructions related to their underlying purpose. For example, Individual #372 had an SO for choosing her leisure/recreation activity, but the methodology did not require staff to document anything about choice-making. She also had an SO to exchange money for items, which was intended to support a personal goal to shop and make purchases, but the data collection methodology only documented participation and did not provide a baseline or measurable objective from which to assess learning about purchasing.

9. None of six ISPs contained a set of action plans that clearly integrated preferences and opportunities for choice in an assertive manner. IDTs demonstrated some increased proficiency in developing action plans that integrated preferences, but offered few opportunities for choice making. Findings included:

- The IDT for Individual #17 did not develop action plans and related instructions that integrated opportunities to make choices.
- Individual #108 wanted to learn to read braille. He had one action plan that indicated he would learn to use a braille phone, but the SAP did not integrate braille equipment.
- Individual #140 had a replacement behavior for making choices, but it had been discontinued because she no longer verbalized; instead the IDT determined it should be continued informally. The IDT should have at least considered development of an SO.

10. None of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. The Monitoring Team found that the IDTs rarely developed such action plans.

11. None of six ISPs met criterion for supporting overall independence. Examples included:

- Individual #17 and Individual #140 had no skill acquisition in place at time of document request.
- Individual #108 had two SAPs that promoted independence, including the use of a color teller that addressed his vision needs, and use of CD player. These were positive. But even so, the IDT had not written his SAP for telephone use to integrate the use of adaptive braille equipment to promote independence as intended.

12. The IDTs did not assertively address risk areas in a consistent manner. Examples included:

- The Monitoring Team was extremely concerned for Individual #140 in this regard. She had experienced significant decompensation in her health, weight, mobility, and functional status and the IDT had not taken assertive action in an integrated and comprehensive manner. The IDT had not developed a plan for collecting the types of comprehensive data needed to determine and address the root causes.
    - The IDT needs to undertake a more thorough and data-based assessment of the root causes of this decompensation and use those findings to develop an appropriate set of action plans. This was further discussed with the IDT during a phone meeting in the weeks following the onsite review.
- For Individual #108, the IDT failed to take into account his dietary texture needs when developing behavioral strategies. On 11/29/17, the IDT met, reviewed his recent Modified Barium Swallow (MBS) results and determined he should receive a

pureed diet and pudding thick liquid consistencies. On 12/12/17, the IDT met to determine what edible reinforcer he would like and listed the following: pop-tarts, vanilla ice cream, M&Ms, and Captain Crunch berries. The IDT did not document any discussion of whether these reinforcers were consistent with the pureed diet. On 1/8/18, Individual #108 was hospitalized for emesis and admitted for aspiration pneumonia, ileus, and possible sepsis. On 1/12/18, an ISPA documented the IDT would look into and determine non-edible reinforcers to use for Individual #108 and that the pop tarts would be discontinued.

- The IDTs for Individual #72 and Individual #17 did not assertively address repeated and ongoing falls with root cause analyses. Neither had a comprehensive falls assessment.
- It was positive the IDT and PNMT had completed a comprehensive assessment of Individual #372's falls and many related risks, but they had not assertively addressed her skin integrity needs. The two pressure wounds had been identified in the past year, but the Integrated Health Care Plan (IHCP) for skin integrity did not require DSP to monitor.
- The IDT for Individual #118 had had not considered a need to address a change of status related to his behavioral health risk, which was still rated as medium despite multiple episodes of violence toward staff, peers, and LIDDA personnel.

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 indicator 12 above, other examples included:

- For Individual #108, the IDT had not assertively addressed his vision needs. He had recently become blind (in last one to two years) and was having a difficult time coping with losing his ability to see. On 10/27/17, an ISPA documented he was seen by the optometrist shortly after admission. The findings indicated his vision loss in the left eye was irreversible, but that a cataract was the cause for his vision loss the right eye. The ISPA further indicated he would be referred to an ophthalmologist for consult to correct the cataract. The IDT, however, had not acted to obtain this consult. On 3/15/18, the IDT met with the family, who requested an update on the status of this issue, but none of the IDT members had any such knowledge.
- Individual #17 had an old recliner and various skin integrity issues. This was not addressed.
- The IDTs did not assertively address changing communication needs. As described in indicator 9 above, Individual #140 had a replacement behavior for making choices, but it had been discontinued because she no longer verbalized; instead the IDT determined it should be continued informally. The IDT should have, at least, considered development of an SO, but should also have considered the need to re-assess her communication needs.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration. Examples included:

- Individual #108 liked going out to eat, going to church and getting his hair cut in the community. The IDT developed a single action plan for one community outing per month. Documentation indicated he had not had any such outings since the ISP.
- Given that Individual #372 was increasingly reluctant to be involved in outings due to her declining health, her IDT struggled to develop appropriate strategies in this area. She did like to go out to eat with her LAR, though, and continued to ask to call him to inquire when they might be able to go. At the ISP, the IDT discussed providing transportation to increase these opportunities, but did not develop an action plan to do so.
- Individual #72's previous ISP, which ended in December 2017, was included in this review to allow for evaluation of progress. It included a goal for participating in the local community Arc, but had not been implemented. Per the QIDP monthly review, this was because the Arc social group did not schedule many trips and most were similar to those he could attend for free with

Richmond SSLC. This failed to support community participation and integration. Per his current PSI, Individual #72 would like to join a community organization or club to make friends, but the IDT did not develop any related action plans in the current ISP.

15. None of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Examples of those that did not meet criterion included:

- The IDT developed work goals for both Individual #17 and Individual #108 without completing a thorough vocational assessment that included vocational exploration and a preference assessment.
- At Individual #118's 2017 ISP, he had indicated significant reservations and anxieties about the proposed goal to work at a community game store, which was a continuation of an unimplemented goal from the previous year. The documentation since the most recent ISP reflected that the action plan had still not been implemented. Per the ISP narrative, he was to be assessed by the Texas Workforce Commission, but the IDT did not develop a specific action plan and there was no evidence of implementation.
- Due to Individual #372's illness and hospice care, the PCP had ordered she could attend her retirement program depending on how she was feeling. The IDT developed an action plan to encourage her attendance at the Forever Young program, but did not develop a corresponding methodology. The behavioral health assessment (BHA) indicated staff should provide her with reinforcement when she chose to leave the home to do other activities. If she refused to leave the home, the BHA recommended giving her a break and checking back with her after 10 to 15 minutes. The IDT did not develop a SO or other plan for this and the PBSP did not address this specific need.
- The apprenticeship program was not operating, and no individuals were working off campus

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs.

Overall, the ISPs provided limited opportunities for learning and functional engagement.

- The IDTs did not place significant focus on skill acquisition. Neither Individual #17 nor Individual #140 had any ongoing SAPs
- IDTs did not ensure action plans were implemented frequently enough to result in functional engagement to meet personal goals and needs. This lack of implementation was pervasive for these six ISPs. For example, Individual #108 had many action plans that were not being implemented, including bowling, assessments for music therapy, use of a weighted ball and special shoes for bowling, a sensory program, aquatic therapy, supported employment, employment, use of a braille telephone, living options plans, and community outings.

17. The IDT did not consistently address barriers to achieving goals. For example:

- IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in indicator 26.
- IDTs did not consistently address barriers to lack of implementation of the ISP. For example, Individual #118's IDT had continued most of his goals and action plans from the previous year without addressing the barriers that had resulted in a lack of implementation. Over the course of the nine months since his ISP, the action plans remained largely unimplemented.
- For Individual #108, the ISP narrative indicated his prior history of drug and alcohol use could be a barrier to community

living. The speech/language pathologist (SLP) suggested Individual #108 might need to see a substance abuse counselor in this regard. This was a thoughtful recommendation, but the IDT did not address it with a specific action plan. Instead, the IDT developed an action plan for counseling to address coping skills in relation to his altered functional status.

18. ISPs did not consistently 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. In addition, as described under indicator 2, IDTs relied on SOs or other staff actions for the bulk of ISP implementation, but rarely developed SOs with specific implementation methodologies and required data collection. For example:

- Individual #17 had no formal implementation methodologies for his leisure or relationships goals and one for work. In that latter area, he had an SO for shredding or answering the phone, but none for staying on task or working off the home.
- Individual #118 had no formal implementation methodologies for his action plans for recreation, relationships, living options, or work.
- Individual #372 had one SAP and three SOs for 18 action plans. The remaining action plans had no specific implementation instructions or methodologies. At least 12 of these required ongoing implementation and supported personal goals, such as those described under indicator 8 above.

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

Summary: There was noticeable improvement in description of individuals' preferences (indicator 19), the overall decision of the IDT (indicator 22), and defining a list of obstacles to referral (indicator 24). The other indicators showed low scores. Much more improvement is needed in conducting a thorough living options discussion and in developing and acting upon a plan to address those obstacles. All indicators in this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 17	108	140	118	372	72			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	67% 4/6	0/1	1/1	0/1	1/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	1/1	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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	options.	0/6									
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	1/1	1/1	0/1	1/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A			
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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Four of six ISPs (Individual #108, Individual #118, Individual #372, Individual #72) included a description of the individual's preference for where to live and how that was determined. Findings for those whose ISPs did not meet criterion included:

- Individual #17 said he wanted to live at Richmond SSLC, but this was not consistent with his PSI, which stated he disliked living there. The IDT did not document any discussion regarding this discrepancy.
- Individual #140's ISP indicated she wanted to live closer to her family, but offered no discussion about how the IDT determined this preference.

20, 25, and 27. None of the six individuals had an annual ISP meeting during this onsite visit and no other ISP meetings were observed, so the Monitoring Team did not score these indicators.

21. One of six ISPs (for Individual #108) fully included the opinions and recommendation of the IDT's staff members. Findings included:

- Assessments typically provided a statement of the opinion and recommendation of the respective team member. This was positive. The only noted exception was the SLP assessment for Individual #372.
- ISPs did not yet consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For Individual #17, Individual #140, Individual #118 and Individual #372, the IRIS format did not consistently specify the opinions of all disciplines.

22. This indicator met criterion. Six of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. The ISPs did not reflect a robust discussion of available settings that might meet individuals' needs. Examples included:

- For Individual #108, who was newly admitted, most IDT members deferred an opinion and did not document a thorough discussion. It was positive, though, that the SLP stated Individual #108 had many barriers preventing successful community living and that the IDT needed to get to the bottom of what was preventing his success as well as identify supports that might help him have a successful transition. Upon admission, it is important for the IDT to have discussion of living options, barriers, and how IDT will assertively address them to facilitate a timely return to community living. The Monitoring Team commends the SLP for this approach and would encourage the IDT to take a similar stance.
- For Individual #372, the IDT did not document discussion of possible living options available to her at present and their potential advantages; neither did the IDT document discussion of her LAR's perceived barriers and how they might be addressed. The LAR did not attend the ISP, so the IDT should not have felt discomforted about having that discussion and documenting it in ISP.

24. Four of six ISPs (Individual #17, Individual #108, Individual #118, Individual #72) met criterion and identified a thorough and comprehensive list of obstacles to referral in a manner that would allow for the development of relevant and measurable goals to address the obstacle. For Individual #140 and Individual #372, the IDT did not identify the lack of individual awareness, but should have.

26. None of four individuals (Individual #17, Individual #108, Individual #140, Individual #372) who were not referred had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. The IDTs for Individual #118 and Individual #72 recommended referral. The IDT for Individual #72 did not identify barriers to transition; his ISP was the one that met criterion. For Individual #118, transition logs continued to document barriers that had not been addressed, including targeting other individuals with physical aggression to get what he wanted and wanting to be able to stay at the home all day by himself rather than work or attend a day program. The transition log and CLDP indicated the IDT did not assertively address these barriers to transition. The IDT held a CLDP and was preparing to move forward with the transition, but Individual #118 became disruptive and physically aggressive at the meeting. The LAR then rescinded the referral.

28. None of six ISPs had individualized and measurable plans for education.

29. Four of six individuals had obstacles identified at the time of the ISP. Two individuals, Individual #118 and Individual #72, had already been referred at the time of their ISPs. Individual #118's referral was since rescinded after the ISP due to behavioral concerns.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.	
Summary: It was good to see that each individual attended and participated in his or her own ISP meeting. This has been a steady increase over the past three reviews. For each individual, however, one or more important members of the IDT did not attend the ISP meeting. Further, ISPs were not implemented for all action	Individuals:

plans in a timely manner. These indicators will remain in active monitoring, though with sustained high performance, indicator 33 might be moved to the category of requiring less oversight after the next review.											
#	Indicator	Overall Score	17	108	140	118	372	72			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

32. ISPs were not implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

33. Six of six individuals participated in their ISP meetings.

34. None of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. The following examples impacted this finding:

- For Individual #17, neither psychiatric staff nor the PCP attended, but should have based on his needs. He received psychotropic medications and had medical concerns regarding his shunt and pressure wounds.
- For Individual #108, OT/PT staff did not participate, but should have. He had significant sensory and adaptive needs related to his vision loss.
- For Individual #372, who had metastatic cancer and was on hospice care, neither the PCP nor a hospice representative attended, but should have.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Full sets of assessments were not determined or obtained for the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	17	108	140	118	372	72			
35	The IDT considered what assessments the individual needed and	17%	0/1	0/1	0/1	0/1	1/1	0/1			

	would be relevant to the development of an individualized ISP prior to the annual meeting.	1/6									
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 one of six individuals (Individual #372). Individual #108 was a new admission, but the Center did provide an ISP Preparation document. It did not include recommended assessments, however.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. None of six ISPs met criterion. Examples of those that did not included:

- For Individual #17 and Individual #118, the vocational and functional skills assessments (FSA) were not submitted on a timely basis.
- The IDT for Individual #108 did not obtain, as needed, an orientation and mobility assessment by a credentialed therapist or a comprehensive dysphagia assessment.
- Individual #372 did not have a FSA.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: IDTs did not revise the ISPs as needed. This competed with the ability of the QIDPs to ensure that individuals received required monitoring/review and revision of treatments, services, and supports. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	17	108	140	118	372	72			
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.

37-38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. This reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports.

- On a positive note, the QIDP for Individual #72 had begun a practice of summarizing current status and any planned next steps

for each action plan in the ISP, rather than just copying and pasting observation notes and progress notes. This included her review of the IHCP action plans. While her process could still use some refinement in places, it was encouraging to see a QIDP monthly that represented synthesis and analysis.

- Otherwise, QIDP monthly reviews provided minimal analysis regarding progress or outstanding needs. The QIDP monthly reviews for Individual #118 were particularly problematic, frequently consisting of the same data repeated month after month.
- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. In some cases, these unimplemented plans had been continued from one ISP year to the next without identifying and addressing the barriers that prevented implementation.

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

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

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
a.	The individual's risk rating is accurate.	17% 3/18	0/2	0/2	2/2	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	1/2	0/2	1/2	1/2	2/2	1/2	2/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #17 – osteoporosis, and skin integrity; Individual #108 – other: "breath support," and other: visual impairment; Individual #612 – falls, and infections; Individual #72 – falls, and constipation/bowel obstruction; Individual #481 – choking, and dental; Individual #552 – infections, and cardiac disease; Individual #351 – falls, and constipation/bowel obstruction; Individual #372 – skin integrity, and fractures; and Individual #470 – GI problems, and urinary tract infections (UTIs)].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #612 – falls, and infections; and Individual #552 –cardiac disease.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission, and, most of the time, updated the IRRFs at least annually. The exception was for Individual #72 in relation to falls. Falls were not included as a risk in his IRRF, despite at least 22 falls that occurred since the last ISP meeting.

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 #17 – osteoporosis; Individual #612 – falls; Individual #72 – constipation/bowel obstruction; Individual #481 – choking, and dental; Individual #552 – cardiac disease; and Individual #351 – falls, and constipation/bowel obstruction.

Psychiatry

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

Summary: It was good to see that Corpus Christi SSLC continued to move forward in creating psychiatry-related goals as per the various criteria in this set of indicators. The goals, however, need improvement so that they can be measurable and objectively monitored (i.e., the psychiatric indicators/symptoms need to be clearly specified and described/defined) and that they are derived from the psychiatric diagnosis. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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

The Richmond SSLC psychiatry department continued to make progress in developing psychiatry-related goals for individuals. This outcome contains four indicators that each get at an important aspect of the goals. Each will be discussed in turn below.

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

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms and goals/objectives related to the increase of positive/desirable behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4. The Monitoring Team looks at the set of goals for each individual. Goals must include the focus of the goal (i.e., psychiatric indicators), address the reduction of symptoms and the increase of prosocial behaviors, and include criterion.

In order to determine the facility's progress toward developing goals, the individual's ISP, annual CPE update, and the psychiatric quarterlies were all examined for the appearance of goals that met these criteria as well as the consistency of the goals in all of these documents.

For Individual #15, Individual #17, Individual #108, Individual #263, and Individual #118 it was not possible to locate any documentation in the ISPs, CPE updates, or quarterlies that met any of these criteria for this indicator and, therefore, for indicators 5, 6, and 7.

For the other four individuals,

- Some, but not all individuals had one or more goals for reduction of symptoms and one or more goals for prosocial behaviors.
- The goals that did exist were not written in terms that were measurable and observable.
- Goals need to have the desired number of occurrences (e.g., two or less episodes per month, 80% of opportunities per month), a length of time (e.g., six consecutive months), and a desired end time (e.g., by December 31, 2018).
- Goals need to, but did not, appear in the IHCP section of the ISP.

Specifically regarding each of the other four individuals,

- Individual #613's record mentioned physical aggression and property destruction as behaviors to decrease, and taking baths as a behavior to increase. These were operationally defined, but the linkage to the underlying psychiatric diagnosis was not specified and they were not consistently discussed in psychiatric quarterlies.
- The ISP for Individual #575 identified reports of auditory hallucinations and self-injury as behaviors to decrease, and seeking attention in a positive manner as a behavior to increase, but no outcome goal was identified and the format was not consistently carried over to the CPE update or the psychiatric quarterlies.
- For Individual #567, the reduction of aggression was identified as a behavior to decrease in the ISP, CPE update, and the quarterlies, but was not formulated as a goal with criterion for progress.

- During the onsite review, the psychiatric team identified Individual #140 as the individual for whom they had made the most progress in developing goals. The newest CPE update was requested as it was dated 2/26/18 and, thus, was not in the records prepared prior to the review. This lists as a psychiatric goal "remain psychiatrically stable for 12 months with no inpatient psychiatric hospitalizations." This could be considered a positive goal, but is not sufficient by itself. The 4/10/17 ISP identified agitation as a goal to decrease and it was operationally defined. There was also mention of catatonic episodes, but these were not described in a precise measurable manner as the descriptor included dark circles under the eyes. There was also a lack of consistency in the description of the goals in the psychiatric quarterlies.

5. Goals must be measurable. That is, the psychiatric indicators in each goal must be observable and measurable. They must be designed so that their reliability can be determined.

- Many goals included some detail in the definition (operationalization) of the psychiatric indicator as noted above in indicator 4. In order for the goal to be measurable, the definition (operationalization) needs to more clearly describe exactly what it is that the person recording information needs to see. This is typically direct support professional staff, but sometimes might be behavioral health services staff or psychiatry staff (e.g., for rating scales). Those recorders need to know how to determine if a psychiatric indicator (symptom) is or is not occurring and if it should or should not be counted.
- As noted above, within the comments for indicator 4, there were inherent problems in the construction of the goals and they were not consistently reported throughout the relevant documentation, so they could not be accurately measured.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis. Goals need to be related to the individual's assessment and diagnosis or diagnoses. The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis.

- The psychiatric indicators did not contain the necessary linkage to the symptoms of the underlying psychiatric diagnosis that would be necessary to substantiate that they were derived from the psychiatric diagnosis established in the assessments.

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

- There was no indication or report in the documentation as to whether the data on psychiatric indicators were reliable for the psychiatric indicators.
- Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.	
Summary: CPEs were formatted correctly for all individuals for this review (with one exception, a 2010 CPE) and for the previous two reviews, too. Similarly, Richmond SSLC showed 100% performance on the admission-related psychiatry actions described in indicator 15 for this and the previous two reviews. Therefore,	Individuals:

these two indicators (13 and 15) will be moved to the category of requiring less oversight. With sustained high performance, CPE content indicator 14 might be moved to this category after the next review. Indicator 16 regarding consistency in diagnostic information in the record showed improvement. These two indicators (14 and 16) will remain in active monitoring.

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	89% 8/9%	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9%	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	1/1	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1

Comments:

13. All of these were formatted as specified, with the exception of Individual #613, whose 2010 CPE did not contain the necessary components.

14. Her CPE was, thus, missing significant information including important historical sections, the physical exam, and labs. The biopsychosocial formulation was also deficient.

15. Four individuals (Individual #15, Individual #108, Individual #263, Individual #118) were admitted within the past two years. 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 all of the individuals, except Individual #263 and Individual #118. The psychiatric diagnoses were consistent in the psychiatric and behavioral sections of the record for all of the individuals, the discrepancies for these two were in the Annual Medical Assessment.

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

Summary: Documentation for the ISP remained about the same as the last review, that is, for some individuals it was complete, but for others it was not. Documentation for the ISP, however, was submitted on time for all individuals, a nice improvement since the last review. The final ISP document was not complete for psychiatry and psychiatry staff did not attend the ISPs for most individuals (and there wasn't thorough documentation showing the rationale for why not). These indicators will remain in active monitoring. Note, however, that all four indicators were met for one individual (Individual #140).

#	Indicator	Overall Score	Individuals: 15	613	17	108	140	263	118	575	567
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	50% 3/6	N/A	1/1	1/1	N/A	1/1	N/A	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	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.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:

18. The information was adequate in all of these, except those of Individual #118, Individual #575, and Individual #567. A consistent deficit for these individuals was the identification of the symptoms of the diagnosis. For example, for Individual #118, the symptoms for his three diagnoses of Bipolar disorder, ADHD, and IED were not specifically identified. For Individual #567, the symptoms for the diagnosis of bipolar disorder in addition to autism spectrum disorder were not identified. The primary deficit in the documentation for Individual #575 was the lack of a combined behavioral health assessment.

19. The information was submitted to the ISP team at least 10 days prior to the ISP for all of the individuals. This was a nice improvement from previous reviews.

20. The attendance sheets for the ISPs indicated that the psychiatrist attended two of the nine ISPs (Individual #108, Individual #140). The psychiatric assistant attended the ISP meeting for Individual #263, but the requirement is that a licensed member of the psychiatric team must attend.

21. Information in the IRRF was deficient for all of the individuals, except Individual #140. For the other individuals, the behavioral health section of the IRRF contained a discussion of the behavioral aspects of their treatment, but relatively little on the factors related

to their psychiatric treatment.

The documentation in the ISP of Individual #140 was significantly more detailed and contained a thorough discussion of the required issues. The difference between the documentation for Individual #140 and the other individuals prompted a comparison between the ISP documentation contained in the electronic documentation submitted prior to the onsite review and the original hard copies to see if there could have been an error in the reproduction of the electronic copies. This reconciliation indicated that there were no discrepancies. The behavioral health section was completely absent from the IRRF for Individual #17 and this omission was also independently confirmed during the onsite review. Although these observations were problematic, it should be noted that during the prior review none of the individuals were found to have adequate documentation in their ISP and, thus, the information identified in the ISP for Individual #140 represented some progress.

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

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Signed consents were present and contained the required information. Indicators 28 and 32 scored 100% for the third consecutive review and, therefore, both will be moved to the category of requiring less oversight. With sustained high performance, the same might also occur for indicator 30 after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

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.

30. The consents included a separate risk benefit discussion for each individual.

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 again maintained good performance on these important foundational aspects of providing behavioral health services. All goals met criterion for measurability for this review and the last two reviews, too. Therefore, indicator 3 will be moved to the category of requiring less oversight. The behavioral health services department also continued to work towards having data that were reliable for all individuals and demonstrated this for two-thirds of the individuals (slightly less than at the last review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:
1. While onsite, the Monitoring Team attended the annual ISP for Individual #241. During the meeting, his long history of engaging in rumination was discussed as well as possible medical and physical side effects that might be occurring because of this (e.g., low weight). The Monitoring Team spoke with the behavioral health services director about possible additional focus on this problem.

3. All individuals with a PBSP had measurable objectives related to behavioral health services that were based on assessment results

5. Six 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 #567 and Individual #17 did not have an IOA assessment in the last six months, and Individual #108 did not have evidence of IOA or DCT assessments. The establishment of reliable PBSP data should be a priority for the behavioral health department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.												
Summary:			Individuals:									
#	Indicator	Overall Score										
10	The individual has a current, and complete annual behavioral health update.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
11	The functional assessment is current (within the past 12 months).											
12	The functional assessment is complete.											
	Comments:											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Richmond SSLC PBSPs continued to be complete in content. This was the case for all individuals for this review and for the previous two reviews, too (with one exception in each of these two previous reviews). Therefore, indicator 15 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	Comments: 15. The Monitoring Team reviews 11 components in the evaluation of an effective behavior support plan. All eight of the PBSPs were										

current and complete. Individual #108 was admitted in October 2017 and had an initial PBSP, but no FSA and, therefore, was not included in indicator 15.

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: Since the last review, it was good to see improvement in the timely completion of annual medical assessments. ISPs/IHCPs generally did not define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. In addition, based on documentation provided, PCPs often had not completed them since early 2017. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. For many individuals reviewed, the most recent interim medical reviews were completed from between January 2017 and April 2017. Two individuals had no interim medical reviews submitted. In addition, 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 generally 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: Since the last review, some improvements were noted with regard to the quality of annual medical assessments. The Center should focus on ensuring medical assessments include, as applicable, family history (i.e., medical history), and childhood illnesses. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	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. It was positive that two individuals' AMAs (i.e., Individual #552, and Individual #372) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Most, but not all included social/smoking histories, and plans of care for each active medical problem, when appropriate. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history (i.e., medical history), and childhood illnesses.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #17 – skin integrity, and other: cervical stenosis with myelopathy; Individual #108 – other: blindness, and seizures; Individual #612 – cardiac disease, and other: rheumatoid arthritis; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – gastrointestinal (GI) problems, and diabetes; Individual #552 – infections, and osteoporosis; Individual #351 – infections, and respiratory compromise; Individual #372 – other: hypothyroidism, and other: anemia; and Individual #470 – GI problems, and other: hypertension].

As noted above, the ISPs/IHCPs reviewed generally did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines, and for many individuals, PCPs had not completed them since early 2017.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	17% 3/18	0/2	0/2	0/2	0/2	2/2	1/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	6% 1/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	1/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #17 – skin integrity, and other: cervical stenosis with myelopathy; Individual #108 – other: blindness, and seizures; Individual #612 – cardiac disease, and other: rheumatoid arthritis; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – GI problems, and diabetes; Individual #552 – infections, and osteoporosis; Individual #351 – infections, and respiratory compromise; Individual #372 – other: hypothyroidism, and other: anemia; and Individual #470 – GI problems, and other: hypertension]. The IHCPs that sufficiently addressed the individuals' chronic or at-risk conditions in accordance with applicable medical guidelines or other standards of care were those for Individual #481 – GI problems, and diabetes; and Individual #552 – osteoporosis. b. As noted above, the ISPs/IHCPs reviewed generally did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The exception was the IHCP for Individual #470 for other: hypertension.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: For the individual who was newly admitted, no annual summary was submitted. If the Center does not correct this issue, at the time of the next review, this indicator might move back to active monitoring. Work also is needed with regard to the timely completion, as well as the quality of dental exams. It was good to see improved dental summaries. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall	17	108	612	72	481	552	351	372	470

		Score									
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. However, due to problems noted during this review, this indicator is at risk of returning to active oversight.									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	38% 3/8	1/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	44% 4/9	1/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a. For the one newly-admitted individual, a dental exam was completed, but a dental summary was not submitted. This indicator has been in less oversight, but if the Center does not correct this issue, at the time of the next review, this indicator might move back to active monitoring.

b. It was positive that for Individual #17, Individual #72, Individual #481, and Individual #372, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Sedation use; and
- An odontogram;

Most, but not all included:

- Information regarding last x-ray(s) and type of x-ray, including the date.
- Specific treatment provided; and
- A treatment plan.

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

- A summary of the number of teeth present/missing; and

- Periodontal charting.

c. On a positive note, eight of the nine dental summaries reviewed included the required components. No dental summary was submitted for Individual #108.

Nursing

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

Summary: Full physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, reproductive assessments, and Braden scores). On a positive note, for about a third of the risk areas reviewed, nurses included status updates in annual assessments, including relevant clinical data. Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year. The Center should focus on ensuring 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. All of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	11% 1/9	0/1	1/1	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	0% 0/11	0/1	0/2	0/1	0/2	N/A	0/2	N/A	0/2	0/1

	nursing protocols or current standards of practice.										

Comments: a. Full physical assessments were not documented for a number of individuals. For eight of the individuals, problems were noted with regard to the completion of thorough physical assessments, including weight graphs, fall assessments, Braden scores, and/or assessments of reproductive systems.

Of note, the annual nursing assessments and quarterly nursing assessments that the Center provided from IView for different individuals differed in content and length. It is unclear whether or not the Center provided the full assessments for all individuals reviewed.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #17 – osteoporosis, and skin integrity; Individual #108 – other: "breath support," and other: visual impairment; Individual #612 – falls, and infections; Individual #72 – falls, and constipation/bowel obstruction; Individual #481 – choking, and dental; Individual #552 – infections, and cardiac disease; Individual #351 – falls, and constipation/bowel obstruction; Individual #372 – skin integrity, and fractures; and Individual #470 – GI problems, and UTIs).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for about a third of the risk areas reviewed, nurses included status updates, including relevant clinical data (i.e., Individual #612 – falls, and infections; Individual #481 – dental; Individual #552 – infections, Individual #372 – skin integrity, and fractures; and Individual #470 – GI problems). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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:

- A PCP IPN, dated 10/14/17, indicated that the day before during bathing, direct support professional staff discovered open abscesses on Individual #17's right hip and left elbow. For 10/13/17, no nursing IPNs were submitted noting these open areas to the skin. As a result, nursing staff had not documented assessing the sites when direct support professional staff identified them.
- Individual #108's IHCP included a goal to say "welcome to Walmart" 20 times in five minutes with adequate respiration. The underlying issue for which the IDT had developed this goal was unclear, so the Monitoring Team could not determine whether or not he experienced a change of status.
- For Individual #612, an IPN, dated 9/26/17, noted drainage and redness to her umbilical area. The nursing assessment did not include an assessment of other areas of her skin to determine whether or not she had additional skin issues. The nurse did not document the temperature of the individual's skin, vital signs, or if the site had an odor.
- On 1/19/18, Individual #72 fell. The nurse's IPN regarding the fall did not include an assessment of the individual's vital signs, gait, dizziness, mobility, or skin. This individual is able to self-report symptoms.
- On 1/18/18, an IPN indicated that Individual #72 had not had a bowel movement recorded for the past 72 hours. The nurse did not document a physical assessment of the individual's bowel sounds, or abdomen prior to completing a rectal exam,

which found no impaction.

- For Individual #552, an IPN, dated 1/26/18, noted: "several lesions to her upper lip and face." The nurse provided no specific descriptions of these lesions, especially since the individual had gone to the Emergency Department the previous day for a UTI and herpes labialis.
- For Individual #552, nursing staff did not implement and/or document assessments to regularly check for symptoms of deep vein thrombosis (DVT) (i.e., swelling, warm skin, pain, redness, problems breathing, rapid pulse, chest pain, coughing up blood).
- An IPN, dated 11/27/17, indicated Individual #372 had a Stage 2 ulcer on her sacral area. However, the nurse did not document an assessment or describe the ulcer. IPNs from the previous day indicated that she had a Stage 1 pressure ulcer, which clearly had progressed to a Stage 2 ulcer.
- An IPN, dated 11/19/17, noted swelling and bruising to Individual #372's right upper thigh. The nursing assessment did not include whether or not the individual's leg was kept immobile, since the note indicated she had a possible fracture/ dislocation. The nurse did not report the temperature of the skin or describe additional skin assessments to identify other potential injuries.
- A PCP IPN, dated 1/6/18, noted the PCP saw Individual #470 for an evaluation of emesis. No nursing IPNs were found addressing nurses' assessment of this issue.

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

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
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. Much work was needed to improve the nursing components of integrated health care plans.											

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: When individuals were referred to the PNMT, the PNMT generally completed timely reviews. However, a number of individuals' IDTs did not make referrals when individuals met criteria for PNMT review or assessment, and the PNMT did not make self-referrals for these individuals. The Center also should focus on the completion of PNMT comprehensive assessments for individuals needing them, and the quality of the PNMT reviews and comprehensive assessments. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 4/8	0/1	0/1	0/1	0/1	1/1	N/A	1/1	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 4/8	0/1	0/1	0/1	0/1	1/1		1/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	29% 2/7	0/1	0/1	N/A	0/1	1/1		0/1	1/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	25% 2/8	0/1	0/1	0/1	0/1	1/1		0/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	20% 1/5	N/A	0/1	N/A	N/A	0/1		1/1	0/1	0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings;	0% 0/4	N/A	0/1	0/1	N/A	0/1		0/1	N/A	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% 0/7	0/1	0/1	N/A	0/1	0/1		0/1	0/1	0/1

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

- Individual #17 met criterion for referral to the PNMT in that he had two or more Stage 2 decubitus in 12 months, but the IDT did not refer him, and the PNMT did not make a self-referral. More specifically, on 10/17/17, he had Stage 3 ulcers on his left hip and left elbow. On 11/8/17, the PNMT recorded a discussion related to his skin wounds, but did not appear to actually refer or formally review the individual. The PNMT asked to attend an IDT meeting and review their plan. According to meeting minutes, on 11/15/17, this was done. The PNMT indicated that because the Stage 3 ulcer was not considered a non-healing or recurrent wound, no referral to the PNMT was made. However, the Stage 3 ulcers should have resulted in a referral, and he had two ulcers on different locations of his body. In addition, on 2/3/18, Individual #17 also had a Stage 2 ulcer to his right elbow. The PNMT should have conducted a comprehensive assessment.
- For Individual #108, a PNMT review, dated 10/11/17, stated that the presenting problem was the "PNMT review," and did not specify the issue that required the review. The PNMT did not state why he had been hospitalized or discuss the individual's risk areas, but rather deferred to the IDT, since he was newly admitted. Based on their review, they should have highlighted justifications for not conducting an assessment. Subsequently, in January 2018, no evidence was found to show the IDT referred Individual #108 to the PNMT, or the PNMT made a self-referral to address the occurrence of aspiration pneumonia. According to an ISPA, on 1/8/18, the MD confirmed this diagnosis (with bowel obstruction). This diagnosis should have resulted in a comprehensive assessment, but did not.
- Individual #612 should have been referred to the PNMT for unplanned weight loss. In April 2017, she weighed 99 pounds, and dropped to 88.40 in that month. In May 2017, she rebounded to 93 pounds. Overall, though, from April 2017 to October 2017, she experienced a 10% weight loss, going from 99 pounds in April to 88.60 in October. No evidence was found to show that the PNMT conducted a review or an assessment.
- Within the six months between 8/30/17 and 3/7/18, Individual #72 had at least 22 falls. Although he technically did not meet criteria for referral until February 2018, the PNMT should have at least completed a review earlier. According to an ISPA, dated 1/4/18, the IDT reported that he had not had any falls since 10/20/17, and that the fall issue was improved. Yet, documentation the Center submitted to the Monitoring Team identified at least seven falls between 10/20/17 and 1/4/18. In addition, a PT evaluation, dated 12/5/17, revealed that he had lost a great deal of lower body strength, dragged his feet, and it took 30 minutes for him to walk 100 feet. The IDT appeared to continue to attribute his falls to behavioral issues, without evidence to support this theory, and the IDT did not appear to take action to identify the cause of his change in status. For example, the IDT did not conduct an analysis to identify the etiology of the falls (e.g., review of falls, comparison with behavioral data, review of video, etc.).
- On 6/9/17, Individual #481 was diagnosed with aspiration pneumonia. On 6/12/17, his IDT referred him to the PNMT, and on 6/14/17, the PNMT initiated an assessment. On 7/10/17, the PNMT completed the assessment. Based on the documentation

submitted, there was limited evidence of the PNMT's action and monitoring, but on 9/25/17, they discharged Individual #481. On 10/22/17, he had a reoccurrence of aspiration pneumonia.

On 11/8/17, the PNMT completed its review. The review stated that the presenting problem was "PNMT review," while the medical history section suggested this review was related to aspiration pneumonia. The PNMT did not document discussion of Individual #481's risk areas and levels, but rather directed the reader to the IDT's risk ratings. The review only identified immediate history pertaining to this event, and provided very minimal discussion of the individual's current health and physical status and its impact on PNM supports. The PNMT offered no analysis of findings, and no recommendations, but identified that the issue was related to lying flat for a lap-coli procedure. Given that the individual might need further testing or hospitalizations, the PNMT should have offered recommendations for ways to reduce his risk of recurring aspiration pneumonia.

- According to meeting minutes, dated 7/19/17, on 7/14/17, Individual #351 went to hospital for a clogged jejunostomy tube (J-tube), and he returned to the Center with a gastrostomy (G-tube). The PNMT did not assess him at that time, but should have. On 7/24/17, after a hospitalization for aspiration pneumonia from 7/20/17 to 7/21/17, his IDT referred him to the PNMT. On 7/26/17, the PNMT review stated that they believed his pneumonia was secondary to improper positioning during his hospitalization for J-tube placement, and that his supports were adequate so a comprehensive assessment was not indicated. Subsequently between 10/4/17 and 10/9/17, he had another aspiration pneumonia event. On 10/10/17, the IDT referred him, and the PNMT initiated an assessment. He died before they completed it.

  In Individual #351's PNMT review, the presenting problem was listed as "PNMT review." The medical history was extremely limited, with no reference to his previous history and the frequency of aspiration pneumonia. The PNMT documented no risk discussion, but rather referred the reader to the IDT's risk ratings. The PNMT did not provide a thorough discussion of supports provided and/or the impact of his illness on his status or changes as a result. Based on a very limited analysis, the PNMT concluded that the aspiration pneumonia occurred at the hospital, and no changes were needed. The PNMT did not offer any recommendations, even about how to prevent this from happening again during future hospitalizations.
- On 11/19/17, Individual #372 fractured her right femoral head. On 11/25/17, after she was discharged from the hospital, the PNMT made a self-referral. On 11/27/17, the PNMT initiated an assessment, and on 12/29/17, completed the assessment.
- On 12/14/17, Individual #470 was referred to the PNMT for a pneumonia and emesis event that occurred from 12/6/17 to 12/13/17. On 12/19/17, the PNMT initiated the review, and on 12/22/17, completed it. The PNMT RN assessment stated that in the morning medical meeting on 12/14/17, this event was identified as aspiration pneumonia. The PNMT provided no rationale for not doing comprehensive assessment. However, PNMT meeting minutes stated that after their review, they could not determine the cause of pneumonia. Without an assessment, it was unlikely that they could have determined the cause.

e. The following provide examples of concerns noted:

- For Individual #108, the PNMT RN reviewed his hospitalizations on 10/5/17, and 1/12/18, but made no recommendations for action.
- The PNMT RN reported that Individual #481's last pneumonia was in June 2016, but it had been in 2017.
- For Individual #372, the PNMT RN assessment indicated that she would not be referred to PNMT. Based on the documentation reviewed, no evidence was found that the PNMT reviewed and discussed this assessment. The PNMT conducted a full

assessment, and the discrepancy was not explained.

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

h. As noted above, five individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #17, Individual #108, Individual #72, Individual #351, and Individual #470). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- For Individual #481, his PNMT assessment did not establish measurable goals, or measurable criteria for discharge, but rather stated that at the end of two months, the PNMT would hold a discharge meeting with the IDT. The PNMT provided no rationale for the two-month timeframe. The SLP was only expected to monitor for improper implementation of the Dining Plan twice in the two-month timeframe, but the Physical and Nutritional Management Plan Coordinators (PNMPCs) were going to monitor twice a week. The PNMT recommended pica sweeps, but it was not clear how that was connected to the individual's pneumonia. The PNMT had not drilled down far enough to determine the root cause (i.e., they identified potential risk due to poor implementation of the oral intake plan, and an upper respiratory infection that weakened him/aggravated existing dysphagia), and/or use data to support the conclusions. For example, it was not clear if the PNMT reviewed all relevant lab work. The assessment did not report on respiratory status, vital signs, residuals, baselines, thresholds, etc. The discussion of medical and health history, and medications and their impact on respiratory health status was weak.
- Individual #372's PNMT assessment only presented her current medical history, and not her past history related to falls, fractures, or complications, such as skin integrity. The PNMT did not document discussion of her risk levels or the need to change them. The PNMT's discussion about behavior did not address if her behavior increased her risk for falls and fractures. Except for her wheelchair, the assessment did not include information to clarify if supports were effective. The PNMT assessment did not outline the equipment she used, but rather said to refer to her PNMP. Recommendations related to bathing made in the body of the assessment were not carried down to the recommendation section, so likely would be missed. The PNMT stated that the etiology/root cause was the fall that resulted in the fracture. The PNMT did not discuss the etiology of the falls in greater detail. In other words, if the fracture was a secondary complication to the falls, then why she is falling? Based on documentation provided, Individual #372 had at least 19 falls from January 2017 through November 2017, at the time of the fracture. On 12/7/17, she fell again, so clearly, even revised supports were not effective, but the PNMT did not address the need for further inquiry or changes.

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. Over the last three reviews, the numbers/percentages of quality PNMPs has declined (i.e., Round 11 – 56%, Round 12- 33%, and Round 13 – 0%). Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470

a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to 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.	6% 1/18	1/2	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: skin integrity, and falls for Individual #17; falls, and aspiration for Individual #108; falls, and weight for Individual #612; choking, and falls for Individual #72; falls, and aspiration for Individual #481; choking, and falls for Individual #552; falls, and aspiration for Individual #351; aspiration, and fractures for Individual #372; and falls, and aspiration for Individual #470.

a. and b., and d. through f. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. The IHCPs also did not identify the action steps necessary to meet the goal/objective, identify the necessary clinical indicators, or define individualized triggers, and actions to take when they occur, if applicable.

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

- Although most PNMPs/Dining Plans had been updated, Individual #351 (i.e., last update was in May 2017, with a draft update, dated 8/28/17, that was never finalized before he died on 10/19/17) and Individual #470 (i.e., aspiration pneumonia and emesis without clear review and updating of the PNMP) had experienced significant changes of status, and it was not clear that the IDTs had updated their PNMPs to address these changes.
- Issues related to risk level and triggers included: inaccurate or missing risk ratings given the individual's current status, and/or no triggers identified when some existed.
- For most of the PNMPs reviewed, issues were noted with regard to the photographs, including, for example, the individual in poor positions in the pictures, photographs that were too small to allow staff to see necessary details, and equipment the

individual needed not shown in pictures (e.g., elbow pads).
- For some individuals, instructions for the following were incomplete or missing: bathing, toileting including personal care, handling precautions, oral care, and/or communication.

Some positives included (except for Individual #351's PNMP, which did not meet his needs based on his significant change of status), PNMPs addressed as applicable:
- Assistive/adaptive equipment;
- Transfers;
- Mobility;
- Mealtime; and
- Medication Administration.

g. Often, the IHCPs reviewed did not include reference to PNMP monitoring or define the frequency. The exception was the IHCP for Individual #17 for falls. Of note, though, the monthly monitoring was not listed as an intervention, but rather under "Reason."

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	17	108	612	72	481	552	351	372	470
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.	25% 1/4	N/A	1/1	N/A	N/A	0/1	N/A	0/1	N/A	0/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/4		0/1			0/1		0/1		0/1

Comments: a. and b. On 9/15/17, Individual #108 had a G-tube placed secondary to repeated aspiration pneumonia prior to his admission to Richmond SSLC. The pneumonias were thought to be related to his family providing an inappropriate diet texture. On 10/5/17, he was admitted. On 10/7/17, he had an aspiration event during feeding. On 10/24/17, the IDT stated that he was a new admission, and had an aspiration event right after admission. This provided justification that tube feeding was the safest for him at that time. They did not yet know if/when he had an MBSS and needed to follow up on that as well.

On 10/9/17, Individual #108's IDT held an ISPA meeting to discuss his desire to return to oral intake, but the only plan discussed was to wait for the doctor to make a recommendation. On 10/26/17, the IDT's meeting documentation indicated that he had an MBSS

scheduled, but then the appointment was cancelled and he was upset. The IDT did not specify a target date to reschedule the test. On 11/3/17, an evaluation for oral intake concluded that his oral cavity and structures appeared within functional limits for oral intake. This assessment recommended an MBSS. On 11/8/17, he had an MBSS with recommendations for therapeutic feedings with pudding consistency and advancement at the discretion of the SLP. The related ISPA also stated that the SLP who participated in the MBSS indicated that he could start on regular food cut into bite size pieces. It did not appear that the IDT clearly outlined a plan, and the inconsistencies noted in this ISPA were of concern. At some point (i.e., the actual date was not clear), he returned to oral intake, although he still had the G-tube. According to an ISPA on 1/8/18, the PCP said Individual #108 had aspiration pneumonia and ordered nothing by mouth (NPO). On 1/19/18, an ISPA indicated that he did not need another MBSS, but was tolerating oral feedings and was on a pureed diet with pudding-thick liquids. The IDT was to find non-edible reinforcers and discontinue using pop tarts. At the time of the Monitoring Team's review, the PNMT had not conducted an assessment, and clearly, the IDT had not developed a plan to ensure that he safely received nutrition through the least restrictive method.

For the remaining three individuals, their IDTs had not provided clear justification for continued enteral nutrition, and a number of inconsistencies were noted with regard to individuals' status with pleasure feedings, and/or the need for evaluations for therapeutic feeding.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.

Summary: Given that for the last two reviews and during this review, individuals reviewed generally had the type of assessment (i.e., comprehensive, update, and/or consult) they needed (Round 11 – 100%, Round 12 – 89%, and Round 13 - 89%), Indicator b will move to the category requiring less oversight. During this review, it also was positive that assessments were generally completed timely. The quality of OT/PT assessments was poor, though, and requires focused efforts. The remaining indicators will continue in active monitoring.

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or	86%	0/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1

	when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	6/7									
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	0/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. and b. It was positive that most individuals reviewed received the type of assessment needed (i.e., a comprehensive assessment or an update) in a timely manner. The following concerns were noted:

- Based on the OT's signature, Individual #17's assessment was completed after the ISP meeting (i.e., on 6/1/17, for an ISP on 5/30/17).
- The Center did not submit the most recent comprehensive assessment for Individual #552. As a result, it was unclear whether or not an update met her needs.
- Although the Center submitted an ISP document for Individual #351, dated 9/13/17, the cover sheet read: "Individual past [sic] prior to his ISP meeting." Individual #351 died on 10/19/17. Due to the fact that it appears the IDT never completed a 2017 ISP for this individual, the timeliness of the assessment is scored as "N/A."

d. 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: Most of the assessments listed diagnoses and identified health issues in the last year, but provided limited to no discussion of their relevance to individuals' OT/PT functional performance or support needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services: Most individuals' preferences were not reflected in recommendations to enhance the development of skills;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: The only assessment that met this criterion was for Individual #612. For the remaining individuals, problems varied. For example, some listed risks, but did not identify their implication for PNM supports and services; some did not include a risk discussion; and some did not appear complete;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For approximately half of the individuals, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: For a number of individuals, assessments included inconsistencies with regard to individuals' functional status, and, therefore, did not provide a clear picture of the individuals' strengths as well as needs for supports. In other instances, descriptions of functional status were incomplete. The only assessments that met this criterion were those for Individual #612, and Individual #481;
- 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): Many of the assessments reviewed did not address fit and/or condition of one or more pieces of assistive/adaptive equipment. The only assessments that met this criterion were for Individual #351, and Individual #470;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: This was not applicable to Individual #108 who was newly admitted. None of the applicable assessments provided a thorough comparative analysis to offer the reader a clear picture of changes over the last year(s);
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the applicable assessments met 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; 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. In addition, without thorough assessments, it was unclear that assessors had identified a complete list of individuals' needs and related OT/PT supports.

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: Overall, individuals' ISPs did not describe their OT/PT strengths and needs, and did not include plans to address their needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	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% 2/16	0/7	0/3	0/1	N/A	1/1	0/1	N/A	1/2	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	25% 1/4	0/1	0/1	N/A	N/A	N/A	N/A	N/A	1/2	N/A

Comments: b. Simply including a stock statement such as "Team reviewed and approved PNMP" did not provide evidence of what the IDT reviewed, revised, and/or approved.

c. and d. Examples of concerns noted included:

- For Individual #17, the IDT did not hold an ISPA meeting to discuss and approve the initiation of direct therapy goals/objectives recommended in the consultation, dated 6/30/17, which were different from those recommended in the annual assessment, dated 6/1/17. Similarly, the IDT did not hold an ISPA meeting to discuss and approve the recommendations for direct therapy from a consultation, dated 2/13/18.
- Based on review of the ISP and ISPAs, the IDT did not discuss or approve Individual #108's OT/PT goals/objectives and program.
- For Individual #372, the IDT held an ISPA meeting to discuss and approve her OT goals/objectives, but not her PT goal/objective.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Most individuals reviewed received timely communication assessments. The quality of communication assessments was poor, though, and requires focused efforts. These indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/R	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A		N/A	N/A	N/A	N/A	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.	83% 5/6	0/1	N/A	1/1		1/1	1/1	N/A	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	63% 5/8	0/1	1/1	1/1		1/1	0/1	1/1	0/1	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% 0/1	N/A	N/A	N/A		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% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: Individual #72 had functional communication skills and was part of the outcome group, so these indicators were not reviewed for him.

a. and b. The following provides information about problems noted:

- The Center did not submit the most recent comprehensive assessment for Individual #17. As a result, it was unclear whether or not an update met his needs.
- Although Individual #552's assessment was entitled a comprehensive assessment, in the first paragraph, the SLP stated it was an update.
- Although the Center submitted an ISP document for Individual #351, dated 9/13/17, the cover sheet read: "Individual past [sic] prior to his ISP meeting." Individual #351 died on 10/19/17. Due to the fact that it appears the IDT never completed a 2017 ISP for this individual, the timeliness of the assessment is scored as "N/A."
- For Individual #372, the SLP conducted a screening. The underlying comprehensive assessment did not meet standards. Therefore, it was not clear that a screening was appropriate to meet her needs.

c. Individual #372's communication screening did not include discussion of pertinent diagnoses or medications.

d. Overall, the assessments did not meet individuals' needs. The following describe some of the concerns with the assessments reviewed:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Most assessments provided limited discussion of individuals' medical and health history, and/or often did not describe the potential impact on communication. The only assessment that met this criterion was for Individual #108;
- The individual's preferences and strengths are used in the development of communication supports and services: Most SLPs listed the individuals' preferences and strengths, but did not incorporate them into recommendations for supports and services. The exceptions were for Individual #612 and Individual #470;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Many assessments reviewed did not list the medications prescribed to the individual, but merely concluded that none impacted communication. Other assessments listed medications and side effects, but did not discuss them specific to the individual. The two assessments that met this criterion were for Individual #108 and Individual #470;
- 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: None of the assessments reviewed met this criterion. From the perspective of an IDT, the grid used was not helpful, because it did not include functional examples;

- A comparative analysis of current communication function with previous assessments: This was not applicable to the individual that was newly admitted. None of the other assessments reviewed met this criterion. Comparisons were non-existent, incomplete, and/or appeared to be inaccurate based on other information;
- The effectiveness of current supports, including monitoring findings: This was not applicable to two individuals. For the remaining 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;
- 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: For the individuals for whom this was applicable, none of the assessments met the criterion. Problems varied from no assessment of AAC/EC to conclusions drawn without sufficient data (e.g., data from direct therapy goals/objectives) to inconsistencies in information included in other parts of the assessments;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence to show compliance with this sub-indicator was present for Individual #108. It was not applicable for two individuals. For the remaining individuals, sufficient information was not provided to show that communication issues did not impact behavioral issues; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that thorough assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	14% 1/7	0/1	0/1	0/1	N/R	1/1	0/1	N/A	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/4	N/A	N/A	0/1		0/1	0/1	N/A	N/A	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/6	N/A	0/1	0/2		0/1	0/1	N/A	N/A	0/1
d.	When a new communication service or support is initiated outside of	N/A									

	an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.										

Comments: a. Lacking in most individuals' ISPs was a functional description of their communication, and/or strategies that others should use to communicate with them.

b. Either the ISPs provided no evidence of the IDTs' review of the individuals' Communication Dictionary, or it was unclear specifically what the IDTs reviewed, because the ISPs included no summary of the IDTs' discussion.

c. Individual #612's IDT did not incorporate the recommended goals/objectives for direct and indirect communication therapy into her ISP. Similarly, Individual #481, Individual #552, and Individual #470's IDTs had not included recommended goals/objectives in their ISPs, or justified not including them.

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: Richmond SSLC was again re-visiting the way SAPs were chosen, written, and managed. This was good to see and was needed. Four of the individuals had no SAPs at the time of this review due to revisions going on at the Center. Three of the other individuals had less than three SAPs. All of the individuals could have benefited from additional SAPs because they had various skill training needs. SAPs, when written however, were measurable and based on assessments. They were not, for the most part practical, functional, or meaningful; and did not have reliable data. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 15	613	17	108	140	263	118	575	567
1	The individual has skill acquisition plans.	56% 5/9	0/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
2	The SAPs are measurable.	82% 9/11	None	1/1	None	3/3	None	2/2	None	0/2	3/3
3	The individual's SAPs were based on assessment results.	91% 10/11	None	1/1	None	3/3	None	2/2	None	1/2	3/3
4	SAPs are practical, functional, and meaningful.	55% 6/11	None	0/1	None	2/3	None	1/2	None	1/2	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	36% 4/11	None	0/1	None	0/3	None	0/2	None	2/2	2/3

Comments:
1. Individual #15, Individual #17, Individual #140, and Individual #118 did not have skill acquisition plans (SAPs). These individuals' previous SAPs were achieved or discontinued due to lack of progress, and the IDT was in the process of assessment and development of new SAPs. The Monitoring Team is supportive of Richmond SSLC's attempt to reevaluate all individuals' SAPs and make data-based decisions to continue, discontinue, or modify current SAPs. In the future, however, the expectation is that all individuals will have SAPs.

The Monitoring Team chooses three current SAPs for each individual for review. There were no SAPs to review for Individual #15, Individual #17, Individual #140, and Individual #118, two SAPs to review for Individual #263 and Individual #575, and one SAP available to review for Individual #613, for a total of 11 SAPs for this review.

2. Eighty-two percent of the 11 SAPs were judged to be measurable (e.g., Individual #567's turn on the shedder SAP). Individual #575's take a spelling test and review the pool rules SAPs were not operationally defined and therefore, were not measurable.

3. A clear improvement from the last review was that over 90% of the 11 SAPs were based on assessment results. The exception was Individual #575's take a spelling test SAP. Her FSA indicated that she could already read and write simple words.

4. The SAPs that were judged not to be practical or functional typically represented a compliance issue rather than a new skill (e.g., Individual #613's wash her clothes SAP), or SAPs that were not clearly related to the individual's ISP vision statement (e.g., Individual #263's name her medications).

5. Individual #575's take a spelling test and review the pool rules SAPs, and Individual #567's turn on the shedder and turn on the radio SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. Individual #263's SAPs did have documentation of recent integrity assessments, however, IOA was scored as 0 and, therefore, her data were scored as not reliable. When integrity checks are completed, if the staff scores below the minimum level, the staff should be retrained and the integrity measure redone. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). 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: The three assessments were current and with sustained high performance, this indicator (10) might be moved to the category of requiring less oversight after the next review. The assessments, however, were not made available to the IDT in a timely manner for more than half of the individuals, and the assessments did not include recommendations for skill acquisition. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
10	The individual has a current FSA, PSI, and vocational assessment.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
11. Individual #140, Individual #108, Individual #575 and Individual #567 had documentation that FSAs, PSIs, and vocational assessments were available to the IDT at least 10 days prior to the ISP.

12. Individual #613's assessments included 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, 29 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, six other indicators were added to this category, in psychiatry, behavioral health, and dental. One indicator in OTPT did not maintain performance and will be returned to active monitoring.

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

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 with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Psychiatric quarterly reviews were completed on schedule and most contained required content. Clinics observed by the Monitoring Team also contained more of the criteria's components than at any previous review

Peer review activities were a regularly occurring part of the behavioral health services department. Graphs for some of the individuals, however, did not contain the types of relevant information that they had in the past.

Acute Illnesses/Occurrences

When an individual was deteriorating or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented.

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

As noted in the last report, numerous problems continued to exist 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.

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.

Although additional work is necessary, it was positive that for over half of the individuals' chronic or at-risk conditions that the Monitoring Team reviewed, 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. However, overall, IHCPs did not include a full set of action steps to address individuals' medical needs.

It was positive that for the non-Facility consultations reviewed, the PCP reviewed consultations and indicated agreement or disagreement, did so in a timely manner, and for the most part, ordered agreed-upon recommendations. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate.

Good improvement was noted with regard to medical practitioners reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

The current Quarterly Drug Regimen Reviews (QDRRs) often contained unnecessary and sometimes clinically incorrect information. The format/content should be revised to provide prescribers with a concise review of individuals' drug regimens. Improvement is still needed with regard to the lab sections of the QDRRs. Since the last review, improvement was noted with regard to prescribers reviewing QDRRs timely.

Based on the Monitoring Team's observations of assistive/adaptive equipment to assess proper fit, the Center regressed with regard to the working condition of assistive/adaptive equipment. The related indicator will return to active oversight. In addition, proper fit was sometimes still an issue.

Based on observations, there were still numerous instances (53% of 49 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

The integration between psychiatric services and behavioral health services was extensive. There was also good collaboration between psychiatry and neurology. Consents for the psychotropic medications were current and the language in the consents was individualized.

The polypharmacy review meetings were scheduled to make sure that every individual who is prescribed psychotropic medication gets reviewed at least once each year. The monitoring requirement is that those individuals for whom medication adjustments are being made should be reviewed at least quarterly. Thus the schedule should be adjusted to ensure that these individuals are reviewed more frequently.

Behavioral health treatment objectives need to be modified when they are achieved, and actions when individuals are not progressing as expected need to be taken.

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: Scoring was about the same as during the last review. Some aspects of the requirements for frequent use of restraint were not discussed by the IDT. The indicators in the category of less oversight will remain so, and the other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	263							
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, these indicators were 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.										
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.										
21	The minutes from the individual's ISPA meeting reflected:	50%	1/1	0/1							

	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.	1/2									
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?	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	50% 1/2	0/1	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).	100% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, these indicators were 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.										
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.	50% 1/2	0/1	1/1							

Comments:

21. Individual #15's IDT suggested that the presence of male staff was a setting event for Individual #15's restraints. The IDT suggested that if Individual #15 is targeting specific male staff, that those staff leave the area. Individual #263's ISPA did not have documentation of a discussion of potential setting events.

23. Individual #263's ISPA indicated that her IDT concluded that consequences did not affect her restraints. The potential role of consequences on Individual #15's restraints was not documented in his ISPA.

29. There was no documentation that Individual #15's IDT reviewed his PBSP.

Psychiatry

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

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: As noted for outcome 2, progress was occurring in the development of psychiatry-related goals. Once more complete, progress can be determined and indicators 8 and 9 can be scored. Even so, when an individual was deteriorating or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A
Comments: 8-9. Without measurable goals and objectives that met criteria for indicators 4-7, progress could not be determined. Thus, the first two indicators are scored at 0%. 10. However, it was clear from the documentation in the interim psychiatric clinics and IPNs related to psychiatric consultations that											

the psychiatrists intervened in-between the psychiatric quarterlies 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 the individuals, except those of Individual #17 and Individual #567 (because these two individuals did not require interim clinics or psychiatric interventions).

11. The interventions that were recommended were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary:			Individuals:								
#	Indicator	Overall Score									
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
24	The psychiatrist participated in the development of the PBSP.										
Comments:											

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: This indicator regarding psychiatry and neurology notes met criteria for all individuals for this review and the two previous reviews, with one exception in September 2016. Therefore, indicator 27 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A
Comments: 27. The neurology notes listed the individual's psychotropic medications. The neurology consultations were also attended by the psychiatrist. The psychiatrist prepared an IPN after the clinic and each quarterly psychiatric review summarized the neurology consultations.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.												
Summary: Quarterly reviews were completed on schedule and most contained required content. Clinics observed by the Monitoring Team also contained more of the criteria's components than at any previous review. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	75% 3/4	1/1	0/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A

Comments:

33. The quarterly reviews were completed every three months for all of the individuals.

34. The documentation related to the psychiatric quarterlies was adequate for all of the individuals, with the exception of Individual #118 and Individual #567. The deficits were both related to the identification of the symptoms of the psychiatric diagnosis, and information on the non-pharmacological treatment interventions recommended by the psychiatrist.

The current documentation format did not contain discrete sections for this content, but it can usually be found in different sections of the note. Going forward, the psychiatry department reported that it was going to use an outline that will ensure that these important topics are consistently discussed.

The current quarterly review notes contained a format that ensured that the laboratory data were clearly presented. In addition, there was a brief review of each medical intervention since the prior review.

35. The psychiatric clinics for Individual #15, Individual #613, Individual #17, and Individual #118 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. A DSP accompanied the individual to the meeting and also participated. However, a member of the DSP staff was not present for Individual #613's meeting because she did not attend 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: Performance improved to a score higher than at any previous review, though more attention was still needed to timely completion and prescriber review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall	15	613	17	108	140	263	118	575	567

		Score									
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	67% 6/9	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1

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 requires 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 six of the nine individuals. Those individuals for whom there were deficits were Individual #613, Individual #108, and Individual #118. The MOSES was completed as required for all of the individuals as required. The only deficit for Individual #613 was a delay in the review of the 7/17/17 AIMS evaluation. For Individual #108, there were delays in both the administration and review of the AIMS as well as the review of the MOSES. The deficits for Individual #118 involved both the administration and review of the AIMS.

It should be noted that at the time of the prior review, deficits in the administration of these side effect monitoring instruments were found for all of the individuals. Thus, the findings of this review indicated considerable progress even though some problems still persisted.

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: All indicators met criteria for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
40	Daily medications indicate dosages not so excessive as to suggest goal	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	of sedation.	9/9									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 40. The dosages of the prescribed medications were not so excessive as to 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 a PBSP. 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: Polypharmacy was managed and reviewed as per this outcome and its indicators. More frequent review, however, was required for some individuals based upon changes occurring in their medication regimens. These indicators will remain in active monitoring, however, with sustained high performance, indicators 44 and 45 might be moved to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6	1/1	N/A	N/A	1/1	1/1	N/A	1/1	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	N/A	1/1	1/1	N/A	1/1	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 3/6	0/1	N/A	N/A	1/1	0/1	N/A	1/1	0/1	1/1
Comments:											

44. There were six individuals whose psychotropic medications met the criteria for polypharmacy (Individual #15, Individual #108, Individual #140, Individual #118, Individual #575, Individual #567). 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 three of the individuals. For the other three, the last polypharmacy review date was Individual #15 9/29/17, Individual #140 5/30/17, and Individual #575 6/28/17. These individuals had all experienced medication changes that would have required quarterly reviews by the committee.

The psychiatry department currently scheduled the reviews by the Polypharmacy Committee, so that every individual who met the polypharmacy criteria would be reviewed at least annually. They will need to adjust their protocol, so that those who are having more frequent medication changes are reviewed quarterly.

The monthly polypharmacy meeting that occurred on 3/14/18 was observed. The reviews were thorough. The nurse case manger and behavioral health services staff who directly worked with the individual attended the meeting and were an integral part of the discussion.

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: Performance remained about the same as at the last review. That is, for some but not all individuals, PBSP objectives were updated; and for some but not all individuals, actions were taken when they were not progressing. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 15	613	17	108	140	263	118	575	567
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	50% 2/4	N/A	N/A	0/1	1/1	N/A	N/A	1/1	N/A	0/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	50% 3/6	1/1	1/1	0/1	N/A	0/1	0/1	N/A	1/1	N/A
9	Activity and/or revisions to treatment were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

6. Individual #118 was scored as making progress toward his target behavior objectives. Individual #108 and Individual #567's PBSP data indicated progress, however, because their data were not demonstrated as reliable (indicator 5), they were scored as 0. The remaining individuals were judged to not be making progress.

7. Individual #118 and Individual #108 achieved PBSP objectives and new objectives were established. Individual #567 achieved his SIB objective in November 2017, however, no new objectives (or rationale why the objective would be maintained) was presented. Similarly, Individual #17 achieved his SIB objective in December 2017, however, no new objectives were established.

8. Individual #613, Individual #15, and Individual #575 were not making progress, however, their progress notes included actions to address the absence of progress. Individual #17, Individual #140, and Individual #263 were also not making progress with some target behaviors, 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: Richmond SSLC maintained high performance, with all but one of the individuals meeting criterion (the other individual was scored just below criterion). Given this high level of performance, and given 100% scoring for the last two reviews, indicator 16 will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.										

Comments:
16. Eight of the nine individuals had documentation that at least 80% direct support professionals (DSPs) working in their residence were trained on their PBSPs. The one exception was Individual #118's PBSP, which was documented to have 75% of the staff trained.

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

Summary: Peer review activities were a regularly occurring part of the behavioral health services department for this review and the past two reviews, too. Therefore, indicator 23 will be moved to the category of requiring less oversight. On the other hand, graphs for some of the individuals did not contain the types of relevant information that they had in the past. This is indicator 20 and the Center should ensure that graphs contain sufficient relevant information in order for this indicator to remain in the category of requiring less oversight after the next review.

Individuals:

Details are provided in the comments below for indicator 20.											
#	Indicator	Overall Score									
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The graphs are useful for making data based treatment decisions.										
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.										
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 graphed PBSP data. Individual #17 and Individual #108's graphs were scored as zero for this indicator, because they did not include the occurrence of important environmental changes (e.g., medication changes, PBSP modifications, etc.).

23. Individual #490 was reviewed in the peer review meeting during the onsite review. He was reviewed because he was a recent admission, and was engaging in dangerous behaviors. His peer review included a review of his history, current interventions in his initial PBSP, hypothesized functions of his target behaviors, and potential intervention modifications. There was participation and discussion by the majority of the behavioral health services team. 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: Indicator 28 met criteria for all individuals for this review and for the last two reviews, too. Therefore, indicator 28 will be moved to the category of requiring less oversight. For two individuals, however, goals were not established as they had been in the past. This is indicator 29, which will remain in the category of less oversight, but this needs to occur for all individuals in order this indicator to remain in this category. Criteria regarding these goals were met for about half of the individuals, about the same as at the last review. Indicator 30 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567

26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.											
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	44% 4/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1	

Comments:
29. Individualized frequency and minimal levels of treatment integrity, IOA, and DCT were not established for Individual #118 and Individual #108.

30. Established frequencies of IOA were not achieved for Individual #613, Individual #17, or Individual #567. Additionally, there was no IOA, DCT, or treatment integrity measures for Individual #108. Individual #118 had IOA, DCT, and treatment integrity assessments in the last quarter that exceeded 80%, however, he did not have established goal frequencies and levels and, therefore, was scored as a zero on this indicator. Ensuring the data are reliable and PBSPs are implemented as written should be a priority for behavioral health services.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(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%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/18									
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 #17 – skin integrity, and other: cervical stenosis with myelopathy; Individual #108 – other: blindness, and seizures; Individual #612 – cardiac disease, and other: rheumatoid arthritis; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – GI problems, and diabetes; Individual #552 – infections, and osteoporosis; Individual #351 – infections, and respiratory compromise; Individual #372 – other: hypothyroidism, and other: anemia; and Individual #470 – GI problems, and other: hypertension).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #72 – constipation/bowel obstruction.

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

Outcome 4 – Individuals receive preventative care.

Summary: Four of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence generally was present to show that the prescribing medical practitioners addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. This was a significant improvement over previous reviews.

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
	ii. Colorectal cancer screening	100% 6/6	N/A	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Breast cancer screening	75%	N/A	1/1	1/1	N/A	N/A	0/1	N/A	1/1	N/A

		3/4									
	iv. Vision screen	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	75% 6/8	1/1	N/A	0/1	1/1	0/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: a. The following problems were noted:

- For Individual #17, the AMA documented the PPSV23 was given 12/3/01, while the official record stated this was an error. State policy is that all individuals receive the PPSV 23. In its comments on the draft report, the State attempted to clarify this issue, but the document the State referenced did not provide information to anwer the Monitoring Team's concerns.
- On 10/5/17, Individual #108 had an initial visual assessment. The recommendation was for him to have further assessment of vision, including an evaluation for cataract surgery, but no documentation of such an assessment was found in the records submitted.
- For Individual #612, auditory brainstem response and otoacoustic emissions testing were recommended, but the records submitted did not include documentation that they occurred. In addition, in January 2017, she was diagnosed with osteoporosis of the hip, but she was prescribed no treatment other than calcium and Vitamin D.
- For Individual #481, on 9/20/17, a DEXA scan showed osteoporosis of the left hip. No FRAX score was calculated and no treatment was provided other than Vitamin D. In addition, the official immunization record indicated that PPSV23 needed clarification. Similar to Individual #17, the State attempted to clarify his vaccination status in its comments, but the information did not address the Monitoring Team's concerns.
- For Individual #552, her last mammogram occurred on 10/24/16. According to her AMA, completed in September, a repeat would be done around 10/24/17, but documentation of this was not found.

b. In addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence generally was present to show that the prescribing medical practitioners addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. This was a significant improvement over previous reviews. The exception was Individual #72 for whom the section on polypharmacy in the AMA was blank, but the individual had psychotropic polypharmacy.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1	N/A
Comments: a. For the two individuals reviewed with DNRs, clinical justification consistent with the State Office guidelines was documented.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: As noted in the last report, numerous problems continued to exist 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. These indicators will remain in active monitoring. In addition, although Indicator f moved to the category of less oversight, based on review of hospitalization information for this review, concerns were noted with regard to the PCP or nurse communicating necessary clinical information to hospital staff. If the Center does not correct this issue, at the time of the next review, this indicator might move back to active monitoring.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	50% 5/10	1/2	1/1	1/2	1/1	0/1	N/A	N/A	1/2	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	20% 2/10	0/2	1/1	1/2	0/1	0/1			0/1	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the	60% 6/10	N/A	1/2	N/A	0/1	1/1	1/1	1/2	1/1	1/2

	disposition.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	60% 3/5		1/1		0/1	N/A	1/1	N/A	1/1	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	80% 8/10		1/2		1/1	1/1	1/1	2/2	1/1	1/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. However, due to problems noted during this review, this indicator is at risk of returning to active oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.			N/A		1/1	0/1	N/A	0/2	1/1	0/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.			0/2		1/1	0/1	1/1	0/2	0/1	1/2

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses addressed at the Center, including: Individual #17 (right elbow cellulitis on 2/5/18, and right hip abscess on 10/14/17), Individual #108 (arthritis on 10/31/17), Individual #612 (asthma on 12/18/17, and nasal congestion/cough on 2/9/18), Individual #72 (pressure ulcer on 1/9/18), Individual #481 (right eye redness on 9/30/17), Individual #372 (abdominal pain on 12/21/17, and viral upper respiratory infection on 1/5/18), and Individual #470 (pneumonia on 12/26/17) .

PCPs assessed the following acute issues according to accepted clinical practice: Individual #17 (right elbow cellulitis on 2/5/18), Individual #108 (arthritis on 10/31/17), Individual #612 (nasal congestion/cough on 2/9/18), Individual #72 (pressure ulcer on 1/9/18), and Individual #372 (abdominal pain on 12/21/17).

b. For Individual #108 (arthritis on 10/31/17), and Individual #612 (nasal congestion/cough on 2/9/18), the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 10/14/17, Individual #17's PCP documented: "Patient was referred to sick call for open abscesses discovered by DSP [direct support professional] during bath yesterday." The individual had no complaints. The exam noted 5 centimeters (cm) of erythema and swelling to the left elbow with an open lesion with purulent drainage. The right hip had a 1.5 cm open lesion

with purulent drainage with 10 cm of induration and swelling. The assessment was abscess "possibly started as pressure ulcers which became infected." The plan was to treat it with oral antibiotics and topical antimicrobial powder. The PCP did not order a culture of the purulent drainage. On 10/17/17, another PCP saw the individual due to nursing staff reporting that the wounds were "getting worse and needs to be revaluated." At that at time, the PCP documented Stage III pressure ulcers of the hip and elbow, and made a referral to the wound care clinic. Again, the PCP did not order a culture of the purulent drainage. On 10/18/17, the wound care clinic completed a culture, and it grew Methicillin-resistant Staphylococcus aureus (MRSA).

Until 11/29/17, the individual was seen weekly in the wound care clinic. From 10/18/17 until 12/4/17, the PCP did not conduct any follow-up evaluations, but agreed with the recommendations of the wound care clinic. On 12/4/17, the PCP documented that the lesions were healed. The plan was limited to the use of elbow protectors to prevent further skin breakdown.

- On 2/5/18, the PCP documented that Individual #17 was seen for right elbow redness. The assessment was open wound of the right elbow. The PCP prescribed local wound care along with the use of elbow protectors. The plan was to follow-up weekly until the wound healed. On 2/13/18, the PCP saw the individual for lower extremity weakness and the right elbow wound. The plan was to refer to neurology for worsening spasticity. The PCP noted the elbow had "worsening erythema," and the assessment was cellulitis with open wound. The plan was to treat with doxycycline and check a complete blood count (CBC). The PCP planned to follow-up in one week. Due to the document request dates, this was the last note in the IPNs. However, an open wound over a joint should have had follow-up planned for sooner than one week. The condition had significantly worsened at the second evaluation.
- According to nursing documentation, on 12/18/17, the PCP saw Individual #612 due to "dry cough with labored breathing." The nursing note indicated the PCP gave orders for nebulizer treatments. The PCP did not document this assessment. On 12/22/17, the PCP documented seeing the individual for an exacerbation of asthma. The individual continued to have wheezing, but reportedly it had improved. The cough and chest congestion continued. The assessment was asthma exacerbation, and the plan was to check for influenza, obtain a chest x-ray, and start prednisone. The PCP planned to follow up on 12/27/17.

  The PCP did not conduct follow-up until 12/28/17. The PCP recorded under the history of present illness section (HPI) that wheezing, cough, and congestion had resolved. However, under the assessment, the PCP noted that wheezing "is still present." Moreover, "continues to have nonproductive cough/chest congestion." The PCP included no plan to address this assessment. The chest x-ray was documented to have no active pulmonary pathology.
- On 1/9/18, the PCP documented that Individual #72 was seen for evaluation of a fall and right ankle pain. The PCP documented that the ankle exam was essentially normal with the exception of a 1 cm round skin opening on the posterior aspect of right ankle. The base and margins were clean and the surrounding skin was mildly erythematous without any bogginess or fluctuation. The PCP's assessment was a friction blister, and the PCP made a referral was made to PT. The PCP ordered the application of topical antibiotic ointment (TAO), and included follow-up in the plan.

  On 1/13/18, the PCP evaluated Individual #72 for an abrasion to the scalp following a fall. The physical exam did not document any follow-up of the friction blister (actually a pressure ulcer). On 1/15/18, nursing staff continued to document that this skin issue was not resolved. On 1/16/18, the PCP evaluated the individual for a corn on the right great toe. The PCP

did not note the pressure ulcer in this evaluation. On 1/16/18, nursing staff noted that the problem resolved.

- On 9/30/17, nursing staff documented that the direct support professional staff reported Individual #481 had right eye redness. Nursing documented: "On assessment, redness (hemorrhage) to right eye's lower sclera and, no discharge from eye, no swelling, no discomfort or no pain and no changes from baseline activity noted." Nursing staff documented that they contacted the PCP who prescribed tetrahydrozoline drops three times a day for three days. The PCP did not document a medical assessment or diagnosis. On 10/6/17, the PCP documented that the individual was seen for follow-up of right eye redness. At that time, the exam was normal.
- On 12/21/17, the PCP evaluated Individual #372 for abdominal swelling. The abdominal exam was pertinent for the left lower quadrant having a large oblong 8-inch mass. The assessment was possible stool impaction. The PCP ordered a KUB (i.e., abdominal x-ray), and the individual was administered a Dulcolax suppository and had some response. The KUB did not show definite evidence of constipation, and on 12/22/17, was repeated at which time, there was evidence of constipation. An enema was given for treatment with good response.

  On 12/22/17, the PCP reassessed the individual noting that the individual had a large bowel movement following an enema, and the abdominal swelling appeared improved, but remained with palpable swelling in the left lower quadrant. The PCP did not document follow-up or resolution of this swelling.
- On 1/5/18, the PCP saw Individual #372 for a for mild cough and sore throat. The assessment was viral upper respiratory infection, and the plan was limited to copious hand washing. The PCP provided no symptomatic treatment, or given that it was the middle of the flu season, assessment of the environment (e.g., were other individuals ill, etc.). The PCP did not document a skin exam to determine if the individual had viral exanthems. The PCP did not document follow-up.
- For Individual #470, only one nursing IPN entry, dated 12/25/17, was found in relation to his status pre-diagnosis of pneumonia. It documented the individual had upper respiratory congestion, cough, and drooling, as well as a large amount of secretions on his clothing and bed, yet the nurse did not document notifying the PCP. The individual was placed on sick call.

  On 12/26/17, the PCP saw the individual due to reports of coughing and congestion that staff noted the previous day. The PCP's assessment was respiratory tract congestion and cough. The PCP ordered labs and a chest x-ray. On 12/27/17, the PCP reevaluated the individual and documented that the chest x-ray showed peri-bronchial thickening and a patchy left lower lobe infiltrate. The PCP started the individual on antibiotics. Even though the individual was diagnosed with bronchitis and/or pneumonia, follow-up did not occur until 1/3/18, after completion of antibiotics. He completed antibiotics and was reported to have no problems

  On 1/6/18, Individual #470 was seen again for emesis. At that time, the PCP documented the individual was being treated with Bactrim for a urinary tract infection (UTI). This was the first documentation by a PCP that the individual was being treated for a UTI. The note failed to include that on 1/2/18, the individual was sent to the ED.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #108 (pneumonia, sepsis, and acute renal failure on 1/5/18, and abdominal pain on 12/5/17), Individual #72 (pneumonia on 1/22/18), Individual #481 (aspiration pneumonia on 10/21/17), Individual #552 (acute viral syndrome on 1/25/18), Individual #351 (endocarditis on 9/9/17, and pneumonia on 10/4/17), Individual #372 (femur

fracture on 11/19/17), and Individual #470 (pneumonia and sepsis on 12/6/17, and UTI on 1/2/18).

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

- On 12/5/17 at around 10:30 p.m., Individual #108 began yelling and crying with complaints of stomach pain. Nursing staff was not able to reach the PCP on call, so the Medical Director was contacted. Nursing staff did not document any orders or a plan, but the individual was placed on sick call. On the morning of 12/6/17, the physician noted there were no complaints of abdominal pain and the abdominal exam was normal.

  On 12/7/17, the individual complained of pain again, and a KUB was obtained. The PCP did not document a re-examination of the individual's abdomen, but noted that the KUB, done on 12/7/17, showed a "mild small bowel ileus." The plan was to give clear liquids and recheck a KUB the next day. On 12/7/17, Individual #108 also had a gastrostomy tube (G-tube) exchange. The individual continued to complain of abdominal pain and G-tube pain.

  On 12/14/17 at 11:00 a.m., the PCP documented that the individual refused an exam in sick-call and denied abdominal pain. At 12:00 p.m., the PCP documented that the individual had a distended and tender belly and was being sent to the ED for evaluation. Individual #108 returned later that day, and on 12/15/17, the PCP saw him for follow-up of constipation. There was no change in the bowel management plan. The next PCP documentation was on 1/3/18 for head banging.
- On 1/5/18, nursing staff documented that Individual #108 had emesis, and that nursing staff initiated monitoring of the individual, and contacted the PCP, who gave orders to give the individual small sips of water. The emesis continued. On 1/6/18, the PCP documented that as the on-call provider, nursing staff provided notification of emesis that morning, and two episodes the previous day. The individual was transferred to the ED for evaluation. The individual's vital signs were reported as: temperature - 94.3 and heart rate - 115. According to nursing staff, the individual's abdomen was distended and tender. The individual was admitted to the hospital and diagnosed with sepsis due to pneumonia, dehydration, acute renal failure, and bowel ileus/partial small bowel obstruction.

  On 1/11/18, Individual #108 was discharged, and on 1/12/18, the PCP saw him. The PCP documented no additional follow-up for this hospitalization for sepsis, pneumonia, and acute renal failure. The next PCP documentation was on 1/21/18, and it was related to head banging.
- On 1/22/18, nursing staff documented that during the noon medication pass, Individual #72 complained of not feeling well, and the nurse noted he was warm to the touch, congested, and coughing. The Monitoring Team found no vital signs documented in IView for this nursing assessment. Based on documentation provided, the PCP did not evaluate the individual during normal business hours, and/or write a note within one business day. The individual was admitted to the hospital with pneumonia, and on 1/24/18, was discharged. On 1/25/18, the PCP conducted a post-hospital assessment noting that the individual went to the ED for fever, hypotension, and hypoxia. The plan was to complete antibiotics and monitor the individual clinically. On 1/26/18, the PCP saw the again, as well as on 1/29/18, for a fall and follow-up of pneumonia.
- On 10/20/17, Individual #481 underwent a laparoscopic cholecystectomy, and at approximately 11:45 a.m., returned to the Center. On 10/20/17, the PCP evaluated him. On 10/21/17, the PCP did not see the individual. On 10/22/17, the PCP documented that the Infirmary nurse reported that the individual had an oxygen saturation in the mid 80s with a heart rate of 110. He was sent to the ED for evaluation. He was admitted with bilateral pneumonia. The computed tomography scan (CT)

showed material in the airway suspicious for aspiration.

On 10/26/17, Individual #481 returned to the Center, and on 10/27/17, the PCP saw him. The plan was to follow-up daily in the Infirmary, have the PNMT conduct a reassessment, obtain a modified barium swallow study (MBSS), and no oral feedings until the MBSS was completed. It was not until 11/1/17, that the PCP next documented. This documentation was related to a J-tube that was exchanged the previous night. The PCP did not document the outcome of the interventions listed in the plan section.

Moreover, the PCP did not attend the post-hospital ISPA meeting that the IDT held. According to the notes from a subsequent ISPA meeting, dated 12/6/17, the dysphagia speech language pathologist (SLP) advised against allowing Individual #481 to resume pleasure feedings. "The IDT advocated on his behalf and informed her that it had been 9 months since [Individual #481's] last episode of aspiration pneumonia and that pleasure feedings were not found to be the cause of his most recent episode-his lap chole [laparoscopic cholecystectomy] was." Therefore, with no documented input from the PCP, the individual returned to pleasure feedings.

- On 9/9/17, Individual #351's PCP documented that nursing staff called regarding a critical lab value for hemoglobin (Hb) of 6.9 that was obtained on 9/8/17. The individual was transferred to the ED for evaluation. He was admitted with Candida mitral valve endocarditis and treated with antifungals. He also received multiple blood transfusions. On 9/11/17, the IDT met to discuss the individual's hospitalization, but the PCP did not attend. On 9/18/17, he was discharged. On 9/19/17, the PCP saw the individual. The next PCP documentation was on 9/21/17. This was not a post-hospital follow-up, but was a referral to hospice.

  On 10/2/17, the PCP documented the next assessment. The PCP noted the individual was doing well, had no new problems, and was being treated for a sacral ulcer. On 10/4/17, the IDT held an ISPA meeting, but no PCP attended to discuss the discontinuation of antifungal treatment.

  On 10/5/17, Individual #351's PCP documented that on 10/4/17, the individual was transferred back to the ED due to a fever and tachycardia. He was admitted and treated for pneumonia. He also was noted to have two Stage II ulcers on the coccyx. He was discharged on 10/9/17. On 10/10/17, the PCP saw him. On 10/13/17, the PCP documented the next follow-up. At that time, the PCP documented that the individual was accepted into hospice, and all treatment for endocarditis would be discontinued. He was transferred to hospice that day, and he died on 10/19/17.
- On 11/19/17, the PCP documented: Individual #372 "seen at sick call for R [right] thigh swelling. Staff reported that she fell on 11/16/17 but was not seen at sick call and no nurses note indicated a fall assessment. She has a black/yellow bruise approximately three half dollar in size oval shaped on R upper lateral/ anterior thigh near R hip. The R thigh is very swollen and painful to movement palpation." The physical exam described a "gross deformity of the right thigh." She was transferred emergently to the ED for evaluation, and admitted. X-rays showed a markedly angulated transverse fracture proximal humeral shaft.

  On 1/25/17, Individual #372 returned to the Center, and the PCP assessed her. The PCP did not document the type of treatment in the note. On 11/27/17, the next assessment documented that the individual was discharged from hospice in

order to undergo surgical treatment (ORIF on 11/21/17). It was also noted that she had a Stage I pressure ulcer on her sacral area (other documentation stated Stage II). On 11/30/17, the PCP documented the individual was readmitted to hospice on 11/28/17, wound VAC was removed, the individual could start PT, and iron would be started for a post-operative anemia. Although the individual was in the Infirmary, the PCP did not see her again until 12/8/17.

- On 12/6/17, nursing staff documented that Individual #470 vomited, and was restless and agitated. He was gasping for air, nose flaring, eyes wide big, and had clammy skin. "Respiratory distress noted but responsive." The nurse indicated she was unable to obtain vital signs. At 4:25 a.m., he was sent to ED via EMS. There was no other documentation surrounding this event, which is very concerning.

  According to hospital records, Individual #470 was admitted with nausea, vomiting, pneumonia with sepsis, dehydration, and uncontrolled hypertension. He also had a CT that showed right renal calculi and trace pleural effusions. He was discharged on 12/13/17, and on 12/14/17, as well as 12/15/17, the PCP saw him.

  The pneumonia was classified as aspiration pneumonia. However, the PCP provided no documentation of how supports would be changed in light of aspiration and recurrent emesis. (The individual continued to have emesis.) On 12/15/17, the IDT held a post-hospital ISP meeting, but the PCP was not in attendance.

  On 12/17/17, the PCP saw the individual for emesis that occurred on 12/16/17. The PCP noted that the last emesis was on 12/6/17; however, the IPN documentation indicated the individual had emesis on 12/14/17, after receiving medications. On 12/18/17, the PCP saw the individual again, and again on 12/19/17, evaluated the individual for emesis. A KUB was then obtained that showed a suspected ileus. On 12/21/17, the PCP saw him again for emesis, and nursing staff administered milk of magnesia to stimulate a bowel movement.

  Hospital records documented that on 1/2/18, Individual #470 was seen in the ED. A CT of the abdomen and pelvis was completed. The individual was diagnosed with a UTI. A PCP assessment, dated 1/3/18, did not include any documentation of the individual being evaluated in the ED the previous day, being diagnosed with a UTI, receiving parenteral antibiotics in the ED, and being discharged with oral antibiotics.

f. Although this indicator moved to the category of less oversight, based on review of hospitalization information for this review, concerns were noted for three out of the 10 hospitalizations or ED visits with regard to the PCP or nurse communicating necessary clinical information to hospital staff. These acute issues included: Individual #108 (pneumonia, sepsis, and acute renal failure on 1/5/18), Individual #72 (pneumonia on 1/22/18), and Individual #470 (UTI on 1/2/18). If the Center does not correct this issue, at the time of the next review, this indicator might move back to active monitoring.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: It was positive that PCPs reviewed the consultation reports the Monitoring Team reviewed, and indicated agreement or disagreement with the recommendations, did so timely, and wrote IPNs that included all of the components State Office policy requires. For the most part, PCPs also wrote orders	Individuals:

for agreed-upon recommendations. If the Center sustains this performance, at the time of the next review, Indicators a, c, and d might move to the category of less oversight. The Center needs to continue to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.											
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 15/15	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2	1/1
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 15/15	2/2	2/2	2/2	2/2	2/2	2/2		2/2	1/1
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.	100% 15/15	2/2	2/2	2/2	2/2	2/2	2/2		2/2	1/1
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	93% 14/15	2/2	2/2	1/2	2/2	2/2	2/2		2/2	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 1/2	0/1	1/1	N/A	N/A	N/A	N/A		N/A	N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #17 for wound care clinic on 10/18/17, and eye on 11/16/17; Individual #108 for neurology on 11/29/17, and eye on 10/26/17; Individual #612 for rheumatology on 12/15/17, and eye on 1/18/18; Individual #72 for endocrinology on 12/29/17, and neurology on 10/10/17; Individual #481 for endocrinology on 9/12/17, and general surgery on 10/30/17; Individual #552 for gastroenterology on 8/2/17, and optometry on 2/18/18; Individual #372 for orthopedics on 12/28/17, and neurology on 1/28/18; and Individual #470 for endocrinology on 10/30/17.

a. through c. It was positive that PCPs reviewed the consultation reports the Monitoring Team reviewed, and indicated agreement or disagreement with the recommendations, did so timely, and wrote IPNs that included all of the components State Office policy requires.

d. When PCPs agreed with consultation recommendations, evidence generally was submitted to show orders were written for all relevant recommendations, including follow-up appointments. The exception was for Individual #612's rheumatology consultation for which evidence was not found to show that the DEXA was submitted to the rheumatologist for review.

e. Individual #17's PCP did not refer the wound clinic consultation to the IDT. The consultation indicated that the individual had two Stage III pressure ulcers.

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

Summary: Although additional work is necessary, it was positive that for over half of the individuals' chronic or at-risk conditions that the Monitoring Team reviewed, 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. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 17	108	612	72	481	552	351	372	470
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.	61% 11/18	0/2	0/2	2/2	2/2	2/2	2/2	0/2	1/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #17 – skin integrity, and other: cervical stenosis with myelopathy; Individual #108 – other: blindness, and seizures; Individual #612 – cardiac disease, and other: rheumatoid arthritis; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – GI problems, and diabetes; Individual #552 – infections, and osteoporosis; Individual #351 – infections, and respiratory compromise; Individual #372 – other: hypothyroidism, and other: anemia; and Individual #470 – GI problems, and other: hypertension).

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 #612 – cardiac disease, and other: rheumatoid arthritis; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – GI problems, and diabetes; Individual #552 – infections, and osteoporosis; Individual #372 – other: hypothyroidism; and Individual #470 – GI problems, and other: hypertension. The following are examples of concerns noted:

- Individual #17's AMA, dated 5/3/17, noted that he ambulated with a walker, but subsequent documentation stated he was non-ambulatory. Based on documentation submitted, the PCP did not appear to conduct an assessment regarding this decline in status. Mobility is an important determinant in pressure ulcer risk. This individual had recurrent wounds and skin infections. The PCP should address basic wound care prevention measures, such as how often the skin should be inspected, skin care, limiting exposure to moisture, nutritional status, positioning, ergonomics, and pressure relief. The PCP's preventive plan consisted of the use of elbow pads.

  In addition, as discussed above with regard to acute issues, on 10/17/17, another PCP documented Stage III pressure ulcers on Individual #17's hip and elbow, and made a referral to the wound care clinic. On 10/18/17, the wound care clinic completed a culture, and it grew Methicillin-resistant Staphylococcus aureus (MRSA). Until 11/29/17, the individual was seen weekly in the wound care clinic. From 10/18/17 until 12/4/17, the PCP did not conduct any follow-up evaluations, but agreed with the recommendations of the wound care clinic.
- Individual #17's AMA addressed the diagnosis of myelopathy stating that in 2013, the electroencephalogram (EEG) showed no evidence of neuropathy or radiculopathy. The recommendation the PCP made to the IDT was to monitor for swallowing and coughing while eating, as well as breathing problems as symptoms of worsening myelopathy. The PCP did not mention monitoring for weakness, numbness, reduced fine motor skills, and changes in walking.

The neurology consult, dated 9/12/17, noted that the individual was on Baclofen for spasticity, but there was no documentation of a physical examination to determine the current status of the individual (e.g., weakness in the extremities, reflexes, etc.). The consult, dated 1/9/18, also provided no assessment, but only stated to continue Baclofen, and follow up in three months.

As noted above, Individual #17's AMA, dated 5/3/17, noted that he ambulated with a walker, but subsequent documentation stated he was non-ambulatory. The AMA included documentation of strength, tone, and sensation in the extremities, but, based on documentation submitted, the PCP did not appear to conduct an assessment when the individual became non-ambulatory. Moreover, this individual appeared to complain of tingling and burning in his lower extremities, and the PCP did not appear to have properly assessed these complaints.

- The PCP commented in Individual #108's AMA that blindness in the left eye occurred in 2016, and was related to an infection that resulted from self-injurious behavior (SIB). The loss of vision in the right eye appeared to be long-term.

  Per the optometry consult, dated 10/5/17, the individual's left eye was blind. The right eye was functionally blind due to a dense cataract. The optometrist recommended referral to ophthalmology for evaluation of right eye cataract surgery. The records reviewed (up to Feb 2018) did not include any ophthalmology evaluation related to cataract surgery.
- On 11/29/17, the neurologist saw Individual #108 for an initial assessment for this newly-admitted individual. The evaluation was six lines and did not include any seizure classification. The consultant concluded that the individual did not appear to be having any side effects of the medication, and recommended follow-up in three months. The AMA did not include the diagnosis of a seizure disorder, and provided no explanation for the use of Valproic Acid, given a history of no recent seizures. The PCP provided no seizure classification, and no plan to obtain an EEG or discuss the ambiguous history with the family.
- Individual #351's AMA clearly outlined a plan for management of chronic hepatitis B that included a liver ultrasound every six months along with labs, including an alpha-fetoprotein (AFP) test. In 2017, an ultrasound did not appear to have been completed (i.e., the last documented ultrasound was on 8/8/16). The only AFP documented was done on 9/8/17.
- Individual #351's PCP did not stage the sarcoidosis in the AMA. The AMA did not include a plan for monitoring for extra-pulmonary involvement, including the schedule for obtaining labs, such as Vitamin D and calcium. The individual's last eye exam was in 2016. Monitoring for eye involvement is necessary. The AMA did not document the date of the last pulmonary consultation, and the Center did not submit any consultation reports for this individual.
- Individual #372 had a significant anemia. The PCP documented that this was a post-operative anemia and started the individual on iron. No evidence was found of testing to rule out GI blood loss. The Center has a clinical guideline related to the evaluation of anemia, which was not followed. However, the individual responded to iron supplementation with an increase in hemoglobin.

Of note, the neurological consultations reviewed for Individual #17 and #108 raised concerns about the quality of the neurology services. Similarly, Individual #72 had cerebellar ectopia, but the neurologist did not document any examination or make any comments about this diagnosis. It was unclear whether the neurologist was aware of it. The consultation report consisted on four lines: "[Individual #72] returns for follow-up. He is continuing to use a walker and remains verbal. In my opinion I don't think there has been any deterioration in his gait since his last visit. I do think we should continue to monitor him, I recommend routine follow-up in 6

months. At the present time, he is not on any medications per my standpoint."

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation was found to show implementation of a number of the action steps that IDTs assigned to the PCPs and 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	17	108	612	72	481	552	351	372	470
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	50% 9/18	0/2	0/2	1/2	2/2	2/2	2/2	0/2	0/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, action steps assigned to the PCPs in the following IHCPs were implemented: Individual #612 – cardiac disease; Individual #72 – constipation/bowel obstruction, and other: osteoporosis; Individual #481 – GI problems, and diabetes; Individual #552 – infections, and osteoporosis; and Individual #470 – GI problems, and other: hypertension.											

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	17	108	612	72	481	552	351	372	470
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. The documentation the Center submitted was insufficient to assess these indicators. The Monitoring Team working with State Office on a solution.											

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: The current QDRRs often contained unnecessary and sometimes clinically incorrect information. The format/content should be revised to provide prescribers with a concise review of individuals' drug regimens. Improvement is still needed with regard to the lab sections of the QDRRs. Since the last review, improvement was noted with regard to prescribers reviewing QDRRs timely. With sustained efforts, after the next review, Indicator c might move to the category of less oversight. At this time, all of the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	59% 10/17	1/2	0/1	2/2	0/2	2/2	2/2	2/2	0/2	1/2
	ii. Benzodiazepine use;	100% 17/17	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 17/17	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	86% 6/7	2/2	0/1	N/A	2/2	N/A	N/A	N/A	2/2	N/A
	v. Anticholinergic burden.	100% 17/17	2/2	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	88% 15/17	2/2	0/1	2/2	2/2	2/2	1/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 7/7	2/2	1/1	N/A	2/2	N/A	N/A	N/A	2/2	N/A

d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	79% 11/14	2/2	1/1	2/2	0/1	1/2	N/A	1/2	2/2	2/2
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.	67% 2/3	0/1	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: b. The Monitoring Team strongly recommends that the Clinical Pharmacist seek advice from State Office on the format and content of the QDRRs. The current format includes a considerable amount of old information (e.g., series of information that dates as far back as 2015/2016), including a number of previous recommendations that are clinically incorrect, as well as articles that are embedded into the QDRRs (i.e., full text as opposed to a link). This combination of issues makes the QDRRs difficult to read/use.

The lab information the Center provided was a flow sheet. It was not clear that this information was complete. Some of the problems with the lab reviews in the QDRRs were: available lab data had not been incorporated into the QDRR report; comments/recommendations were not included on abnormal lab values; and/or recommendations made in relation to abnormal lab values did not comport with current standards of practice.

For Individual #108, the assessment for metabolic syndrome was incomplete.

c. Since the last review, improvement was noted with regard to prescribers reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was generally presented to show they implemented them. The exceptions were for:

- The QDRR, dated 1/8/18, for Individual #72 indicated that he was past due for an electrocardiogram (EKG) with the last one done on 10/21/16. No recent EKG was submitted in the documentation.
- For Individual #481, the Clinical Pharmacist recommended decreasing esomeprazole from 40 milligrams (mg) to 20 mg. The PCP agreed, but the dose remained at 40 mg.
- For Individual #351, the Clinical Pharmacist made a recommendation about Hepatitis B management. The PCP agreed, but did not implement the recommendation.

e. For Individual #17, the Pharmacist sent a clinical intervention in relation to Ibuprofen describing the potential for drug interactions. Several options were listed for the PCP. The records reviewed did not indicate which option the PCP selected, but it appeared the individual received the Ibuprofen.

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	Individuals:

relevant dental outcomes. These indicators will remain in active oversight.											
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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 #372 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 with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: N/A			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									

Comments: Individual #372 was edentulous.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Given that over the last three review periods and during this review, individuals reviewed had needed restorative work completed in a timely manner (Round 10 – 100%, Round 11 – N/A, Round 12 – 100%, and Round 13 - 100%), Indicator e will move to the category requiring less oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	63% 5/8	1/1	0/1	0/1	1/1	1/1	1/1	0/1	N/A	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	75% 6/8	1/1	0/1	1/1	1/1	1/1	1/1	0/1		1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	63% 5/8	1/1	1/1	0/1	1/1	1/1	0/1	1/1		0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	33% 1/3	N/A	0/1	N/A	1/1	N/A	N/A	N/A		0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A		N/A
f.	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 #372 was edentulous.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on the documentation submitted, none of the nine individuals the Monitoring Team responsible for the											

review of physical health reviewed received emergency dental care.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	25% 1/4	N/A	0/1	N/A	N/A	0/1	N/A	1/1	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	25% 1/4		0/1			0/1		1/1		0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	25% 1/4		0/1			0/1		0/1		1/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4		0/1			0/1		0/1		0/1
Comments: b. Although data was provided to show suction tooth brushing occurred for Individual #481, and Individual #470, because their ISPs/IHCPs did not include action steps to define the frequency, the Monitoring Team could not determine whether it was provided as needed.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Given that over the last two review periods and during this review, the Dentist generally assessed individuals' appropriateness for dentures and made clinically justified recommendations (Round 11 – 80%, Round 12 – 100%, and Round 13 - 86%), Indicator a will move to the category requiring less oversight. The remaining indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	86% 6/7	N/A	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									

Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected.

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

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	2/2	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 #17 – osteoporosis, and skin integrity; Individual #108 – other: "breath support," and other: visual impairment; Individual #612 – falls, and infections; Individual #72 – falls, and constipation/bowel obstruction; Individual #481 – choking, and dental; Individual #552 – infections, and cardiac disease; Individual #351 – falls, and constipation/bowel obstruction; Individual #372 – skin integrity, and fractures; and Individual #470 – GI problems, and UTIs).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #72 – falls, and constipation/bowel obstruction.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data were often 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 several review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	17	108	612	72	481	552	351	372	470

		Score									
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% 0/13	0/2	0/2	N/A	0/1	0/2	0/1	0/1	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly.

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

- An ISPA, dated 11/8/17, noted that on 10/13/17, direct support professional staff reported a boil on Individual #17's right thigh, which the PCP described on 10/14/17 as "open abscesses discovered to right hip and left elbow." As discussed above, for 10/13/17, no nursing IPNs were submitted noting these open areas to the skin. As a result, nursing staff had not documented assessing the sites when direct support professional staff identified them. The ISPA indicated that these areas were not getting better, and the PCP referred the individual to off-campus wound care and ordered elbow protectors. In addition, Individual #17 was not to sit in his wheelchair for more than one hour, and change positions frequently to prevent future pressure ulcers. The ISPA also noted that the IDT "discussed a positioning schedule to prevent recurrent wounds," and recommended that the PCP revise the order to a two-hour maximum in the wheelchair. There was no discussion about increasing his risk rating for skin integrity to high or revising the IHCP to include proactive interventions. It was not until 2/9/18, after staff removed his shirt and found open wounds on both elbows, that the IDT held a follow-up ISPA to discuss what was put in place to address the individual's skin issues. Concerns included:
    - Documentation was not submitted to show that his positioning was changed, or that he did not sit in his wheelchair for more than one hour.
    - Nursing staff did not include in his IHCP or document regular proactive assessments of his skin to note any reddened areas and intervene before skin breakdown occurred. The open decubiti he experienced reflected poor skin care, and a lack of nursing skin assessments.
    - The recliner he preferred had a broken leg extender (i.e., the left foot rest remained extended) meaning staff had to lift him over the chair in order for him to be able to sit in it. This placed him at risk for fractures/injuries.
    - Documentation did not show how long this chair had been broken, and/or whether or not Habilitation Therapies staff had determined it was an appropriate positioning alternative, given his posture and his diagnoses of cervical

myelopathy and stenosis, as well as GERD.
    - There was no indication that the Dietician was involved in these discussions, since he had experienced some weight loss during the year.
    - There was a discrepancy between the PCP order for a one-hour limit in his wheelchair and the February 2018 PNMP, which stated a two-hour limit.
    - Even after nursing staff were alerted during the onsite review week to the significant concerns regarding the lack of proactive nursing skin assessments, by the end of the review week, nursing staff still had not begun to implement skin assessments.
    - It appeared that staff had become desensitized to Individual #17's complaints of pain, aches, and not feeling well. During the medication administration observation, nursing staff essentially did not acknowledge any complaint he made.
- In the ISPAs provided, the IDT made a few notations regarding Individual #108's visual limitations. For example, on 10/27/17, the IDT indicated: "referral to counseling to deal with being blind," on 11/6/17: "he trails walls and his immediate environment throughout the day and he remembers where everything is," and on 12/19/17: "the orientation and mobility specialist visits with [Individual #108] 3 or 4 times a week." Although it appeared that the IDT had made some efforts to address Individual #108's needs related to his vision issues, the IDT had not developed a plan or modified the IHCP to ensure that interventions were in place and were effective. Based on review of the ISPAs, it was unclear whether or not he had begun the counseling, whether or not it was effective, and whether or not the Orientation and Mobility Specialist initiated any interventions, such as assisting him to learn braille as he had requested.
- An ISPA, dated 10/11/17, noted that since 8/30/17, Individual #72 fell seven times. Although the data presented about these falls indicated these were not due to his behavior, the IDT concluded that: "most of his falls are related to behavior reasons." Based on the ISPAs provided, the IDT had not conducted a thorough analysis regarding his falls and had not completed a tally of the total number of falls, which would have shown that the interventions the IDT initiated had not decreased his falls over time. The data the Center provided in response to Document Request TX-RI-1803-IV.1-20 indicated that between 8/30/17, and 3/7/18, Individual #72 fell at least 22 times. At the time of the review, the IDT had not put any proactive interventions in place to prevent him from falling.
- According to the information presented, Individual #481's IDT did not develop IHCPs to address his high-risk areas of choking, and dental.
- Of significant concern, Individual #552's IDT had not developed and implemented an IHCP to monitor her cardiac status related to her risk for DVTs. In October 2014, she had experienced a DVT to the right saphenofemoral vein, and she was treated with Lovenox and Coumadin, and then changed to Xarelto, which was discontinued on 6/6/15, at which time, she was started on baby aspirin. DVTs can be life-threatening, as the blood clots in the veins can break loose and lodge in the lungs blocking blood flow (i.e., pulmonary embolism). At the time of the review, the IHCP did not include interventions to regularly and proactively assess this issue, especially because on occasion, Individual #552 was confined to her bed/room, for example, in January 2018, when she experienced shingles and a UTI. Since the IDT had not taken action to implement ongoing nursing assessments (i.e., assessing for redness, pain, hot areas to the skin, swelling to the individual's legs, coughing, chest pain, rapid breathing, or dizziness, as well as monitoring to ensure that changes in positioning are frequently implemented), it was unclear if the IDT understood the seriousness of the risk of DVTs.
- In October 2014, Individual #372's last DEXA scan showed osteopenia. The most recently due DEXA scan was not completed

due to his movement. The AMA, dated 8/24/17, noted that "he has multiple risk factors for osteopenia including immobility and lack of exercise." However, his IDT did not include any proactive interventions in the IHCP to address his high level of risk and prevent fractures, such as monitoring staff's transfers.

- An ISPA, dated 11/27/17, noted that when Individual #372 was admitted to the Infirmary, she had a Stage 2 ulcer on her sacral area. The IDT also discussed her right femur fracture and agreed to the following interventions:
    - Hourly check and change;
    - Reposition with pillows under trunk/hips alternating between left semi side-lying and supine every hour;
    - Place pillows between legs while in bed;
    - Transfer with gait belt and assistance of two staff;
    - May use wheelchair for all mobility;
    - Head-of-bed elevation at 30 degrees;
    - No sitter, direct support staff will check hourly;
    - PT will update PNMP;
    - In-service direct support staff;
    - Only use adult briefs for toileting due to being fragile with leg fracture; and
    - Move to Infirmary bed with alternating, and pressure mattress.

  Although the IDT noted these recommendations in the ISPA and her pressure ulcer healed, there was no Change of Status IHCP provided to show that all these recommendations were formally put into place and/or implemented.

  The ISPA, dated 12/8/17, indicated Individual #372 was found on the floor in her room after returning to her home from the Infirmary and the IDT decided on the following actions:
    - Residential Coordinator will in-service staff on Level of Supervision (LOS); and
    - Bed alarm to be put in place.

  The ISPA, dated 12/12/17, noted that the IDT discontinued her emergency LOS, and agreed to place Posey Soft Rails on her bed, while she continued to receive PT services. The ISPA, dated 1/22/18, included a review of her falls using video, and noted a loss of balance when she was "bumped." However, the IDT did not complete an analysis of the falls, and/or develop proactive interventions to prevent her from falling and sustaining additional injuries. Unfortunately, the ISPA, dated 1/29/18, reported that on 1/29/18, Individual #372 was again found on the floor mat next to her bed, and that the bed alarm was broken and the Posey soft rails were in place. Clearly, the interventions listed in the ISPAs had not prevented her from falling, and thus, had not protected her from further injury and harm.
- For Individual #470, the ISPAs, dated 12/15/17, 12/20/17, and 1/23/18, showed IDT discussion related to the issue of recurrent emesis. However, they provided no data regarding how long he had been having episodes of emesis, dates, or other aggregate data in order to determine possible causes for his episodes over the past few years. Without collecting all of the data addressing emesis, the IDT did not have a way to identify trends/patterns or even determine if this issue was better or worse than before.
- In May 2017, the IRRF noted that Individual #470 did not have a history of UTIs. However, he had one in June 2017, and again in January 2018, and the IDT did not update the IRRF. The organisms were not listed in the nursing documentation, which would have assisted in determining possible causes of his UTIs, especially if E coli. was present. The ISPAs reviewed did not

indicate that the IDT was noting a Change of Status regarding UTIs, since there was no discussion found. Consequently, the IHCP did not contain any proactive interventions to try to prevent further UTIs from occurring.

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. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators 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. Although some progress was noted, work was still needed to ensure that medication administration nurses listened to individuals' lung sounds in accordance with their needs during medication administration in alignment with the indicators. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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.	75% 3/4	N/A	1/1	N/A	N/A	1/1	N/A	0/1	N/A	1/1
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an	33% 1/3	N/A	1/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A

	enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	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 with 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 #17, Individual #108, Individual #612, Individual #72, Individual #481, Individual #552, Individual #372, and Individual #470.

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. Although some progress was noted, work was still needed to ensure that medication administration nurses listened to individuals' lung sounds in accordance with their needs during medication administration in alignment with the indicators. The following provide examples of the positive and negative findings:

- The nurse listened to Individual #108's lung sounds before and after medication administration. She did a great job telling him what she was going to do so as to not startle him due his visual issues.

- For Individual #481, the nurse completed the process so quickly that it was clear he was not actually listening for lung sounds. The Center's nurse auditor recognized the problem, and pulled the nurse for immediate retraining.
- Individual #351's IHCP did not include regular assessments of lungs sounds or a respiratory assessment. More specifically, the IHCP only required "PRN," or as needed assessments, which was not adequate for his high risk for aspiration and his declining health status.

f. Often, medication nurses used the individuals' PNMPs and checked the position of the individuals prior to medication administration. The exception was for Individual #612.

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: The IDTs of a number of individuals who met criteria for PNMT referral had not made referrals, and the PNMT had not made self-referrals. In addition, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
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;	17% 2/12	0/1	1/3	0/1	1/1	0/1	0/2	0/1	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/1	0/3	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/3	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/3	0/1	0/1	0/1	0/2	0/1	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/3	0/1	0/1	0/1	0/2	0/1	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show										

	progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	50% 4/8	0/1	0/1	0/1	0/1	1/1	N/A	1/1	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls for Individual #17; falls (three goals/objectives) for Individual #108; falls for Individual #612; choking for Individual #72; falls for Individual #481; choking, and falls for Individual #552; falls for Individual #351; aspiration for Individual #372; and falls for Individual #470.

a.i. and a.ii. Individual #108's goal/objective to walk 600 feet and Individual #72's goal to slow his pace of eating were clinically relevant, and achievable, but not measurable.

b.i. The Monitoring Team reviewed eight areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: skin integrity for Individual #17, aspiration for Individual #108, weight for Individual #612, falls for Individual #72, aspiration for Individual #481, aspiration for Individual #351, fractures for Individual #372, and aspiration for Individual #470.

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

- Individual #17 met criterion for referral to the PNMT in that he had two or more Stage 2 decubitus in 12 months, but the IDT did not refer him, and the PNMT did not make a self-referral. More specifically, on 10/17/17, he had Stage 3 ulcers on his left hip and left elbow. On 11/8/17, the PNMT recorded a discussion related to his skin wounds, but did not appear to actually refer or formally review the individual. The PNMT asked to attend an IDT meeting and review their plan. According to meeting minutes, on 11/15/17, this was done. The PNMT indicated that because the Stage 3 ulcer was not considered a non-healing or recurrent wound, no referral to the PNMT was made. However, the Stage 3 ulcers should have resulted in a referral, and he had two ulcers on different locations of his body. In addition, on 2/3/18, Individual #17 also had a Stage 2 ulcer to his right elbow.

- No evidence was found to show the IDT referred Individual #108 to the PNMT, or the PNMT made a self-referral to address the occurrence of aspiration pneumonia in January 2018. According to an ISPA, on 1/8/18, the MD confirmed this diagnosis (with bowel obstruction).
- Individual #612 should have been referred to the PNMT for unplanned weight loss. In April 2017, she weighed 99 pounds, and dropped to 88.40 in that month. In May 2017, she rebounded to 93 pounds. Overall, though, from April 2017 to October 2017, she experienced a 10% weight loss, going from 99 pounds in April to 88.60 in October. No evidence was found to show that the PNMT conducted a review or an assessment.
- Within the six months between 8/30/17 and 3/7/18, Individual #72 had at least 22 falls. Although he technically did not meet criteria for referral until February 2018, the PNMT should have at least completed a review earlier. According to an ISPA, dated 1/4/18, the IDT reported that he had not had any falls since 10/20/17, and that the fall issue was improved. Yet, documentation the Center submitted to the Monitoring Team identified at least seven falls between 10/20/17 and 1/4/18. In addition, a PT evaluation, dated 12/5/17, revealed that he had lost a great deal of lower body strength, dragged his feet, and it took 30 minutes for him to walk 100 feet. The IDT appeared to continue to attribute his falls to behavioral issues, without evidence to support this theory, and the IDT did not appear to take action to identify the cause of his change in status.

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

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of clinically relevant, measurable goals/objectives, integrated progress reports with 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	17	108	612	72	481	552	351	372	470
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	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% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	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. In addition, documentation generally was not found to confirm the implementation of the PNM action steps that were included in IHCPs.

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

- On 10/13/17, a boil was discovered on Individual #17's left elbow and also an open area was found on his right hip. On 10/17/17, nursing documentation indicated it was not healing, and they were determined to be Stage 3 wounds. However, it was not until 11/8/17, that the IDT met. On 2/9/18, the IDT met to discuss how often he should reposition himself. The documentation included a number of unresolved contradictions. For example, one sentence identified the frequency as one hour, the next said two hours, while still another said one to two hours. As discussed elsewhere, the IDT did not refer Individual #17 to the PNMT.
- With regard to Individual #72's falls, the IDT met frequently, but generally the outcome of these meetings was to continue to monitor his falls. Although the IDT speculated as to why he was falling and whether the falls were related to behavior, the IDT did not use a data-based approach to attempt to identify the underlying cause of the falls, which was necessary to identify effective interventions. The PT reportedly indicated Individual #72 experienced a decline in his functioning, but did not initiate direct therapy or provide a rationale for not doing so.
- As discussed elsewhere in this report, on 10/22/17, the PNMT conducted a review of Individual #481 for aspiration pneumonia. However, the PNMT made no recommendations, and did not document whether or not they reviewed the status of recommendations from their previous assessment (i.e., completed 7/10/17). The IDT decided to conduct an MBSS, and on 12/6/17, held an ISPA meeting to discuss the results. The IDT stated that he had not had pneumonia for nine months, but this was inaccurate, because he had one in June and one October. The Speech Language Pathologist (SLP) argued that he was weaker and that oral intake was not recommended, based on the findings of pooling, and that he was aging and had a weaker swallow. Despite these concerns and with no documented input from the PCP, the IDT decided he should resume oral intake.

c. On 9/25/17, the PNMT met with Individual #481's IDT to discuss his discharge. As the audit tool guidelines indicate, the discharge ISPA should include, for example, discussion of objective data to justify the discharge, evidence that any new recommendations were implemented into the individual's IHCP (or justification provided for not doing so), and proactive re-referral criteria. Neither the individual's IHCP nor the ISPA documentation showed evidence that the PNMT and IDT revised the IHCP to address the PNMT's findings and recommendations.

Similarly, during the week of the onsite review, the Monitoring Team member attended a PNMT discharge meeting for Individual #372. Without the documentation for this meeting, the Monitoring Team could not score it. However, the Monitoring Team member shared concerns about the meeting with the Director of Habilitation Therapies. For example, the PNMT members read the report, but had no discussion with the IDT. They reported that the individual had only fallen once since the fracture of her femur, but she had two falls (i.e., 12/7/17, and 1/29/18). PNMT members observed her only twice while showering. They said that staff did not implement the PNMP accurately the first time (i.e., 1/24/18), but did not monitor her again until 3/5/18. Other monitoring was limited to once per week for one month related to transfers. Re-referral criteria were a "consistent" five-pound weight loss in a month (it was not clear what this had to do with falls), and any incident of falls. Waiting for another fall to occur was not a proactive approach.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	47% 23/49	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	N/R	
Comments: a. Comments: a. The Monitoring Team conducted 49 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 10 out of 23 observations (43%). Staff followed individuals' dining plans during 11 out of 24 mealtime observations (46%). Staff completed transfers correctly during two out of two observations (100%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A									
Comments: a. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: Overall, for the individuals reviewed, IDTs did not have a way to measure	Individuals:

clinically relevant outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.											
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 2/19	0/7	1/3	0/1	0/1	0/1	0/1	0/2	0/2	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/19	0/7	0/3	0/1	0/1	0/1	0/1	0/2	0/2	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/16	0/7	0/2	0/1	0/1	0/1	0/1	N/A	0/2	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/16	0/7	0/2	0/1	0/1	0/1	0/1	N/A	0/2	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/16	0/7	0/2	0/1	0/1	0/1	0/1	N/A	0/2	0/1
Comments: a. and b. The goals/objectives included in individuals' ISPs/ISPAs that were clinically relevant and achievable, but not measurable were those for Individual #108 (i.e., walking 600 feet), and Individual #552 (i.e., allowing use of weighted belt). For Individual #481, the goal/objective in the ISP was different from the goal/objective the therapist recommended, and no explanation was provided for the discrepancy. Individual #372's PT goals/objectives were not included in the ISP or incorporated through an ISPA. c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives in individuals' ISPs/ISPAs, integrated progress reports with 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. The Monitoring Team conducted full reviews for all nine individuals.										

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	8% 1/13	1/4	0/3	0/1	N/A	0/1	0/1	N/A	0/2	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/7	0/1	0/3	N/A	N/A	N/A	0/1	N/A	0/2	N/A
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that OT/PT supports were implemented. Even when the											

QIDP included information, it was not in the form of an analysis that assisted the IDTs to determine whether or not further action was required.

b. For a number of individuals, ISPAs were not found to show IDTs discussed their discharge from OT and/or PT therapy. For other individuals reviewed (e.g., Individual #17, and Individual #108), the ISPAs or discharge summaries did not provide data and clinical justification to support the decision to discontinue the services.

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

Summary: Based on the Monitoring Team's observations of assistive/adaptive equipment to assess proper fit, the Center regressed with regard to the working condition of assistive/adaptive equipment. As a result, Indicator b will move back to active oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 55%, Round 10 – 59%, Round 11 - 82%, Round 12 – N/R, and Round 13 – 58%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]

#	Indicator	Overall Score	Individuals: 527	676	585	725	540	27	777	481	202
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. However, due to problems with working condition noted during this review, Indicator b will return to active oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	58% 11/19	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
		Individuals:									
#	Indicator		719	16	570	69	479	300	328	493	428
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		296								

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: b. Based on observations to assess the fit of adaptive/assistive equipment, concerns with regard to the following equipment being in working order were noted: Individual #719 - flex cuff elbow orthoses, Individual #16 – wheelchair's calf rests, Individual #570 – calf supports, and Individual #296 – head rest. As a result, Indicator b will return to active oversight.

c. Based on observation of Individual #725, Individual #27, Individual #481, Individual #202, Individual #16, Individual #570, and Individual #300 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #719's flex cuff elbow orthoses did not appear to fit correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. 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.

Because ISP indicators 1-3 were not met (i.e., regarding personal goals, measurability, and available data), progress could not be determined or assessed for all but one goal. Action steps were not consistently implemented for any individuals

Although none of the SAPs were found to be complete, there were major improvements in SAPs compared to previous reviews.

Richmond SSLC collected engagement data in all the day treatment sites and residences. These measures were all done during the day. Engagement measures need to be extended to the residences in the evening

As noted in previous reviews, the Leon C home had particularly low levels engagement when observed by the Monitoring Team. This was in somewhat stark contrast to the other three homes on the unit where there were staff engaging with individuals in small groups, materials were available, and pre-determined activities were being conducted. The Center should provide some additional resources and direction to the home regarding this.

For the applicable individual, the IDTs did not have a way to measure a clinically relevant outcome related to dental refusals.

It was concerning that over four days and multiple observations, the Monitoring Team member only saw one individual with an AAC device. The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner.

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 one goal that met criteria with indicators 1-3 was not progressing. These	Individuals:

indicators will remain in active monitoring.											
#	Indicator	Overall Score	17	108	140	118	372	72			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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.

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 personal goal, the living options goal for Individual #72 met criterion for all three of those indicators. The documentation from the previous ISP year indicated no group home tours had been completed. Individual #72 had not had any living options exposure since his most recent ISP, so no progress had yet been made, but that being said, the QIDP monthly review indicated two potential providers had been identified for pending visits.

Otherwise, there was no basis for assessing progress because the IDTs failed to develop many personal goals that were also measurable. The Monitoring Team found the continued 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	17	108	140	118	372	72			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/4	0/1	0/1	Not rated	Not rated	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. The Monitoring Team's evaluation of this indicator relies upon the input of all its members, based on observations, interviews, and review of documentation that reflects implementation. Overall, none of six ISPs had documentation that reflected consistent implementation. In addition, Monitoring Team observations and interviews identified significant gaps in staff knowledge and competence for four of six individuals (Individual #17, Individual #108, Individual #372, Individual #72). Scoring was not done for two individuals for this indicator due to Monitoring Team limited observations (Individual #140, Individual #118).

40. Action steps were not consistently 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: Even though much more work was needed regarding the activities assessed with these indicators, all four scored higher than at the last review (or maintained at 100%). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 15	613	17	108	140	263	118	575	567
6	The individual is progressing on his/her SAPS	11% 1/9	None	0/1	None	0/3	None	0/2	None	N/A	1/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 3/3	None	N/A	None	N/A	None	2/2	None	N/A	1/1
8	If the individual was not making progress, actions were taken.	50% 1/2	None	1/1	None	N/A	None	N/A	None	N/A	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	86% 6/7	None	1/1	None	1/1	None	2/2	None	N/A	2/3

Comments:

6. Individual #567's turn on the shredder SAP was rated as progressing. Some SAPs (e.g., Individual #613's wash clothes SAP) were not making progress. Other SAPs had reliable data, however, there was not enough data to determine progress (e.g., Individual #575's take a spelling test and review the pool rules SAPs). Other SAPs had insufficient data to determine progress, but were scored as zero because the data were not demonstrated to be reliable (e.g., Individual #108's operate a music player SAP). Finally, some SAP data did indicate progress (e.g., Individual #263's name her medications SAP), but were scored as not making progress because they did not have reliable data.

7. Individual #263's name her medications and count money SAPs, and Individual #567's turn on the water SAP were achieved, and all three SAPs were moved to the next step (objective).

8-9. Individual #613's wash her clothes SAP she was not progressing, however, actions (i.e., review the lack of progress with the IDT) were documented to address the lack of progress. On the other hand, Individual #567 was not progressing on his turn on the water SAP and there were no actions to address his lack of progress. Overall, there were data based decisions to continue, discontinue, or modify SAPs in 86% of the SAPs. Evidence of data-based decisions to continue, discontinue, or modify SAPs represents another improvement over the last review.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: One SAP contained all the required components; the others contained most, but not all. Positives included including pictures in the SAP for the staff, and implementing a new SAP format. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
13	The individual's SAPs are complete.	9% 1/11	None	0/1	None	1/3	None	0/2	None	0/2	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although only one SAP was scored as complete, the vast majority of SAPs contained the majority of necessary components.

One common missing component was specific instructions for teaching the skill. For many SAPs, it was unclear from the SAP training sheet, if the SAP represented training multiple steps at a time or each step individually. For example, Individual #108's operate his music player SAP included two steps: insert the cartridge into the music player and push the appropriate buttons. It also included the fading of prompting across two more steps. It was unclear if each step (insert the cartridge and push the buttons) were taught in the same training trial, or taught individually. It is recommended that the instructions clearly state if the SAP involves the training of multiple steps, or one step at a time.

Four SAPs (Individual #108's dial the phone, and Individual #567's turn on the shredder, turn on the water, and turn on the radio SAPs) included one step. Individual #108's dial the phone was scored as complete. Individual #567's SAPs were not scored as complete because he was visually impaired and the prompt sequence (e.g., gesture) was not appropriate.

The majority SAPs did an excellent job of including detailed photos of some of the more complex SAPs (e.g., Individual #108's operate the color teller, use a coffee maker, make a bed), and of individualizing the reinforcers following a correct response. Overall, the new SAP format represented an improvement in SAP quality at Richmond SSLC.

Outcome 5- SAPs are implemented with integrity.												
Summary: The Monitoring Team's ability to observe SAP implementation was hindered by various refusals by individuals and schedule changes. SAPs were observed for one individual and done correctly, but data were not recorded correctly, an important aspect of SAP implementation. Some SAPs had regular checks of implementation integrity. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
14	SAPs are implemented as written.	0%	None	N/A	None	N/A	None	N/A	None	0/2	N/A

		0/2									
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.	36% 4/11	None	0/1	None	0/3	None	0/2	None	2/2	2/3

Comments:
14. The Monitoring Team attempted to observe several SAPs, however, due to individual refusals, and changes in individual's schedules, the implementation of only two SAPs was observed. Individual #575's review the pool rules and take her spelling test SAPs were implemented as written, however, her data were incorrectly scored by the direct care staff and they were, therefore, scored as zero for this indicator.

15. A schedule of SAP integrity collection and a goal level was established for all SAPs. These frequencies and levels of SAP integrity were achieved for four SAPs (Individual #567's turn on the radio and turn on the shredder SAPs, and Individual #575's review the pool rules and take a spelling test).

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

Summary: Most SAPs were reviewed monthly and most SAPs had graphed data. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
16	There is evidence that SAPs are reviewed monthly.	64% 7/11	None	1/1	None	3/3	None	0/2	None	2/2	1/3
17	SAP outcomes are graphed.	82% 9/11	None	1/1	None	3/3	None	2/2	None	0/2	3/3

Comments:
16. The majority of SAPs had a data based review in the QIDP monthly report (e.g., Individual #613's wash her clothes SAP). Several SAP reviews, however, only included one month of SAP data, which did not allow data-based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #567's turn on the radio SAP).

17. There were no SAP data and, therefore, no graphs for Individual #575's review the pool rules and take a spelling test SAPs. The remaining nine SAPs were graphed.

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

Summary: Richmond SSLC was measuring engagement (good to see), but only during first shift, not in the evening or on weekends (needs improvement). The Center's self-scoring was much higher than the Monitoring Team's, raising questions of validity of their scoring tool and/or problems with reliability. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	15	613	17	108	140	263	118	575	567
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	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1

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 #575, Individual #17) to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

As noted in previous reviews, the Leon C home had particularly low levels engagement when observed by the Monitoring Team. This was in somewhat stark contrast to the other three homes on the unit where there were staff engaging with individuals in small groups, materials were available, and pre-determined activities were being conducted. The Center should provide some additional resources and direction to the home regarding this.

19. Richmond SSLC tracked engagement in all residential and treatment sites. Engagement was measured in residential sites, however, only during the 1st shift. In order to adequately measure engagement across all treatment sites, it is important to include engagement measures in the residences in the evenings (and weekends) when the majority of individuals are present and the majority of residential programming is occurring.

20. The engagement goal was individualized to each residence and day program site.

21. The facility's engagement data indicated that Individual #108 and Individual #567's residential and day treatment sites did not achieve their goal level of engagement. Generally, the facility's engagement scores (78% of individuals) were substantially higher than the Monitoring Team's engagement scores (22% of the same individuals). In order for the facility to improve engagement, it is critical that they first have a reliable measure of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Same as last time, individuals participated in community outings, but the various criteria to ensure frequency, individualization, and training were not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	15	613	17	108	140	263	118	575	567

		Score									
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, only Individual #108 had established goals for this activity (which he did not achieve).

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 about 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: There was collaborative work and communication between the Center and public school. The school IEP, however, was not integrated into or with the ISP. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	795							
25	The student receives educational services that are integrated with the ISP.	0% 0/1	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: For the applicable individual, the IDT did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1			0/1						
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1			0/1						
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1			0/1						
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1			0/1						
Comments: a. through e. For Individual #612, no plan was submitted to address her refusals, and need for sedation.											

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: Overall, IDTs did not have a way to measure clinically relevant communication outcomes for the individuals reviewed. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	13% 1/8	N/A	0/1	0/2	N/A	0/1	0/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/8		0/1	0/2		0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the	0%		0/1	0/2		0/1	0/1	0/1	0/1	0/1

	measurable goal(s)/objective(s).	0/8									
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8		0/1	0/2		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% 0/8		0/1	0/2		0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #17, and Individual #72 had functional communication skills.

Individual #612's IDT did not incorporate the recommended goals/objectives for direct and indirect communication therapy into her ISP. Similarly, Individual #481, Individual #552, and Individual #470's IDTs had not included recommended goals/objectives in their ISPs.

The goal/objective that was clinically relevant, but not measurable was Individual #351's goal/objective related to activating an electronic device using a switch. Unfortunately, he died before his IDT implemented this goal/objective.

c. through e. As noted above, Individual #17, and Individual #72 had functional communication skills. Individual #72 was part of the outcome group, so further review was not conducted for him related to communication. Individual #17 was part of the core group, so a full review was conducted. For the remaining five individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals included in their ISPs/ISPAs, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	17	108	612	72	481	552	351	372	470
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/5	N/A	0/1	0/2	N/R	0/1	0/1	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% 0/3	N/A	0/1	N/A		0/1	0/1	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. Examples of concerns included:

- For none of the goals did the QIDP monthly reviews show specific data related to implementation.
- On 2/16/18, after the Monitoring Team submitted its list of individuals for review, Individual #481's SLP wrote a note indicating that between March and October 2017, he received direct speech therapy, and that he frequently missed sessions. At least between August and October 2017, other IPNs were not included in the documents submitted substantiating the provision of therapy, summarizing data, or communicating with the IDT about attendance concerns.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	291	479	344	502	72				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	0% 0/1	0/1	0/1	0/1	0/1	0/1				
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/1	0/1	0/1	0/1	0/1	0/1				
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	N/R									
Comments: a. and b. It was concerning that over four days and multiple observations, the Monitoring Team member only saw one individual with an AAC device. Staff had to remove Individual #291's AAC device from the bag on the back of her wheelchair. She was not able to access it herself and required assistance to manipulate the pages. She was clearly familiar with the items contained on the pages, but dependent on staff with no independent access to the device. She was able to use and understand some sign language, but she had no name sign.											

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.

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.

A new admissions and placement coordinator was appointed to Richmond SSLC in the interim time period since the last review. The Monitoring Team enjoyed meeting her and talking about the Settlement Agreement, Richmond SSLC's transition history and challenges, and her short and long term goals for the department. The remainder of the staff were the same as at the last review, providing some stability and allowing for performance to improve, which was evident to the Monitoring Team.

For instance, although not yet at criteria, the set of CLDP supports were more measurable and more comprehensive than ever before. This was positive to see and given this progress and the transition department staff's responsiveness to feedback, it is likely that even more progress will be seen at the next review. The primary area for focus should be upon the pre-move inservice training for community provider staff. Another area for focus is to ensure that the CLDP addresses important historical information, even if those issues are no longer exhibited in the individual's life.

IDT and LIDDA participation in transitions remained high. Focus upon some specific considerations in planning for a transition, were not addressed at all in the documentation (e.g., clinician contact, clinician site assessment, staffing collaboration). It was good to see attention being paid to the quality of the transition assessments, and progress was noted, though more work needed to get to criteria. Pre move site reviews occurred; more thorough competency checking of provider staff was needed.

Post move monitoring was done, for the most part, thoroughly and good detail was provided for every support. Areas for continued focus are looking for the evidence listed in the CLDP as well as pursuing all three prongs of evidence (observation, interview, documentation). The PMM should also be sure to accurately record yes/no for provision of each support. This sets the occasion for follow-up and for the PMM, APC, and IDT to be informed about the status of each support. Post move monitoring, observed by the Monitoring Team, was done professionally, pleasantly, and covered all of the supports. The report accurately reflected what was observed by the Monitoring Team.

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: Richmond SSLC made considerable progress compared to previous reviews. Although not yet at criteria, the set of CLDP supports were more measurable and more comprehensive than ever before. This was positive to see and given this progress and the transition department staff's responsiveness to feedback, it is likely that even more progress will be seen at the next review. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	245	359							
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: Four individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #245, Individual #359). Both individuals transitioned to community homes operated under the State's HCS program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Richmond SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 18 pre-move supports for Individual #245 and 10 pre-move supports for Individual #359.
  - For Individual #245, all but six of the pre-move supports were for pre-move training. The remaining six, for obtaining equipment, addressing environmental concerns, and receiving certain healthcare services met criterion for measurability.
  - For Individual #359, all but one of the pre-move supports were for pre-move training. These are discussed further below. The remaining support, for informing the primary correspondent of the expected move date, was measurable.
  - Overall, the Center had made good progress in developing measurable supports for pre-move training for both individuals. To continue to move toward compliance, the Center should continue to focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough. Findings included:
    - All supports described the provider staff who needed to be trained and have a competency check completed.
    - All the supports provided a list of topics as the content to be covered under each broad area of training. Most of these supports indicated the specific knowledge provider staff would be required to know by the time of the transition, which was positive. For example, pre-move training supports for preferences, as well as some

habilitation and behavioral supports, specified what staff would be expected to know.
        - Still, some did not fully meet this standard and did not provide specific criteria by which competency could be measured. For example, inservice supports called for training in two areas, medical diagnoses and medications. The former indicated this would include signs, symptoms, and treatment, but did not provide these details. The latter support indicated it would include administration, purpose, and possible side effects, but only addressed purpose.
    - All the pre-move inservice supports referenced methodologies for training and these varied by subject matter. It was positive the IDTs did not limit training methodologies to discussion and didactic learning, but often specified demonstration and role-play as well.
    - Most supports included a reference to how competency would be determined. Some supports relied upon written tests, requiring a score of 85%. However, overall, the written exams did not test competency sufficiently. Testing needed to be constructed to measure the specific criteria that would demonstrate staff were competent to provide supports as required. The tests did not include questions for many of the topics and/or competencies listed as needed under each support, so there was no evidence of related staff knowledge.
    - For both individuals, a pre-move support indicated the Center registered nurse (RN) or designee was to provide inservice on medical diagnoses and medications to provider staff who would be working directly with the individuals and the provider RN. The support called only for administration of a competency exam to the RN, and not to the other specified staff, so it did not describe a methodology for measuring the knowledge of these other staff. The Center did not provide evidence of the testing material for Individual #245, so the Monitoring Team could not assess whether it was constructed to address measurability. For Individual #359, the testing material consisted of six questions that did not address the full scope of needed staff knowledge for her health care needs. It did not address her cardiac disease needs at all.
    - It was positive that some supports indicated demonstration or role play would also be required as evidence of competence, but the Center did not provide evidence this occurred.

- Post-Move: The respective IDTs developed 74 post-move supports for Individual #245 and 51 post-move supports for Individual #359. Many post-move supports were measurable, but this was not yet occurring across the full set of supports.
    - For Individual #245, most post-move supports were measurable. Those that did not meet criterion included:
        - A support called for Individual #245 to participate in various work opportunities at the provider's office facilities three times a week. The support did not specify how many hours of work he would be offered or whether this would be paid work at a specific rate.
        - A support called for him to participate in activities in the community to further his exposure and to work on skills in the community, such as money management, including visits to adult day care centers in the area. This was overly broad in purpose and did not specify how furthering exposure would be defined or measured. Aside from the visits to adult day care centers, it did not define any specific activities that might contribute to exposure or skill development, and did not offer any expectation about how visiting adult day care centers would contribute either. This made it difficult for the PMM to determine whether the support had been met. As a result, the PMM ended up documenting only that he was attending a day habilitation program.

- For Individual #359, post-move supports that did not meet criterion included:
    - The IDT developed a support that called for her to work at the day habilitation program daily, so the provider could assess her for community work skills and get her acclimated to a regular work schedule. The support did not state any expectation for employment at any time.
    - Individual #359's support for required supervision was broad and used descriptors such as minimal and basic to describe her needs, which was inaccurate and open to interpretation.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. This represented substantial improvement. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. To meet criterion, the IDTs should continue to make improvement toward developing comprehensive supports that address behavioral and psychiatric history, including how the provider could recognize re-emerging concerns and address then pro-actively. Findings included:
    - For both individuals, the IDT did develop some very detailed pre- and post-move supports related to their current behavioral needs. This was positive.
    - On the other hand, Individual #245's IDT did not develop pre-move supports that ensured provider staff had knowledge of his significant behavioral and psychiatric history.
        - The CLDP Profile included a narrative description a long history of aggression and legal issues, including theft of property, larceny and theft charges, unlawful carrying of a weapon, an allegation of having injured a man after arguing with the man's girlfriend, and an arrest for aggravated assault with a deadly weapon. He had been found incompetent to stand trial and subsequently remanded to a state hospital before being sent to Mexia SSLC. Some post-move supports alluded to these concerns, such as the post move support for supervision. This support indicated provider staff should monitor him more closely on outings to places where he might be more likely to steal or obtain alcohol, but these behaviors were not included in the pre-move training supports for staff knowledge.
        - The CLDP narrative provided an extensive discussion of how to address falling as an attention-seeking behavior. The IDT included some of these strategies in pre- and post-move supports, such as giving him positive attention once per shift and praising him for showing good behaviors, but did not provide any indication this was related to falling behavior. The IDT did not address other related strategies, such as reviewing his walker guidelines once per shift, praise for using the walker correctly and how to respond appropriately to and record sliding to the floor and/or self-reporting a fall.
        - Other historical behavioral and psychiatric needs included disturbed mood, otherwise unspecified, and hoarding. The narrative indicated these symptoms were not being tracked because he no longer received psychiatric medications, but this would not obviate the need to ensure provider staff had awareness in case of recurrence. This was particularly true because the discontinuation of his anti-depressant medication was very

recent, having just occurred in May 2017, some four months before his transition. The CLDP also included strategies to address sexual comments, inappropriate touching of others, and exposing himself, but did not provide any detail about how or how often these behaviors occurred.
        - The behavioral health assessment included a recommendation that daily data collection should be continued. The CLDP narrative further stated the provider would track targeted behaviors from the PBSP until Individual #245 saw the community psychologist, but none of his behavioral supports included this as a requirement.
    - For Individual #359, neither pre-move nor post-move supports addressed her history of elopement or the extent and nature of her assaultive behavior.
    - Also for Individual #359, the IDT did not address her significant history of trauma, especially as that would inform the development of psychiatric treatment in the community. Her history included sexual trauma and exploitation, physical trauma, including head injury from a motor vehicle accident, frequent psychiatric hospitalizations as a child, and the suicide of her mother, after which she was alone with the body for 24 hours. It was unclear why the IDT had not considered the need for counseling to address these needs.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop clear and comprehensive supports in this area. Examples of supports that met criterion and those that did not included:
    - Both CLDPs specified certain needs for ongoing nursing oversight and/or monitoring, such as a biweekly nursing evaluation of vital signs, weight, appearance and side effects for Individual #245 and monthly monitoring of weight for Individual #359. This was positive. Overall, Individual #245's set of supports for nursing oversight was comprehensive, but this was not true for Individual #359. For example, Individual #359 was at risk for cardiac disease and for side effects of psychiatric medications, but the CLDP did not include a support for any routine nursing monitoring of these symptoms.
    - Neither CLDP included supports that addressed supervision needs in a comprehensive manner.
        - For Individual #245, it was positive the CLDP included a thorough discussion of his community supervision needs in the narrative, which was replicated in the post-move supports. To move toward compliance, the IDT also needed to ensure provider staff had knowledge of these needs as of the first day of his transition, as indicated above under indicator 1. The IDT developed a pre-move training support that included his supervision needs related to mobility, but did not require any pre-move provider staff knowledge of supervision requirements related to his behavioral needs. In addition, the Special Considerations document provided as training material stated staff were to provide 15-minute check while in the bathroom or bedroom as falls precautions. This was not discussed in the CLDP or any support developed.
        - For Individual #359, a pre-move training support for reinforcing appropriate behavior indicated provider staff should keep in mind she had made allegations of sexual incidents, to make sure they were aware of her whereabouts at all times and to encourage her to let them know whenever she wanted to leave the area. No supports emphasized her history of elopement or provided a full understanding of her history of sexual trauma and potential for further exploitation. Also, her habilitation assessment included a recommendation that she be monitored while playing video games to prevent accessing of X-rated materials, but the IDT did not

discuss whether this was necessary. The post-move support for supervision did not address these specific concerns, stating she was on routine supervision "which translated to her day-to-day treatment, training, independence and safety needs could be met with minimal staff supervision and/or assistance." It then went on to say she displayed independent community mobility, but would need basic staff supervision at all times. It was positive the Transition QIDP identified the need for CLDP to more thoroughly address her history of sexual encounters and allegations and related increased level of supervision, but the resulting supports did not accomplish this.

- Per the AMA, Individual #245 had a history of chronic hyponatremia. In 2014, he was hospitalized for treatment of an acute episode of hyponatremia, believed to be secondary to an elevated Depakote level. This information was not discussed or referenced in the CLDP and the IDT did not develop any supports for staff knowledge of this concern or related symptoms to monitor. The post-move support for monitoring of possible side effects did not specifically address hyponatremia. The support calling for the community PCP to make recommendations for routine medical care did not reference this concern. This would have been important information for the community PCP to know as he or she made decisions about periodic drug level monitoring.
- Per the IRRF, Individual #245 had elevated risks in many areas, including a high risk for falls and osteoporosis. Per the IRRF, he had experienced 26 falls in the year preceding the most recent ISP. The CLDP included pre-and post-move supports for supervision and staff assistance when he appeared unsteady, as well as the use of a gait belt, rollator walker, and helmet. This was positive, but as described above, the IDT did not integrate the behavioral strategies used successfully in the past when some falls were identified as attention-seeking in nature. Per the habilitation assessment, attention seeking behavior remained an identified trigger for falls.
- Per the IRRF, Individual #359 had an elevated risk for infections and skin integrity, but the IDT did not address this assertively. For example, per the nursing assessment, Individual #359 had experienced multiple infections (ear infections, possible herpes on her lips, and blepharitis), as well as skin lesions during the previous year, but the CLDP did not include any supports for staff knowledge and monitoring. She also had a diagnosis of acne vulgaris and the nursing assessment indicated she should be encouraged to wash her face daily. The IDT developed a support for staff to monitor for acne exacerbations and report these promptly to the provider nurse, but did not include the instruction for preventative daily washing.
- Individual #359's AMA indicated she would need to have ongoing EKGs to monitor for QTC while on psychiatric medications because a prolonged QT interval was associated with ventricular tachycardia and sudden cardiac death. The IDT did not develop any specific supports to convey this knowledge.
- Individual #359's psychiatric assessment indicated she should continue to have her prolactin level checked annually, but the CLDP did not address this need.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Neither CLDP assertively addressed these outcomes. Findings included:
  - The IDT for Individual #245 used his vision statement from the ISP as a basis for identifying his important outcomes. This was particularly positive because the IDT had documented he had meaningfully participated in the development of the vision. The IDT identified hosting an annual backyard barbecue party, meeting new people by visiting a specific

barber shop he was familiar with as well as attending a specific church, and expanding his independence skills by using a microwave. The IDT developed supports for each of these and provided a justification for not addressing a final outcome (to assist with household chores) in the vision statement.

- On the other hand, Individual #245's IDT did not address his desire to live with family. Per the Transition Log, his brother stated he would like for him to eventually return home, but this was not possible at the present time due to the mother's medical condition. The IDT should have explored with the brother what supports would need to be in place to facilitate moving to his family's home in the future when current circumstances resolved. This information could have been used to develop additional supports, such as for expanding independent living skills.
- For Individual #359, the CLDP did not address important outcomes assertively. The IDT identified important outcomes based on some of her preferences, such as playing video games, dining out, favorite foods, playing with her dolls, and being able to purchase items she liked, but did not address other important outcomes.
    - Individual #359 wanted to have roommates who were close to her age and functioning level so she would have someone to interact with. After her trial visit, she stated that she didn't like the home because the other individual could not talk. She stated that she didn't have anybody to talk to at the day habilitation program. Per interview with transition staff, Individual #359 had recently moved from the original setting to a new home (operated by the same provider) where she did have appropriate roommates she enjoyed spending time with. This was positive.
    - Per the ISP and PSI, she had other personal life goals such as having a boyfriend and getting married someday, working more, and earning more money, but the CLDP did not address these.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
    - Per the ISP, Individual #245 enjoyed making money, but his work attendance was sporadic and based on his mood. His PSI stated he would have liked to change the type of work that he did and where it was located, but the vocational assessment update did not provide any information about work exploration. At the time of his trial visit, Individual #245 visited day habilitation programs, but didn't want to attend any of them, largely because he felt others there were lower functioning. In response, the CLDP narrative documented the IDT's decision for him to have work opportunities at the provider's home office three days a week. The discussion further indicated the provider would work on trying to identify work that might interest him, although it did not specify how this would be implemented. The final recommendation and support did not specifically address additional work exploration, stating only that he would participate in various work opportunities at the provider's office.
    - Individual #359 had an ISP goal to work 10-15 hours per week as a stocker at a local store in the electronic department, which was consistent with her stated preferences. Per the PSI, she took pride in her work accomplishments and liked earning money; in fact, she wanted to earn more so she could buy the things that she liked. The IDT did not develop assertive supports for employment. Per an ISPA on 10/4/17, during which the final choice of provider was made, Individual #359 stated she didn't like the day hab because all the people there were old and disabled and most could not talk. She also stated that she couldn't earn any money at the day hab. The IDT did state it shared these same concerns and felt they were valid; further, they expressed to the LAR that attending a day programming site with peers that are older and function on a lower cognitive level would put Individual #359 at risk for regression in her skills. The LAR acknowledged the concern, but felt it could be addressed at a later time. The IDT

agreed to develop a support that only called for her to work at the day habilitation program daily so the provider could assess her for community work skills and get her acclimated to a regular work schedule. The support did not state any expectation for employment at any time. This was disappointing because the ISPA narrative also indicated the provider owner had expressed prior to the trial visit that they would be able contract with another program to provide vocational opportunities. It documented provider staff present at the meeting were not able to confirm this, but there was no evidence the IDT completed any follow-up to secure these opportunities in the month before the CLDP meeting on 11/2/17.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included elements of positive reinforcement and other motivating components and met criterion. Both CLDPs provided specific pre-move and post-move supports for providing contingent and noncontingent positive reinforcement on a daily basis.

- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed some supports related to teaching, maintenance, participation, and acquisition of specific skills.
    - For Individual #245, the CLDP met criterion. It included two specific skill acquisition programs: using the microwave to make snacks and small meals, and identifying if he received correct change when making purchases. The CLDP also included supports to continue encouraging him to bathe thoroughly and with as much independence as possible.
    - Individual #359's CLDP did not meet criterion. The IDT developed three supports related to toothbrushing, but these were conflicting in terms of supporting her independence. One support indicated staff were to provide hand-over-hand assistance, which was not consistent with her assessed toothbrushing skills, while another stated broadly that staff should provide supervision. Per her PSI, she wanted to learn to use a stove, cook, use a metro bus, and shave independently. The CLDP did not address any of these or any other skill acquisition.

- All recommendations from assessments are included, or if not, there is a rationale provided: Richmond SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Center had made significant improvement in its process for reviewing the discipline assessments for thoroughness, which was positive. For example, in its review of the annual medical assessment for Individual #245, the IDT identified issues of incorrect, missing or outdated information and updated these. In addition, the IDT expanded upon the medical recommendations to reflect these updates. Still, the IDTs did not consistently address recommendations with supports or otherwise provide a justification. Examples included:
    - For Individual #245:
        - The QDRR for Individual #245 recommended his seizure diagnosis should be specified to determine the best treatment. The IDT documented only that the PCP and neurologist had not pursued specifying his seizure disorder at the time, but did not provide any rationale as to why this was not needed or appropriate.
        - The AMA recommended physical therapy (PT) for gait training and leg strengthening exercises. The CLDP include a support for provider staff to encourage and assist him when necessary to perform leg strengthening and general conditioning exercises three times a week. This did not address the recommendation for physical therapy.

- The AMA recommended a DEXA scan every two years, but the IDT did not develop a specific support.

- For Individual #359, the CLDP did not address the following recommendations or provide justifications:
  - The medical assessment indicated she would need to be monitored for QT elongation.
  - The habilitation assessment stated recommendations for instruction on kitchen safety, including how to handle hot/cold, sharp, or breakable items, for good kitchen hygiene, and for a dietary consult to ensure she had knowledge of a healthy diet.
  - The habilitation assessment also stated she needed assistance to complete an application form, write a resume, and how to participate in an interview.
  - The nursing assessment recommended dietary counseling to address her morbid obesity.

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

Summary: The PMM's performance continued to improve. Post move monitoring was done, for the most part, thoroughly and good detail was provided for every support. Areas for continued focus are looking for the evidence listed in the CLDP as well as pursuing all three prongs of evidence (observation, interview, documentation). The PMM should also be sure to accurately record yes/no for provision of each support. This sets the occasion for follow-up and for the PMM, APC, and IDT to be informed about the status of each support. Post move monitoring, observed by the Monitoring Team, was done professionally, pleasantly, and covered all of the supports. It was good to see indicator 3 move to 100% scoring. This set of indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	245	359							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							

8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	N/A							

Comments:

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

4. The Monitoring Team observed good progress in the efforts of the PMM to provide detailed comments describing the status of supports. Still, PMM Checklists did not yet always provide valid and reliable data. To continue to move toward compliance, the Center should continue to focus improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Findings included:

- In some supports, the language was broad and vague as described above under indicator #1.
- In other instances, the evidence provided was not consistent with the individual's needs or supports. For example, for Individual #245, the 45-day PMM indicated the community PCP had made changes in his medications, including to increase Klonopin and Risperdal and to discontinue Celexa and Remeron. Per the list of medications prescribed at transition, he was not taking the latter three medications. The PMM Checklists did not provide any information about the circumstances that led to those being prescribed in the first place. In responding to the question regarding whether any changes in medications had been made, the PMM indicated none had occurred at both the seven-day and 45-day PMM visits.
- Sometimes, data/information were not provided. These appeared to be oversights, but occurred in a number of instances. For example, at the time of the 45-day PMM visit for Individual #245, no data were provided for the support related to his preferences and dislikes. For Individual #359, at the time of the seven-day PMM visit, the comments for a support related to her diet ended in mid-sentence.
- Sometimes, the PMM addressed portions of a support. For example, for Individual #245's nutrition requirements, the PMM did not address the caloric requirement at any of the three PMM visits. For Individual #359, post-move supports described extensive expectations for health care and medical needs that needed to be covered in the initial PCP visit, but the comments addressed very few of these.
- Most of the CLDP supports required several prongs of evidence, including interviews, observations, and review of documentation. This was positive to see. The PMM did not yet consistently address these required prongs. In particular, the PMM frequently failed to reference the review of documentation, such as leisure logs and staffing schedules, or conversely, sometimes relied on documentation and did not document completing the required interviews.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written. Examples of important supports not in place as required included the following:

- For Individual #245:
  - He had not received training for money management, which was due within the first seven days. At the time of the seven-day PMM visit, the provider indicated it would begin within the next reporting period. At the time of the 45-day PMM visit, the provider indicated he was still being assessed and the training had not yet begun. At the time of the 90-day PMM visit, the PMM marked the support as not applicable and provided no justification for this assessment.
  - The CLDP included a post-move support for the provider to assist Individual #245 to plan to host a backyard BBQ/party by 10/15/17, but no planning had been undertaken through the first 90 days.
  - By the time of the 90-day PMM visit, the provider continued to indicate Individual #245 was still being assessed for training on using the microwave. This was due on 9/25/17 and ongoing weekly.
  - A post-move support called for the PCP to make recommendations for a number of specific needs, including consults, lab values and periodic drug level monitoring, follow-up monitoring, and care for specific diagnoses, but the evidence provided did not address most of these.
  - Individual #245 had a post-move support for daily documentation of his blood pressure, with a goal of less than 140/90, and to hold his medication and notify the nurse if less than 90/50. The PMM documented at all three PMM visits that there had been no incidents of blood pressure being less than 140/90. The documentation did not indicate what the upper ranges of his blood pressure had been.
  - Individual #245 had a post-move support to see the dentist within 90 days. At the time of the 90-day PMM visit, a dental appointment had not occurred and no scheduled visit was described.
  - At the time of the 45-day PMM visit, the PMM documented the provider no longer cut his food into bite-size pieces per a dietitian consult and deemed the related support to no longer be necessary. The documentation did not provide any rationale for this change to his diet texture. The PMM should have documented sharing the dietitian consult with the IDT and obtaining their input to ensure Individual #245's safety with this upgraded texture, particularly since the bite-size texture was a recent upgrade from a ground diet. As discussed with transition staff, the Center should still undertake to confirm with the provider whether this change is safe and meets his needs.
- For Individual #359:
  - At the time of the seven and 45-day PMM visits, the provider had not begun an assessment of community work skills as required.
  - Individual #359 had a support for the community PCP to receive an information packet related to her medical and health care needs at the time of the initial appointment. At the time of the 45-day PMM visit, documentation had not been obtained this had occurred.
  - A post-move support called for the PCP to make recommendations for a number of specific needs, including consults, lab values and periodic drug level monitoring, follow-up monitoring and care for specific diagnoses, but the evidence provided did not address most of these.
  - At the time of the 45-day PMM visit, the PMM documented Individual #359's diet had been modified per doctor's order from 1500 calories with dietary reflux precautions to 2000-2500 calories per day with no reference to the reflux precautions.
  - The PMM documentation indicated Individual #359 was not brushing her teeth three times a day. It indicated she was refusing to do so at times, but did not provide any detail about how often refusals were occurring.
  - At the time of the seven and 45-day PMM visits, the evidence provided indicated Individual #359 was drinking at least

16 ounces of water a day, but the support called for 90 ounces.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was not consistently correct. The PMM consistently indicated supports were in place, but the evidence collected did not always support that conclusion. For most of the supports the Monitoring Team identified as not in place based on the evidence provided, including but not limited to the examples provided in indicator 5 above, the PMM scored them as present or occasionally as not applicable, when they should have been scored as not in place.

7 - 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. As described in the previous indicators, the PMM frequently did not accurately identify the absence of a support or an emerging concern, and did not identify any issues that required follow-up by the IDT. For example, the PMM should have alerted the IDT to Individual #245's consistently elevated blood pressures and change in diet texture, as well as the change to Individual #359's diet in the face of her morbid obesity. Also, Individual #359's provider was addressing her behavioral needs in a manner inconsistent with the PBSP as well as using restrictive approaches under the guise of positive reinforcement.

9. The Monitoring Team attended the post move monitoring 12-month visit for Individual #712. The PMM went through the list of supports one by one and spent about an hour with one of the direct care staff members, questioning her about various aspects of supports for the individual. In particular, she spent a lot of time asking her questions about the individual's behavior plan, data, and communication style. The PMM's style was professional and pleasant. She did not use leading questions, and she took the time needed to make notes, ask follow-up questions, look at documentation, and observe the individual and various observational components of the post move monitoring activity, such as looking for adaptive equipment. Ensuring that each piece of evidence called for in the CLDP and going further by looking for all three prongs of evidence (when relevant) are the next steps in the PMM moving toward, and achieving criteria with this indicator. Her receptiveness to feedback and desire to make improvements in her post move monitoring competence were again evident to the Monitoring Team.

10. The PMM's report of the post move monitoring activity reflected what the Monitoring Team observed.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: Both individuals had negative events occur that could have affected their transitions. For one, a home change was made and the provider did a good job of planning for the transition. For the other, problems occurred during a family home visit shortly after his transition. Although some work had been done to reduce the likelihood of this occurring (e.g., included in pre-move inservice content), some gaps in planning may have contributed to the event occurring (e.g., not checking provider competency regarding activities to reduce the likelihood of problems with visits with family). This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall	245	359								

		Score									
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments:

11. Both individuals had experienced at least one PDCT event. Findings included:
    - Individual #245 had experienced two such events, law enforcement contact and a seven-day psychiatric hospitalization, both of which occurred when he refused to return to the provider home when visiting his mother. The IDT discussion cited several factors as things the provider could have done differently and indicated the problem was anticipated and addressed in the CLDP and pre-move inservice.

      It was positive the IDT evaluated changes that needed to be made and developed recommendations to be carried out by the provider if similar circumstances were to occur. The IDT should also have used the PDCT process to complete a critical analysis of any changes that could have been made in the transition planning process that may have reduced the likelihood of the negative event occurring in the first place. This component of the PDCT process allows IDTs to identify performance improvement needs. Findings included:
        - The PDCT ISPA indicated the provider did not follow the steps that were set forth in the PBSP in the pre-move inservice for dealing with verbal aggression. The CLDP did include an extensive support for dealing with verbal aggression that may have been successful if implemented as written, however, the pre-move testing did not demonstrate provider staff had achieved the required level of competency.
        - The PDCT ISPA indicated there were no efforts to talk to Individual #245 before this visit to detail with him the length of the visit. His mother requested this visit, but did not instruct the provider of the length until he was at the home already. The CLDP did not include assertive supports that addressed this need. One support for encouraging positive interactions did indicate he needed to be told of changes in his day, but again the pre-move testing did not test whether provider staff attained this knowledge.
        - The PDCT ISPA indicated the provider did not talk to him to set any boundaries for this visit. The CLDP did not address the need to set such boundaries. It only addressed the need for the provider to ensure the family was aware of his supervision needs when they visited.
        - The ISPA also indicated Individual #245's Depakote dosage was changed during his psychiatric hospitalization. This was concerning given his history of hyponatremia related to that medication and should have been flagged for heightened monitoring for possible symptoms.

    - Within the first 90 days, on 2/15/18, Individual #359 had moved to a different home than the one to which she originally transitioned, but it was operated by the same provider. The move occurred because the provider was unable to come to terms on a new lease with the homeowner from whom the home was rented. This was not something the IDT could have anticipated.

	Per the PDCT documentation, the provider ensured adequate supports were in place to facilitate this transition, such as ensuring the same staff also moved to the new home. Per interview, Individual #359 had adjusted well to the new environment, particularly because she had new roommates she had more in common with. The PDCT documentation indicated the IDT met on 2/23/18, within a week of the PDCT event, to review the circumstances. This was timely, but the PDCT ISPA was not recorded until after the Monitoring Team requested the documentation. In the future, transition staff should take care to ensure documentation is completed timely.

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: Indicators 13 and 18, regarding IDT and LIDDA participation, again scored at 100% and with sustained high performance both might be moved to the category of requiring less oversight after the next review. Indicators 15, 16, 17 focus upon some specific considerations in planning for a transition, but were not addressed at all in the documentation. This can probably be easily corrected with certain prompts included at various times during the transition, and also including this in the CLDP document. It was good to see attention being paid to the quality of the transition assessments, and progress was noted, though more work needed to get to criteria. Pre move site reviews occurred; more thorough competency checking of provider staff was needed. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	359							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							

15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as 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 consistently meet criterion for this indicator. Even so, it was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. This remained an area of need, however. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Assessments provided for review often met criterion for timeliness. Findings included:
  - Individual #245's CLDP indicated the dental assessment had been updated to fall within 45 days of transition, but the assessment provided for review did not reflect the more recent dates of his dental assessment. The dental assessment was dated 7/31/17, but the CLDP indicated it had been updated on 9/12/17.
  - It was positive the IDTs documented review of the QDRR in the CLDPs.
  - The IDTs should also ensure they update the Integrated Risk Rating Form (IRRF) within 45 days of transition.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments did not consistently meet criterion. For example, the AMA for Individual #245 did not include information about his colonoscopy on 6/27/16, reporting instead that his most recent screening took place in 2015. The CLDP included a support for strategies to address sexual comments, inappropriate touching of others, and exposing himself, but the BHA did not provide any detail about this history.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition. For example, the vocational assessment for Individual #245 did not provide relevant recommendations for transition or focus on the new community settings. Instead, it indicated he would continue to work at the Main Work Center and be evaluated for the Forever Young, both on-campus programs at Richmond SSLC.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. Both CLDPs met criterion for this indicator. In addition to the detailed Transition Logs, Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA and Center staff. These were helpful in understanding how the Centers transition processes ensured necessary participation.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for these two CLDPs. Findings included:

- Although there was progress in this area, the IDTs did not yet consistently identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- It was positive the Center made an effort to define how provider staff competency would be confirmed that went beyond a written exam. To continue to move towards compliance, the Center should ensure the written exams it relies on to demonstrate competency are constructed to cover all essential knowledge. The testing materials the Monitoring Team reviewed fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Neither CLDP included this statement.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs.

- For Individual #245**,** the CLDP did not initially make a clear statement of the IDT's consideration of this need. The transition had been delayed from its originally scheduled date of 9/5/17 after the LIDDA completed a Pre-Move Continuity of Care visit to the home and called for the delay due to concerns about the adequacy of the bathroom set-up. The IDT then held a CLDP addendum meeting, at which time the IDT identified the need for habilitation therapy to complete a settings assessment. The IDT discussed the results of this assessment and made appropriate adjustments to CLDP supports at that time. To move toward compliance, the IDT should take care to complete these considerations from the outset of transition planning.
- For Individual #359, the CLDP did not include a statement of the IDT's consideration of this need.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the

community, and Facility and provider direct support staff meeting to discuss the individual's needs. Neither CLDP included the required statement or information.

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

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the neither of these two PMSRs accomplished this.

- For both individuals, the PMM relied upon implementation of pre-move training supports to confirm provider staff were prepared to implement supports as needed. As described above regarding indicators 1 and 14, the CLDP included numerous pre-move supports for pre-move training, but these did not yet fully meet criterion for ensuring that provider staff were competent for either individual.
- For Individual #245, the PMM also documented several pre-move supports were not in place, but did not document a specific plan to ensure and document their timely completion before the move. Missing pre-move supports included a ramp for wheelchair accessibility, grab bars installed in the toilet area, and the stationary bike. The Center also had not completed pre-move supports for a flu vaccination or to be seen by the podiatrist. Per the seven-day PMM visit documentation, most of these supports had been completed by the time of the transition, which was positive, but this should have been confirmed and documented prior to the seven-day post-move mark. The wheelchair ramp did not appear to have been in place at the time of the seven-day PMM visit, however, the documentation at the time of the 45-day indicated it was in place at that time, but did not give a date of accomplishment.
- The Center should have completed a PMSR for Individual #245 for the originally scheduled transition date of 9/5/17, and per interview, transition staff indicated this had occurred. The Monitoring Team requested to review this document to further evaluate whether the concerns raised by the LIDDA that resulted in the delayed transition, as described above in indicator 16, had also been accurately identified by the Center's pre-move processes. The Center did not provide the requested documentation

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Neither individual moved in a timely manner, however, for one individual, transition activities were occurring regularly and the delay was due, in part, to conducting a wider exploration of community options. For the other individual, some health factors delayed the transition, but other factors and activities that also delayed the transition could have been completed in a more timely manner by the IDT. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	245	359							
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	0/1	1/1							

Comments:

20. One of two CLDPs, for Individual #359, met criterion for this indicator.
    - Individual #245 was referred on 1/18/17 and transitioned on 9/20/17. Much of the delay was attributable to health concerns, including Dilantin toxicity and increased seizures, which were unavoidable. Other factors, including the need to obtain a competency evaluation and the LIDDA's concern about the bathroom accessibility, could have been identified and addressed in a timelier manner.
    - Individual #359 was referred on 11/4/16 and transitioned on 11/6/17. This also exceeded 180 days, but the Transition Log documented ongoing activity, at a reasonable pace, by transition staff and the IDT to facilitate the community exploration process.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - HHSC PI cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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