United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: December 3-7, 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 Team noted a number of problems related to issues with the provision of integrated clinical services. More specifically, although different documentation provided different numbers, over the six months prior to the review, a number of individuals had pressure ulcers and some individuals experienced multiple pressure ulcers, including Stage 3 and/or 4 ulcers. The Monitoring Team requested additional documentation, but it was not possible to determine the exact numbers of pressure ulcers individuals had experienced over the last six months (i.e., three different documents provided three different numbers), or other important information about the pressure ulcers, such as origin and time to healing. Center staff had not conducted a comprehensive review of pressure ulcer data,

and/or put effective plans in place to reduce individuals' risks to the extent possible. Individual #388 and Individual #535, who were part of the review group, provided examples of the lack of interdisciplinary team (IDT) and Physical and Nutritional Management Team (PNMT) integrated planning and implementation of plans to prevent and treat pressure ulcers.

In addition, in the previous six months, numerous individuals were diagnosed with pneumonia/aspiration pneumonia. Again, the numbers were difficult to confirm, but according to the Center's episode tracker, in the six months prior to the review, there were 34 diagnoses of pneumonia, and 25 of those were aspiration pneumonia. Moreover, as discussed in the section on mortalities, since the Monitoring Team's last review in March 2018, nine individuals died. At the time of the onsite review, at least four individuals who died had pneumonia listed as a cause of death. Although the cause of Individual #54's death, which occurred the week after the Monitoring Team's onsite review, was still pending, prior to his death, this 25-year-old was admitted to the hospital for pneumonia. At the Friday morning medical meeting, during the week of the onsite review, the status of seven of the eight hospitalized individuals was discussed. Six of the seven individuals were hospitalized with pneumonia. Individual #388 and Individual #599, who were part of the review group, provided examples of the lack of interdisciplinary team (IDT) and Physical and Nutritional Management Team (PNMT) integrated planning and implementation of plans to prevent and treat pneumonia.

The Medical Department included a review of pneumonia cases as part of the morning medical meeting. This methodology might not be adequate given the number of individuals diagnosed with pneumonia and the number of deaths attributed to pneumonia. A pneumonia committee might be a more effective mechanism for reviewing these cases in-depth.

Based on information provided, Center staff had not fully analyzed the data related to pneumonia and/or put effective plans in place to reduce individuals' risks to the extent possible. Based on a review of recent Quality Assurance/Quality Improvement (QA/QI) Committee minutes, dated 10/30/18, staff reviewed numbers by month, types of pneumonias (e.g., aspiration, bacterial), individuals' feeding routes, individuals with multiple aspiration pneumonias, and homes/units of individuals with diagnoses of pneumonia. Some discussion occurred related to individual cases in which the PNMT was involved. However, although staff speculated about different potential causes, they had not conducted full analysis of available information to help to narrow down potential contributing factors within the system. For example, based on review of the QA/QI Committee minutes, staff had not conducted in-depth assessment of whether or not IDTs and the PNMT were conducting quality assessments to determine the underlying causes or etiologies of individuals' pneumonia diagnoses. Other lines of inquiry would need to include

analysis of data related to, for example, immunizations of individuals and staff, Physical and Nutritional Management Plan (PNMP) monitoring, environmental surveys, infection control/hand washing, staff illness/sick-call, etc. This type of analysis is needed to provide the basis for any plan that is developed to address the issue.

Plans to address the pressure ulcer and pneumonia issue will need an interdisciplinary approach, including the Medical, Nursing, Habilitation Therapies, and Residential Departments, at a minimum. Based on the Center's analysis of information, a number of issues potentially would need to be addressed, such as improvement of IDT/PNMT assessments, development and implementation of needed supports to address the etiology of individuals' pneumonia diagnoses or pressure ulcers, the provision of appropriate vaccinations, revisions to reporting requirements for direct support professionals and nurses, wheelchair or positioning plan modifications, improvements in PNMP implementation, adherence to clinical pathways and nursing guidelines, etc. As the Lead Monitor discussed with the Center Director on the Friday of the onsite review, and the Monitors included in their formal exit comments, the Monitors requested urgent follow-up with regard to issues related to pneumonia, as well as pressure ulcers.

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, or were already in, the category of requiring less oversight. During this review, three other indicators sustained high performance scores and will be moved to the category of requiring less oversight. These were in restraint and abuse/neglect/incident management.

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

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

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

<u>Restraint</u>
Crisis intervention restraint continued to be well managed at Richmond SSLC. This was good to see, and was due, at least in part, to the Center's long-term restraint manager. There was some increase in the frequency of crisis intervention restraint over the second part of the nine-month review period. The Center, however, analyzed their data and showed that this was a function of the new admissions of two individuals. One restraint was discovered during video review of another restraint. It was good to see this video restraint review practice occurring. All psychiatry-related indicators for usage of crisis intervention chemical restraint continued to meet criteria.

During the onsite week, the Monitoring Team observed the usage of gloves with Individual #320 that raised questions about whether the usage might be PMR-SIB. The Center presented information during the onsite week and during the subsequent week further explaining the usage and their plan to monitor usage. Based on this, the Monitoring Team concurred that this was not PMR-SIB.

The Monitoring Team requested, and was provided with, a demonstration of two different types of SUR techniques (cross arm stabilization, arm neutralization) that had been used with an individual in the prior week. DSP staff from the home provided the demonstration. The demonstration showed that staff used these techniques in precisely the way described in the SUR Training Manual. This was good to see. Furthermore, the staff competently answered various questions about restraint application and usage following the demonstration.
Some attention needs to be paid to:

- Ensuring that IDTs thoroughly review any contra-indications for usage of crisis intervention restraints. In the past, Richmond SSLC had a special document/form on which they showed this discussion.
- Entering the correct IMRT information into the IRIS document.

It was positive that for most restraints reviewed, nurses initiated monitoring timely. However, many problems previously identified with regard to nursing assessments for restraints continued to exist (e.g., lack of detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; failure to follow the nursing guidelines related to the administration of chemical restraints; lack of assessments to determine whether or not individuals sustained injuries, etc.).

<u>Abuse, Neglect, and Incident Management</u>
Since the last review, the Incident Management department again experienced significant staff changes. At the time of the onsite review, the Center did not have an Incident Management Coordinator (IMC). Due, at least in part, to the absence of IMC leadership, overall, there was regression in performance regarding management of incidents, investigations, and abuse/neglect protocols at Richmond SSLC since the last review.

UIRs were lengthy and difficult to review and analyze. Most exceeded 40 pages, consisting primarily of cut and paste from other documents with little context or narrative that described investigatory activity. As a result, more than three-quarters of the monitoring indicators scored less than 100%. This included:

- Timely reporting of allegations and incidents.
- Timely completion of investigations.
- Immediate action following an allegation of ANE (primarily alleged perpetrator reassignment).
- Staff cooperation with HHSC PI investigators.
- Collection of relevant evidence and using it to reach investigation conclusions.
- Supervisory review detecting problems with investigations.
- Documentation to show investigation recommendation implementation.

The Monitoring Team, however, is optimistic that improvements will occur once a new IMC is appointed. Furthermore, the new Center Director has a strong background in incident management and, based upon observations of IMRT, Review Authority, QAQI Council, and other meetings, the Center Director will likely actively move the Center forward in this area.

Other
The IDT was doing some review of pretreatment sedation (in one case TIVA), however, not all required content was discussed. A strategy was developed, but not implemented or reviewed.

The Center needed to make improvements with regard to the completion of clinically significant Drug Utilization Evaluations (DUEs), as well as conducting follow-up on the studies completed.

Restraint

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

Summary: Richmond SSLC continued to have a good crisis intervention restraint management program. This was good to see, and was due, at least in part, to the Center's long-term restraint manager. Increases in restraint frequencies were related to individuals who were newly admitted. These indicators remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	139	140	314	298	320	672	72	543
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	73% 8/11	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	0/1	0/1	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 (February 2018 through October 2018) were reviewed. There was an ascending trend in the rate of crisis intervention restraint over the second part of the nine-month review period. The behavioral health services director provided a supplemental graph that showed the increase to be due to crisis intervention restraints for two individuals who were admitted within the past year. It was good to see this type of more in depth analysis of the overall restraint data. The frequency of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. In addition, the average duration of a crisis intervention physical restraint increased by more than one minute compared with the last review.

There were few occurrences of crisis intervention chemical restraint and no occurrences of crisis intervention chemical restraint. There were no usages of protective mechanical restraint for self-injurious behavior (PMR-SIB), however, during the onsite week, the Monitoring Team observed the usage of gloves with Individual #320 that raised questions about whether the usage might be PMR-SIB. The Center presented information during the onsite week and during the subsequent week further explaining the usage and their plan to monitor usage. Based on this, the Monitoring Team concurred that this was not PMR-SIB.

There were two reported injuries during the application of restraint, but they were deemed to be non-serious (however, see comments below in the outcome and indicators regarding nursing's post-restraint reviews and assessments). The number of individuals who had one or more crisis intervention restraints each month remained about the same as at the last review, at about eight.

The Center used non-chemical restraints for healing two times in the nine-month period. A decreasing trend in the usage of pretreatment sedation for conducting medical and dental procedures was evident in the data, graph, and narrative provided by the Center. The number of individuals who had TIVA remained about the same as at the last review (about 13 per month). The Center might consider cases where the individual might be able to transition from needing TIVA to a pretreatment sedation medication.

Thus, facility data showed low/zero usage and/or decreases in 8 of these 11 facility-wide measures (use of crisis intervention chemical and mechanical restraint, use of PMR-SIB, injuries during restraint, number of individuals who had restraint, use of non-chemical restraints, pretreatment sedation, and TIVA [pretreatment sedation for medical and dental were combined into a single measure by the Center).

Restraint reduction committee continued to be active. A meeting was not held during the week of the onsite review. Minutes from the three recent meetings showed review of restraints and of an application of Ukeru protocols.

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

2. Six of the individuals selected for review by the Monitoring Team were subject to restraint. Of these six individuals, six received crisis intervention physical restraints (Individual #218, Individual #139, Individual #314, Individual #298, Individual #672, Individual #543), and two also received crisis intervention chemical restraint (Individual #139, Individual #314). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for four of the six individuals. The other three individuals selected by the Monitoring Team had no restraints making a total of seven 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: One restraint was discovered during video review of another restraint. It was good to see this video restraint review practice occurring. Indicator 11 needs attention, that is, proper discussion and documentation. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	314	298	672	543				

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.	88% 7/8	1/1	2/2	1/2	1/1	1/1	1/1			
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.	0% 0/2	0/1	0/1							
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for six different individuals (Individual #218, Individual #139, Individual #314, Individual #298, Individual #672, Individual #543). Of these, six were crisis intervention physical restraints, and two were crisis intervention chemical restraints. 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. One restraint was identified (discovered) during video review of another restraint. Documentation did not include information for this indicator (or for many other indicators in this section of this report).

9. When criterion for indicator 2 is met, this indicator is not scored. That was the case for four of the six individuals. For the other two individuals, a functional assessment had not been completed and/or there was little evidence of implementation of informal strategies and engagement of the individual in activities.

11. Documentation in the IRRF or in the special form created by Richmond SSLC for its own use a few years ago, did not contain all of the required information regarding potential contra-indications for restraint usage.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary: Due to sustained high performance over this and the previous three reviews, indicator 12 will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	218	139	314	298	672	543				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1				
Comments: 12. In response to a request from the Monitoring Team, DSPs involved in a recent restraint with Individual #139 provided a demonstration of two types of SUR interventions. Their demonstrated was done correctly and, moreover, the staff competently answered a number of questions from the Monitoring Team, too.												

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: Due to sustained high performance, indicator 13 will be moved to the category of requiring less oversight. Indicator 14 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	314	298	672	543				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1			1/1							
Comments: 13. This activity was not conducted for the discovered restraint.												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: It was positive that for most restraints reviewed, nurses initiated monitoring timely. However, many problems previously identified with regard to nursing assessments for restraints continued to exist (e.g., lack of detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; failure to follow the nursing guidelines related to the administration of chemical restraints; lack of assessments to determine whether or	Individuals:

not individuals sustained injuries, etc.). These indicators will remain in active monitoring.											
#	Indicator	Overall Score	218	139	314	298	672	543			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	13% 1/8	1/1	0/2	0/2	0/1	0/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/8	0/1	0/2	0/2	0/1	0/1	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/8	0/1	0/2	0/2	0/1	0/1	0/1			

Comments: The restraints reviewed included those for: Individual #218 on 9/7/18 at 2:50 p.m.; Individual #139 on 9/1/18 at 10:50 a.m. (chemical), and 9/4/18 at 10:53 a.m.; Individual #314 for 6/29/18 at 4:48 p.m., and 6/29/18 at 5:26 p.m. (chemical); Individual #298 on 6/6/18 at 11:30 p.m.; Individual #672 on 7/13/18 at 9:08 a.m.; and Individual #543 on 9/1/18 at 1:55 p.m.

a. through c. Some positive findings included:

- For seven of the eight restraints, nurses initiated monitoring of the individual at least every 30 minutes from the initiation of the restraint. The only exception was for Individual #672 for whom a nurse was not notified of the restraint until an hour and a half after the initiation of the restraint.
- For Individual #218, the nurse properly monitored vital signs and mental status.

The following provide examples of problems noted:

- For Individual #218, in an IPN, dated 9/7/18, at 4:29 p.m., the nurse noted the individual was able to move her hands without difficulty, but the nurse did not document whether or not an assessment of range-of-motion in her shoulders was conducted, given that this type of restraint has the potential to cause an injury to this area.
- For Individual #139's chemical restraint on 9/1/18, the Restraint Checklist and Face-To-Face Debriefing data were not provided. A nursing IPN, dated 9/1/18, at 5:34 p.m., did not include the rationale for the chemical restraint, the dosage of the Haldol administered, the site the injection was administered, the individual's behavior while receiving the injection (e.g., whether he needed to be restrained for the injection), and/or an assessment to determine whether or not the individual sustained an injury. The Monitoring Team member could not interpret the Medication Administration Record (MAR) provided. Documentation was not provided to verify that nursing staff assessed the individual's vital signs, mental status, and behavior according to the applicable nursing guideline.
- For Individual #139's physical restraint on 9/4/18, a nursing IPN, dated 9/4/18, at 3:11 p.m., did not include specific descriptions of the individual's behaviors. It only noted he was "aggressive and combative." It was not clear from the documentation provided why he was sent to the Emergency Department (ED) via Emergency Medical Services (EMS), or what his status was at the time he was sent. Although the IPN noted he was refusing vital signs, it did not include an assessment of his cognition or mental status, or describe specific symptoms of his "acute psychosis." Based on the documentation provided, nursing staff did not complete and/or document assessments upon his return from the ED, or conduct additional follow-up. The nursing documentation did not describe an assessment to determine whether the individual sustained any injuries from

the restraint process.

- For Individual #314's physical restraint on 6/29/18, the IView documentation did not include a mental status assessment. The Center's response to the Monitoring Team's document request indicated that an IPN "could not be located." No nursing assessment to determine whether or not the individual sustained injuries was found.
- For Individual #314's chemical restraint on 6/29/18, the Center did not provide a PCP order. A nursing IPN, dated 6/29/18, at 7:39 p.m., did not provide a justification for the administration of the chemical restraint, a description of her mental status and behavior at the time, the time the chemical restraint was administered, the site where the injection was given, whether the individual was restrained when the injection was given, or whether the individual sustained any injuries. The nurse did not conduct and/or document vital signs and assessments in accordance with the nursing guidelines for a chemical restraint. The Monitoring Team member could not interpret the MAR provided.
- According to the Restraint Checklist, on 6/6/18, Individual #298's restraint occurred as a result of "aggression towards police officer," and it was discovered on video. State Office provides weekly information to the Monitors related to a number of different types of incidents, including any police contact. Based on review of these reports, State Office did not notify the Monitors of this incident.

  For this restraint, the Center did not provide a Face-To-Face Debriefing form. The Center's response to the Monitoring Team's document request indicated: "Discovered Restraint." The assessment found in IView, dated 6/6/18, at 9:55 p.m., did not indicate it was conducted in response to a restraint episode, nor did a status update that was documented in an IPN, on 6/7/18, at 8:12 a.m. Documentation did not indicate why the police officer was at the individual's home, except for the documentation on the Restraint Checklist that stated: "When a police officer walked into the home, individual jumped up from the couch and attempted to throw a table at him. Staff attempted to redirect him from attacking the police."
- For Individual #543's restraint on 9/1/18, Center staff did not provide an IPN, and indicated that it: "could not be located." This was concerning given that the Restraint Checklist indicated that Individual #543 was "sitting in bedroom with a tie tied around his neck. Staff tried to assist with removing the tie and he became aggressive." At this time, a nurse should have completed a suicide assessment, and then, reassessed the individual throughout the day, but documentation was not submitted to show this occurred.

  In its comments on the draft report, the State disputed this finding, and stated: "The face to face debriefing form (TX.RI.1812.1.50.b) shows a suicide assessment was completed by BHS staff and nursing completed an assessment and follow-up assessments." When a nurse responds to a situation in which an individual has made a suicidal gesture, such as tying a scarf around his/her neck, in order to ensure the individual is safe from harm, the licensed nurse has a responsibility to conduct a suicide assessment to evaluate the individual's mental state of mind as well as their physical status related to any injuries. Nurses administer medications for depression, anxiety, and mood disorders, and should be assessing and documenting these assessments for at-risk individuals, especially in the event an individual makes a suicidal statement or gesture. The documentation to which the State referred in it comments did not document such nursing assessments.

  The State has recognized that the demographics of the SSLCs is changing, particularly with the increase in admissions of individuals with significant mental health issues. If an individual with a history of suicidal ideation is admitted to a SSLC, the home nurse, Case Manager, and medication nurses working with the individual should complete training on conducting suicide

	screenings and assessments in order to meet the needs of that individual. Such training should clarify that it is an expectation that a licensed nurse assessing an individual that had just made a suicidal gesture would not only assess the individual's physical status, but also assess if they are still having thoughts and feelings of harming themselves. As appropriate, nurses should report these findings to the PCP and IDT.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: The restraint for Individual #314 6/29/18 was recorded and reported (in IRIS) as a 39-minute restraint, however, when interviewing the two staff who applied this restraint, they described a 39-minute episode of restraint-like behavior management efforts with only the last four or five minutes being an actual horizontal hold. Documentation for what was recorded as a 39-minute HO restraint, along with staff interview, showed confusing and contradictory data. Clearly, the IRIS form did not accurately record what happened during the 39 minutes. Given the Center's past high performance in restraint documentation, this indicator will remain in less oversight, however, the Center should ensure that restraint documentation is as correct as it has been in the past.			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: For indicator 16, IRIS forms did not have the customary entry documenting IMRT review. IMRT minutes did show that review occurred, which was good to see continuing to occur, but these data also belong on the IRIS form. While onsite, the Center provided a written statement describing actions that were to be immediately put into place to ensure proper entries are made in IRIS. This indicator will remain in less oversight due to the Center's history of sustained high performance in this and due to its plan to correct this.			Individuals:									
#	Indicator	Overall Score										
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.											

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: Proper protocols were followed regarding psychiatry's involvement in crisis intervention chemical restraint. With sustained high performance both of these indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	139	314								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 2/2	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. Two individuals in the review group had received crisis intervention chemical restraint during this review period. Individual #314 was given Geodon 20 mg IM on 6/29/18 and Individual #139 received Haldol 5 mg IM on 9/1/18. The post chemical restraint clinical review form for both of these incidents was reviewed by the clinical pharmacist and the psychiatrist within the required time frame. 48. Only one psychotropic medication was used for both of these episodes.												

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Supports were generally in place to reduce future likelihood of incidents occurring. This included PBSPs. SSLC requirements regarding individuals who received streamlined investigations, however, were not being followed. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	314	298	672	543	678		
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	1/1	2/2	3/3	2/2	1/2	1/1		
Comments: The Monitoring Team reviewed 12 investigations that occurred for seven individuals. Of these 12 investigations, seven were HHSC PI											

investigations of abuse-neglect allegations (one confirmed, three unconfirmed, one inconclusive, one unfounded, one referred back to Center for administrative review). The other five were for facility investigations of serious injuries (fractures of nose, clavicle), ingestion of a foreign object, an unauthorized departure, and a sexual incident.

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 #218, UIR 19-032, HHSC PI 47470398, administrative referral of a neglect allegation, 10/9/18
- Individual #139, UIR 18-247, HHSC PI 47398874, inconclusive allegation of physical abuse and neglect, 8/19/18
- Individual #314, UIR 18-203, HHSC PI 47115948, unconfirmed neglect allegation, 6/15/18
- Individual #314, UIR 18-200, witnessed ingestion of foreign object, 6/13/18
- Individual #298, UIR 18-218, HHSC PI 47227931, confirmed allegation of emotional abuse, 7/10/18
- Individual #298, UIR 18-231, HHSC PI 47327308, unfounded allegation of physical abuse, 7/26/18
- Individual #298, UIR 18-176, sexual incident, date unknown
- Individual #672, UIR 18-148, HHSC PI 46710808, unconfirmed allegation of physical abuse, 4/8/18
- Individual #672, UIR 19-023, witnessed fracture, nose, 10/5/18
- Individual #543, UIR 18-254, HHSC PI 47407814, unconfirmed allegation of physical abuse, 8/25/18.
- Individual #543, UIR 19-001, unauthorized departure, date unknown
- Individual #678, UIR 18-216, discovered fracture, clavicle, 7/2/18

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 investigations, criminal background checks and duty to report forms were completed and available for review. For eight of the 12, the investigation was regarding solely allegations of staff misconduct and, for each of these, there were no relevant individual-related trends to be reviewed.

For two of the other four investigations, the Center had data and reviewed trends (e.g., self-injury, unauthorized departure). For the remaining two, there was no prior history or occurrences (e.g., new admission, fall due to tripping on another individual's wheelchair). For Individual #543 UIR 19-001, the UIR incorrectly stated that unauthorized departures were not part of his PBSP, but this was not the case.

Five 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 two of these individuals (Individual #298, Individual #325). HHSC PI quarterly reviews were conducted regarding whether the individuals were

appropriate (i.e., met criteria) for streamlined investigations. The SSLC requirement that there be a plan to reduce/address the likelihood of future false allegations was not, however, in either of the PBSPs or in any other plan. The PBSP for Individual #298 mentioned that he does sometimes call DFPS and report incorrect information and that he should be assisted, if needed.

- 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: There were problems with proper reporting in more than half of the investigations (e.g., timeliness, to administrators). In general, the Center did not do a thorough consideration/exploration of the circumstances around reporting. This is a priority area for the Center to fix. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	218	139	314	298	672	543	678		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	42% 5/12	0/1	0/1	0/2	2/3	1/2	1/2	1/1		

Comments:

2. The Monitoring Team rated five of the 12 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.

Most reporting issues were related to incomplete and/or confusing information in the UIR. There was insufficient clarity to validate timely reporting and/or to be able to determine the reporting sequence.

- Individual #218 UIR19-032: The UIR showed that the incident occurred at 6:00 pm, was reported to the facility director/designee at 6:05pm, but was not reported to DFPS intake until 10:16 pm. This was, therefore, a late report. The UIR did not, however, show any attempt to explore or examine the circumstances around this late reporting.
- Individual #139 UIR 18-247: The incident occurred at 6:12 pm, was reported to the facility director/designee at 6:51 pm, and to DFPS intake at 7:27 pm. The UIR showed the reporter as unknown, but additional exploration of the late reporting was not done.
- Individual #314 UIR 18-203: Lack of clear description of the circumstances around this incident and the reporting made it impossible to determine if the incident was reported properly.
- Individual #314 UIR 18-200: The UIR did not show when the injury was determined to be a serious injury. Therefore, timely reporting could not be determined. Furthermore, on page 12 of the UIR, there was a statement that the incident was not

reported immediately.

- Individual #298 UIR 18-218: The individual was the reporter, however, the investigation stated that two staff were witnesses to the incident and did not immediately report it.
- Individual #672 UIR 18-148: This may have been self-reported by the individual, but the UIR did not explore this or any circumstances regarding reporting. The UIR states on page 2 that it was not reported within one hour and that there was no justification for not reporting within an hour.
- Individual #543 UIR 18-254: The HHSC PI report stated that the incident occurred at 2:00 pm and was reported at 3:48 pm. The report had two different times for facility director/designee notification, 4:42 pm and 3:31 pm. Confusing and conflicting UIR information and data should be identified in Facility review and, if there are special circumstances, they need to be presented 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: For the one individual to whom indicator 3 applied, questions were answered correctly. However, given the Center's problems in correct reporting (indicator 2, above), this indicator will continue to remain in active monitoring.

For indicator 4, the ISPs for four individuals did not have an adequate summary of the past year's injuries/incidents/allegations. This indicator will remain in less oversight, but this should be corrected.

Individuals:

#	Indicator	Overall Score	218	139	314	298	672	543	678		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1						1/1			
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										

Comments:

3. Because indicator #1 was met for six of the individuals, this indicator was not scored for them. For Individual #543, staff correctly answered the Monitoring Team's questions about identification of abuse and reporting of abuse.

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

Summary: Immediate re-assignment of alleged perpetrators did not occur in two

Individuals:

cases, and could not be determined in two other cases. In a fifth case, emotional assessment of the individual did not occur timely. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	218	139	314	298	672	543	678		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	58% 7/12	1/1	0/1	0/2	2/3	2/2	1/2	1/1		

Comments:

6. In five of the investigations, the alleged perpetrator was not immediately re-assigned to no direct contact with individuals (Individual #139 UIR 18-247, Individual #314 UIR 18-203), an emotional assessment was not conducted timely (Individual #298 UIR 18-218), or the Monitoring Team could not determine whether staff re-assignment did or did not occur (Individual #314 UIR 18-200, Individual #543 UIR 18-254).

Outcome 5– Staff cooperate with investigations.											
Summary: One-third of the investigations contained instances of staff failure to cooperate with investigatory procedures. This was a somewhat pervasive issue at the Center as evidence by the examples in the below comments. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	314	298	672	543	678		
7	Facility staff cooperated with the investigation.	67% 8/12	1/1	1/1	1/2	2/3	1/2	1/2	1/1		

Comments:

7. In four investigations, there was indication of staff failure to cooperate with the investigation:
   - Individual #314 UIR 18-200: The HHSC PI report noted a concern regarding staff interrupting Individual #314 in their interview. This is a problem because staff should not try to intervene in individuals' responses.
   - Individual #298 UIR 18-218: The HHSC PI report noted staff failures to show up for scheduled interviews.
   - Individual #672 UIR 18-148: The HHSC PI report expressed a concern that they attempted to contact the Center's social worker five times over a seven-day period with no response. HHSC PI was never able to conduct this interview.
   - Individual #543 UIR 18-254: The HHSC PI report noted that two staff did not respond to phone calls from the investigator. The Center, however, did subsequently implement re-inservicing for both staff.

In addition to the above four (out of 12) examples, during the onsite week, a recent investigation was discussed during review authority meeting on 12/6/18. It was regarding HHSC PI 47529622, an investigation in which HHSC PI reported about an attempt by one alleged perpetrator to influence the statement of another alleged perpetrator.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Investigations were not well written and indicated problems in the conduct of investigations. This needs attention from the Center and incident management department. Indicators 9 and 10 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	314	298	672	543	678		
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.	58% 7/12	1/1	0/1	2/2	2/3	1/2	1/2	0/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	58% 7/12	1/1	0/1	2/2	2/3	1/2	1/2	0/1		

Comments:
In general, it was difficult for the reader to understand the investigatory activities in the investigation reports (the UIRs). There was much content that was cut and pasted from other documents, such as detailed nurse reports, detailed PBSPs, repeat of what was already in the HHSC PI report, and so forth. Because of this, many UIRs were 40 to 50 pages long. Little/no content was devoted to investigating or summarizing what all those notes might mean. Content/notes that indicated a complication, or revealed important information, did not also include exploration of those circumstances.

9-10. The investigations scored 0 did not meet criteria because they did not include interviews with all relevant staff or video review when possible, did not involve deeper Center investigation of inconclusive findings, and/or included blank analysis of evidence sections of the UIR.

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: Three investigations did not have documentation of completion within the required timelines. Two of these three had confusing/absent information. This needs to be corrected if this indicator (12) is to remain in the category of requiring less oversight after the next review. Indicator 13 will remain in active monitoring. Improvements to the Center's investigation review process are needed. Given the Review Authority and IMRT meetings observed during the onsite week, the Monitoring Team expects there to be improvement seen at the next review.			Individuals:									
#	Indicator	Overall Score	218	139	314	298	672	543	678		
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the									

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).	category of requiring less oversight.									
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.	0% 0/12	0/1	0/1	0/2	0/3	0/2	0/2	0/1		

Comments:

12. Three investigations did not meet criteria. One (Individual #298 UIR 18-218) was completed in 13 days with no extension. Two others did not contain enough information to make a determination (Individual #218 UIR 19-032, Individual #298 UIR 18-176). In a comment on the draft version of this report, the State commented that HHSC PI delivered the completed investigation for UIR 18-218 to the facility on Monday, 7/23/18. But even so, the signature date by the investigator showed 7/23/18, which is what is used to determine scoring for this indicator. In another comment, the State wrote that UIR 19-032 was completed by HHSC PI on time. This is correct. But the allegation involved in this investigation was referred back to the Center (i.e., an administrative referral). There was no date or information in the Center's UIR as to when the Center completed its investigation.

The Center provided minutes of the quarterly OIG/APS/ICF-Regulatory meetings (5/23/18, 10/24/18). The minutes showed a good exchange of information and discussion.

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 most of the investigations, nothing was submitted to document post investigation review by the IMRT or a Review Authority. For those for which a Review Authority form was submitted, the forms were incomplete.

A new process, however, began about a month prior to the onsite review. Two of these Review Authority meetings were observed by the Monitoring Team. They were led by the Center Director. There was good discussion and recommendations generated for the four cases that were reviewed. Furthermore, the Monitoring Team also observed IMRT meetings throughout the onsite week. The meetings were also facilitated/led by the Center Director. There was good communication and interaction between those in attendance.

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: The Center had correctly re-instated its significant injury audit protocol. Therefore, indicator 14 will be returned to the category of requiring less oversight. On the other hand, non-serious injury investigations were not conducted correctly	Individuals:

or completed once started for all three individuals who had one or more non-serious injuries for which an NSI investigation form should have been completed. Indicator 15 will remain in active monitoring.											
#	Indicator	Overall Score	218	139	314	298	672	543	678		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	57% 4/7	1/1			1/1	1/1		1/1		
Comments: 15. Four individuals did not have any non-serious injuries for which an NSI investigation was required. The other three individuals had one or more non-serious injuries to which an NSI investigation should have been done, but either it was not done or was not completed (i.e., 0/3 individuals).											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: Two investigations did not meet criteria with indicator 16 because there were poorly worded recommendations (Individual #314 UIR 18-203) or important topics for recommendations/actions were absent (Individual #543 UIR 19-001). Recommendations were not implemented for many investigations. Indicators 17 and 18 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	314	298	672	543	678		
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.	43% 3/7	0/1	1/1	0/2	0/1	1/1	1/1			
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	75% 6/8	0/1			2/3	1/1	2/2	1/1		
Comments: 17. Three investigations had recommendations for disciplinary actions and these were taken timely. For the other four, either there was no documentation showing implementation, or evidence/documentation provided did not show that the recommendation was actually implemented.											

There were two cases in which there was a confirmation of physical abuse category 2. In both cases, the employment of the confirmed staff member was terminated.

18. For two cases, there was no documentation showing the recommended programmatic actions were taken (Individual #218 UIR 19-032, Individual #298 18-218).

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Trend data, analysis, and actions were not at criteria. 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. Four of the required data sets were not being tracked and trended: staff and individuals.

20-23. There was some descriptive analysis of some data sets, but no analysis tying anything together. Reports were quarterly, but they should include longitudinal data, which these did not. Some important data went unnoticed/un-reviewed. For instance, there were 34 serious injuries, and nine confirmed cases by HHSC PI in the Monitoring Team's tier 1 documents.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542

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

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

In its comments on the draft report, the State requested clarification and stated: "The policy was developed with assistance from the anesthesiologists. Specific suggestions for improvements would be helpful." The TIVA Selection Criteria policy provided a list of criteria to be used in evaluation for TIVA. A number of high-risk conditions were excluded. The medical staff also completed a "medical clearance" assessment. This statement incorrectly implies the procedure carries no risk for the individual. Dental surgery is considered a low-risk procedure; however, the individual may have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address, perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery.

For this use of TIVA for Individual #535, informed consent was not present (i.e., two dentists and one MD were supposed to see the individual, but only one dentist and one MD saw the individual). However, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and nurses completed post-operative vital sign flow sheets.

b. For Individual #320, the Center did not submit evidence of interdisciplinary discussion regarding the medication and dosage. Evidence of informed consent was not found for either use of pre-treatment sedation for dental procedures. For its use on 8/23/18, staff did not document confirmation of the individual's nothing-by-mouth status, although, for the use of pre-treatment sedation on 5/10/18, they did.

On a positive note, for both uses, nurses documented pre- and post-procedure vital signs, and the Dentist wrote a note describing the procedures and assessments completed.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	If the individual is administered oral pre-treatment sedation for	N/A									

	medical treatment, proper procedures are followed.											
	Comments: a. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical procedures.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.												
Summary: The IDT was doing some review of pretreatment sedation (in this case TIVA), however, not all required content was discussed. A strategy was developed, but not implemented or reviewed. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/1				0/1					
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 1/1				1/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 1/1				1/1					
4	Action plans were implemented.	0% 0/1				0/1					
5	If implemented, progress was monitored.	0% 0/1				0/1					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1				0/1					
Comments: 1-6. This outcome and its indicators applied to Individual #314's 6/25/18 TIVA. 1. Available documentation for Individual #314 had evidence of informed consent, but not the other required content. 2-3. Individual #314's treatment strategy (quarterly teeth cleanings) was based upon the hypothesized cause, in the ISPA, and written												

as an action plan.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	666	500	384	758					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 5/7/18, Individual #666 died at the age of 54 with causes of death listed as pneumonia, respiratory failure, and septic shock.
- On 5/9/18, Individual #284 died at the age of 56 with causes of death listed as respiratory failure.
- On 6/15/18, Individual #500 died at the age of 54 with causes of death listed as septic shock, pneumonia, and status epilepticus.
- On 6/22/18, Individual #412 died at the age of 71 with causes of death listed as cerebral palsy, and sepsis.
- On 6/24/18, Individual #384 died at the age of 63 with causes of death listed as pneumonia, respiratory failure, and septic shock.
- On 7/12/18, Individual #515 died at the age of 65 with cause of death listed as pneumonia.

- On 9/1/18, Individual #758 died at the age of 58 with causes of death listed as septic shock, multi-system organ failure, and acute respiratory distress syndrome.
- On 10/29/18, Individual #372 died at the age of 80 with cause of death listed as renal cell carcinoma of the left kidney with metastasis to the lung.
- After the Monitoring Team's onsite review, on 12/19/18, Individual #54 died at the age of 25 with causes of death pending. The Monitoring Team has requested further information related to this individual's death. Prior to his death, he was admitted to the hospital for pneumonia.

Since the Monitoring Team's last review in March 2018, the number individuals who died was concerning, and Center staff should engage in additional analysis to determine commonalities that might need to be addressed. At the time of the onsite review, at least four of the eight individuals who died had a diagnosis of pneumonia. Although the cause of Individual #54's death, which occurred the week after the Monitoring Team's onsite review, was still pending, prior to his death, he was admitted to the hospital for pneumonia. Moreover, during the Friday morning medical meeting, during the week of the onsite review, the status of seven of the eight hospitalized individuals was discussed. Six of the seven individuals were hospitalized with pneumonia. The Medical Department included a review of pneumonia cases as part of the morning medical meeting. This methodology might not be adequate given the number of individuals diagnosed with pneumonia and the number of deaths attributed to pneumonia. A pneumonia committee might be the more effective mechanism for reviewing these cases in-depth.

Based on information provided, Center staff had not fully analyzed the data related to pneumonia and/or put effective plans in place to reduce individuals' risks to the extent possible. Based on a review of recent QA/QI Committee minutes, dated 10/30/18, staff reviewed numbers by month, types of pneumonias (e.g., aspiration, bacterial), individuals' feeding routes, individuals with multiple aspiration pneumonias, and homes/units of individuals with diagnoses of pneumonia. Some discussion occurred related to individual cases in which the PNMT was involved. However, although staff speculated about different potential causes, they had not conducted full analysis of available information to help to narrow down potential contributing factors within the system. For example, based on review of the QA/QI Committee minutes, staff had not conducted in-depth assessment of whether or not IDTs and the PNMT were conducting quality assessments to determine the underlying causes or etiologies of individuals' pneumonia diagnoses. Other lines of inquiry would need to include analysis of data related to, for example, immunizations of individuals and staff, PNMP monitoring, environmental surveys, infection control/hand washing, staff illness/sick-call, etc. This type of analysis is needed to provide the basis for any plan that is developed to address the issue.

Plans to address the pneumonia issue would need an interdisciplinary approach, including the Medical, Nursing, Habilitation Therapies, and Residential Departments, at a minimum. Based on the Center's analysis of information, a number of issues potentially would need to be addressed, such as improvement of IDT/PNMT assessments, development and implementation of needed supports to address the etiology of individuals' pneumonia diagnoses, the provision of appropriate vaccinations, adherence to clinical pathways and nursing guidelines, etc. As the Lead Monitor discussed with the Center Director on the Friday of the onsite review, and the Monitors included in their formal exit comments, the Monitors requested urgent follow-up with regard to issues related to pneumonia.

b. through d. Evidence was not submitted to show the Facility conducted thorough reviews of nursing care and/or medical care, or an analysis of medical/nursing reviews to determine additional steps that should be incorporated in the quality improvement process. As

a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. Some of the problems noted included:

- For Individual #666, it was difficult to determine if the necessary medical recommendations were identified. The clinical death review (CDR) focused on the 72 hours before his death. The causes of death were pneumonia, sepsis, and respiratory failure. This individual had multiple admissions to the hospital due to aspiration pneumonia. A review that focused on the last 72 hours of life is unlikely to reveal information related to clinical care that is necessary to identify potential problems, and proactively address them to prevent their recurrence with other individuals. The focus of the review should have been the long-term care for this individual over the past year. The family requested aggressive management. The review should have addressed the issues of aspiration and pneumonia and whether the supports were adequate. (e.g., following hospitalizations, the IDT should have conducted thorough reviews to determine if and how the supports should be altered to minimize a repeat recurrence of aspiration pneumonia).
- For Individual #500, the CDR did not address several issues. According to the nursing death review, the individual received timely follow-up from an epileptologist. He also had a history of kidney stones and urinary tract infections (UTIs), but continued to receive Topiramate. According to the clinical death review, there appeared to be an association between seizures and the development of UTIs (i.e., UTIs might have lowered the seizure threshold). The individual had recurrent kidney stones and recurrent UTIs, and the CDR discussed UTIs as a causal factor for seizure development. However, the individual continued to receive an AED that is associated with the development of kidney stones. The CDR briefly mentioned the association of Topiramate with the development of kidney stones and the possibility of replacing Topiramate with another anti-epileptic drug (AED) due to this association, but there was no recommendation to address this potential concern for other individuals.
- On 4/24/18, Individual #384 was hospitalized with severe hyponatremia with a sodium of 121. It was also documented that she had hypokalemia. The CDR did not provide additional information for the diagnosis of hyponatremia (i.e., was the hyponatremia acute or chronic?). If the hyponatremia was chronic, there should have been an evaluation to determine the etiology and treatment implemented. Several individuals the Monitoring Team reviewed were diagnosed with hyponatremia, so the PCPs should be knowledgeable about the appropriate workup for hyponatremia. Additionally, the PCPs should refer the individuals to the appropriate specialist, such as nephrology or endocrinology, to assist with the management of hyponatremia.
- For Individual #758, the CDR did not adequately address the issue of the critical labs. The CDR stated that the individual's critical lab values were consistent with Stage II chronic kidney disease (CKD). As the Medical Director agreed during interview with the Monitoring Team member, this statement was inaccurate. The blood urea nitrogen (BUN)/Creatinine levels documented in the labs were:
    - 5/29/18 - 31/1.17;
    - 6/5/18 - 26/1;
    - 7/2/18 - 25/1.05;
    - 7/23/18 - 30/1.28; and
    - 8/31/18 - 60/1.99.

  The 8/31/18 values were not consistent with Stage II CKD. The change in BUN and creatinine were acute changes and were not consistent with the previous stable lab values. These critical elevations might have indicated the presence of a serious condition, such as severe dehydration or a gastrointestinal bleed. This problem (an acute and marked increase in the BUN) should have been addressed immediately, rather than being referred to the PCP for evaluation during sick-call. The individual was found unresponsive and in cardiac arrest shortly after the critical labs were reported. During the onsite review, these

issues were discussed with the Medical Director. While it is not clear whether or not the outcome would have been different had staff taken additional steps while waiting for transfer of the individual to the hospital (e.g., starting intravenous fluids), the CDR did not address the issue of the PCP's management of an acute elevation in the BUN.

- Although incomplete, the nursing mortality review for Individual #758 raised further concerns regarding her care and treatment. For example, the report concluded that documentation "did not support" that nursing staff administered Suplena three times a day, or that nurses completed enteral water flushes ordered in July 2018 (250 milliliters) every four hours. Although the QA nurse recommended that: Center staff: "Revisit Dietary/Care Management orders for individuals on Leon (home) who are enterally fed to ensure that diet/supplement/water flush orders are being implemented," this recommendation should have been expanded to all applicable homes on campus. The QA nurse also recommended: "Nurses on Leon should be retrained to use the facility form to document enteral feedings/supplements/flushes and a random audit for 3 months will be completed." It was not clear that three months of monitoring was sufficient. As the Monitoring Team has pointed out during several onsite reviews as well as in reports, fluid intake and its tracking have been problematic, due to what appears to be problems with Care Tracker and IRIS documentation. Moreover, although the Center provided a number of emails that included amount and frequency of fluid intake, it was not clear which individuals had specific orders for fluid intake, and if staff had implemented and documented these orders as written.
- For Individual #384, the Center provided the Quality Improvement Death Review of Nursing Services that included a summary of events from her last hospitalization in April 2018 to her death on 6/24/18. Consequently, the mortality review did not address any of her nursing care and services while at the SSLC. Although the review indicated that the goals for each area of the IHCP had been "met," the Quality Assurance (QA) nurse did not comprehensively review the quality and clinical appropriateness of the goals and interventions contained in the IHCP. In addition, the report noted: "ACPS [acute care plans] - not reviewed. Rationale: Acute care plan training is currently being scheduled to ensure Nurses are implementing plans to address acute health issues using the newly revised training for Acute Care Plans. After training is completed, care plan audits will be conducted to evaluate competency and that Nurses are proactively implementing plans to address elements in a preventative approach." It was concerning that the QA nurse did not review acute issues and care plans. Regardless of whether training was underway to correct problems with the development and implementation of acute care plans, this individual's mortality review should have assessed the care provided to her to address acute as well as routine nursing care, particularly given that the reason for the training was previous concerns about the quality of acute care plans and their implementation.
- Overall, most nursing reviews did not include review of pertinent information from the electronic record related to the quality and appropriateness of nursing assessments; acute care plans; the Integrated Health Care Plan (IHCP) goals, interventions and implementation; the Integrated Risk Rating Form (IRRF) documentation regarding risk ratings; the nursing comprehensive annual, and nursing quarterly assessments; and/or the documentation of care and follow-up. Often, the recommendation sections of the reports identified some significant issues and recommendations, but the reports did not include information to support them.
- Although Individual #666's Quality Improvement Death Review of Nursing Services reflected a summary of acute events starting from 11/9/17, and a review of ACPs, QIDP integrated reviews, IRRF risk ratings, IHCPs, immunizations, and nursing annual and quarterly assessments, this review was not comprehensive. As the Monitoring Team has previously recommended, training for the QA Nurses regarding conducting mortality reviews is needed.

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, although some improvement was noted, the recommendations were not consistently written to ensure that changes made resulted in improved outcomes or outputs. For example, for Individual #500, one recommendation read: "Within 45 days of death review, Trinity Nurses should be retrained to use Nursing Care Guidelines templates for IPN documentation of seizures and enter results of seizure activity and assessments in IView." Although Center staff submitted the curricula and training rosters, there was no indication that staff put a monitoring system in place to ensure nurses correctly completed IPN and IView documentation when individuals experienced seizures. As a result, it was not clear that concerning practices changed.

In addition, even when staff identified follow-up activities to ensure that the expected outcome of the corrective action was achieved, documentation did not support successful completion. For example, a recommendation related to Individual #384's death read: "Within 45 days, Case Managers should meet with facility IDT to address timeliness in following recommendations of consultations such as GJ [gastrostomy/jejunostomy] tube leakage/dislodgements and other health issues and monitor random consultations monthly Xs [times] 3 months to ensure recommendations are addressed." Center staff provided some IPNs that mentioned treatments and/or recommendations from the PCPs or consultations, but the documentation did not validate that consultation recommendations were timely implemented. In addition, Center staff did not include data to show how many consultations or recommendations occurred (N) in comparison with how many were reviewed to provide an indication of whether the sample was representative of actual practice.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	ADRs are reported immediately.	33% 1/3	1/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	33% 1/3	1/2				0/1				
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	33% 1/3	1/2				0/1				
d.	Reportable ADRs are sent to MedWatch.	0% 0/2	0/1				0/1				

Comments: a. through d. On 6/1/18, staff reported that Individual #672 had leukopenia. Staff completed an adverse drug form identifying two drugs that potentially caused it, and completed one probability scale.

- In its comments on the draft report, the State disputed this finding, and stated: "The clinical pharmacist noted there was an option to add two drugs within the 'suspected drugs involved' field in RL solutions (TX-RI-1812-IV.19 page 4 of 7). Therefore, another form was not initiated since the leukopenia may have been caused by the two antipsychotics, and the probability scale applied to both medications. (TX-RI-1812-IV.19, page 6 of 7). The probability scale used by the center is the Naranjo Adverse

Drug Reaction Probability Scale. This scale is used for determining the likelihood of whether an ADR is actually due to a drug rather than the result of other factors. It is not drug specific."

- It is unclear why the State disputed the Monitoring Team's findings. The Monitoring Team assigned all positive scores with regard to the Center's handling of this potential ADR, and merely commented that one form was used in completing the probability scale. The Monitor made no changes to the original finding.

Individual #672 had chronic hyponatremia that was attributed to the use of Depakote. Therefore, she received daily salt tablets. There was no documentation that the hyponatremia was reported as a potential adverse drug reaction.

Individual #599 had thrombocytopenia that was attributed to Phenytoin, but no ADR form was submitted.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: The Center needed to make improvements with regard to the completion of clinically significant DUEs, as well as conducting follow-up on the studies completed. These indicators will continue 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.	50% 1/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	50% 1/2

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

- On 10/30/18, the Center completed a study that they labeled as a DUE. The rationale was to evaluate the safety and effectiveness of Clobazam use for the treatment of seizure disorders as some individuals were receiving dosages above the Federal Drug Administration (FDA)-recommended dosage of 40 milligrams (mg) per day despite concurrent use with other anti-epileptic drugs (AEDs). The conclusion was that less than half of the individuals were obtaining benefit from Clobazam use. The recommendation was to consider broad spectrum agents, such as Valproic acid and lamotrigine.

  Achieving the goal of determining the overall safety and effectiveness of Clobazam by conducting a DUE with a small sample size would be difficult, and as such, this was not considered a clinically-relevant DUE. The effectiveness of this drug has been studied in large randomized clinical trials. If individuals do not have adequate seizure control or remain refractory, a more appropriate recommendation would have been to refer the individuals to an epileptologist for further evaluation.
- On 7/30/18, a DUE on phenytoin that was presented to the P&T Committee. The rationale for the DUE was to ensure adequate monitoring of phenytoin levels, make sure the dose was optimized, and minimize adverse drug reactions. Based on data related to the number of seizures and therapeutic levels, the conclusion was that it appeared that most of the individuals were deriving some benefit from phenytoin.

	There was no specific plan of correction. However, the P&T minutes for the 10/30/18 meeting included a follow-up DUE that addressed the issues for each individual.

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, 26 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, four other indicators were moved to this category, in ISPs, psychiatry, and skill acquisition.

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

Assessments

Full sets of assessments were not determined for the individuals, though the IDTs did do a better of obtaining those assessments that they had deemed as necessary. Individuals had current FSA, PSI, and vocational assessments. Less than half of the assessments included recommendations for SAPs.

In psychiatry, CPE content was complete. Documentation prepared by psychiatry for the annual ISP was complete. Psychotropic medication risk-benefit discussion and information was in the consent forms. In general, however, there was very little information relative to psychiatric services in the Behavioral Health section of the IRRF. Center-wide data indicated that psychiatry was not attending most of the ISPs, without psychiatrist participation in the decision to attend and without rationale if he or she did not attend.

In behavioral health, clinicians need to ensure that interim PBSPs are replaced by complete PBSPs based on a functional assessment within at least three months from the admission of the individual.

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.

On a positive note, for seven of the nine individuals reviewed, PCPs completed the annual medical assessments (AMAs) in a timely manner. Quality of the AMAs still needed improvement, particularly with regard to inclusion, as applicable, of complete family histories, childhood illnesses, and plans of care for each active medical problem, when appropriate.

Individuals reviewed frequently did not have annual dental exams completed within 90 days of the ISP meeting, which impacted the availability of updated information in the annual dental summaries that IDTs used for planning purposes. However, improvement was noted with regard to the quality of dental exams.

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

It was positive that as needed, Registered Nurses (RNs) completed Post Hospitalization Reviews for the individuals reviewed, and the PNMT discussed the results. In comparison with previous reviews, this was a significant improvement. Improvements are needed with regard to the timely referral of individuals to the PNMT, and/or the PNMT making self-referrals of individuals who meet criteria. When referrals occurred, the PNMT conducted timely reviews for the individuals the Monitoring Team reviewed, but the quality of the reviews needed improvement. The quality of PNMT comprehensive assessments for the two individuals varied considerably, but neither identified a comprehensive set of recommendations to address the individuals' needs and the underlying etiologies of their PNM issues.

The Center's performance with regard to the timeliness of OT/PT assessments needs improvement, including for annual updates/assessments, as well as when individuals experienced changes in status requiring assessment. Overall, the quality of the OT/PT assessment updates required substantial improvement.

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

Individualized Support Plans

Most QIDPs, during interviews, demonstrated an improved level of knowledge about needs and preferences of the individuals they serve. This was good to see. The QIDP department continued to develop strategies and systems for enhancing QIDP performance overall. For example, (a) the QIDPs now met each week for training and information sharing, and (b) there was an emphasis on improving tracking and follow-up of ISPA action steps, which had yielded some early positive results in some cases.

Richmond SSLC showed progress in the number of goals that were individualized and meaningful (from 12 to 17), the number that were written in measurable terminology (from one to 10), and the number for which there were reliable data (from one to six). There was a range of performance across individuals. That is, for one individual, there were good goals in five of the six areas, whereas for another individual there was a good goal in one of the six areas. To be more specific, the Center had made progress toward developing personal goals that addressed important relationships in meaningful ways, but considerable work remained to be done for employment goals.

Regarding planning to meet the goals, none of ISPs had a full complement of action plans that laid out a clear path to meet each goal. Some goals had no action plans that were clearly related.

Individuals participated in their ISPs. For example, Individual #72 actively co-facilitating his annual meeting. This took planning and practice with Individual #72 and his QIDP. The ISP document and the annual meeting observed for Individual #72 met criteria with all of the indicators regarding most integrated setting planning. This was good to see and demonstrated that Richmond SSLC had the capacity to do so for all individuals.

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.

ISPs were not consistently implemented in a timely manner.

In psychiatry, Richmond SSLC appeared poised to move forward regarding the development of psychiatric indicators and goals, but had not yet done so. That is, to choose relevant psychiatric indicators for decrease and for increase, to put them into goals that are in the ISP/IHCP, and to collect data on these indicators. The temporary absence of an onsite psychiatry lead may hamper efforts in the short term.

Behavioral health services continued to be a real strength of the Center. Behavioral health services maintained its generally good performance despite losing key staff since the last review, including the director of the department. In behavioral health Richmond SSLC continued to engage in activities to collect PBSP data and to increase the likelihood that those data were reliable. Seven of nine met criteria with indicator 5. This was good to see.

In skill acquisition, there was improvement in some areas. First, all individuals had at least one SAP. On the other hand, all of these individuals could have benefited from additional skill acquisition opportunities. There was an increase in the percentage of SAPs for which there were reliable data.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: Richmond SSLC showed progress in the number of goals that were individualized and meaningful (from 12 to 17), the number that were written in measurable terminology (from one to 10), and the number for which there were reliable data (from one to six). There was a range of performance across individuals. That is, for one individual, there were good goals in five of the six areas, whereas for another individual there was a good goal in one of the six areas. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	140	320	672	72	678	599				
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	3/6	2/6	1/6	5/6	3/6	3/6				
2	The personal goals are measurable.	0% 0/6	2/6	0/6	0/6	3/6	3/6	2/6				
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	1/6	0/6	0/6	2/6	1/6	2/6				

Comments:
The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #678, Individual #140, Individual #599, Individual #320, Individual #672 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.

Although not part of the criteria for this indicator, 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.

Richmond SSLC's IDTs continued to work toward developing personal, measurable goals. For this review period, none of the six ISPs

contained individualized goals in all areas; therefore, none had a comprehensive set of goals that met criterion. Still, Richmond SSLC continued to make progress in this area, as described below.

1. During the last monitoring visit, the Monitoring Team found 12 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, 17 personal goals met criterion. Findings included:

- The personal goals that met criterion were the leisure goals for Individual #678, Individual #140, and Individual #72; the relationship goals for Individual #678, Individual #140, Individual #599, Individual #320, and Individual #72; the work goals for Individual #678 and Individual #72; the independence goals for Individual #140, Individual #599, and Individual #72; and, the living options goals for Individual #599, Individual #320, Individual #672 and Individual #72.
- Of the remaining personal goals, many were not aspirational.
- As reported in the previous monitoring report, 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.
- It was also positive the Center had made progress toward developing personal goals that addressed important relationships in meaningful ways. Examples included teaching Individual #72 to Skype so that he could maintain weekly contact with his family and expanding Individual #678's relationship with a special friend to include community participation. While these were positive examples, the Center still needed to ensure these well-developed goals were implemented.
- Considerable work remained to be done for employment goals.
    - Two individuals (Individual #678, Individual #72) had aspirational personal goals that met criterion for reflecting their preferences in this area. Individual #678 had a goal to volunteer part time as praise team member in the music department at the Center, with a longer-term aspiration to participate in musical activities in a community church. Individual #72 had a goal to get a job as an office clerk, which he confirmed as his preference during the annual ISP meeting held onsite during this monitoring visit. Again, however, there had been little movement towards achievement of these goals.
    - The remaining four individuals had goals that did not reflect any personal preferences for work or meaningful day activity. For example, three individuals (Individual #140, Individual #599, Individual #672) only had goals for attendance.

2. The Monitoring Team reviewed the 17 personal goals that met criterion for Indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 17 personal goals, 10 met criterion for measurability. This was a significant improvement from the last monitoring visit, when one was deemed to be measurable. For the remaining personal goals, the IDT often stated the goals in broad terms without projecting a timeframe for, or a clear path toward, achievement.

3. For the 10 personal goals that met criterion in indicator 2, six had reliable and valid data and also met criterion for this indicator. These were the relationships goal for Individual #678, the independence goal for Individual #140, the relationships and independence goals for Individual #599, and the leisure and living options goals for Individual #72. This also represented progress since the previous monitoring visit, when one personal goal was found to have such data. In large part, this improvement reflected a corresponding improvement in the reliability and validity of data collected for skill acquisition programs (SAPs), as discussed elsewhere in this report.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: Scoring overall remained low for this set of indicators. However, there was some improvement in indicators 8, 9, 10, and 11. 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	140	320	672	72	678	599			
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	0/6	1/6	4/6	1/6	2/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	1/1	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. Overall, none of six ISPs had a full complement of personal goals that laid out a clear path of assertive action plans to meet each goal. Some goals had no action plans that were clearly related. For example:

- For Individual #678, the ISP did not include any specific action plans for her day goal of volunteering as member of the praise team at the Center.
- For Individual #320, the IDT recommended the LAR research homes for the visually impaired and could also benefit from coordinating with the social worker and transition department for the purpose of implementing her living options goal. The IDT did not develop specific action plans to implement these strategies.

Still, it was positive the IDTs had made some progress in this area. The Monitoring Team identified ten goals that included relevant action plans. Examples included:

- Individual #140's leisure goal to walk independently was supported by action plans for direct physical therapy and gait training as well as other strategies that might strengthen her lower limbs, such as swimming.
- Individual #599's relationships and independence goals focused on his ability to communicate effectively and his action plans included both a communication SAP and direct speech therapy.

9. One of six ISPs contained a set of action plans that clearly integrated both preferences and opportunities for choice in an assertive manner. Findings included:

- Individual #678's ISP met criterion. The IDT integrated her enjoyment of music across several goal areas and evidenced collaboration between the speech/language pathologist (SLP) and behavioral health staff for making choices through the use of an augmentative/alternative communication device (AAC).
- For four of the five remaining individuals (Individual #140, Individual #320, Individual #672, Individual #72), IDTs often developed action plans that integrated preferences, but offered few opportunities for choice-making.
- For Individual #599, the IDT developed a good approach for teaching him to indicate choice through AAC, but had not appropriately assessed his preferences for integration into his action plans. His Preferences and Strengths Inventory (PSI) indicated he was newly admitted and that his preferences in many instances had not been determined, however, at the time the PSI was completed, he had been at the Center for 10 months. This was ample time to assess his preferences in an assertive manner.

10. One of six ISPs (Individual #599) addressed strengths, needs, and barriers related to informed decision-making. This assessment was based on the integration of communication action plans to communicate his choices. Other findings included:

- While Individual #678 also had action plans that addressed communication and choice, this indicator was judged to not meet criteria because the ISP failed to address another significant need in this area. The IDT had determined that she needed guardianship for possible community living, but did not develop a related action plan.

- For Individual #672, the IDT had not made an accurate and thoughtful assessment of her decision-making strengths and needs or developed needed action plans. Her Individual Capacity Assessment (ICA) was completed in a rote, cut and paste, manner. For each area of competency, the IDT provided only the following statement: the IDT, with input from the LAR, makes decisions on her behalf and will identify any areas of need and ensure all support and services are implemented to ensure her needs are met throughout her daily routine, in addition to providing training opportunities in the areas identified. Without the benefit of an adequate assessment, the ISP did not integrate needed action plans.

11. One of six (Individual #140) ISPs met criterion for supporting overall independence. Examples included:
    - Individual #140 had action plans that addressed her key independence needs for communication and ambulation.
    - Individual #320 had SAPs to dress herself and brush her teeth, which was positive. The IDT also indicated a need for increased mobility/ambulation within her home, but the IDT did not develop a complete set of action plans in the ISP that would have addressed the identified needs. For example, habilitation therapies had not assessed for the use of cane or walker to enhance level of independence in mobility as recommended.
    - Individual #72 had two SAPs for cooking, which was positive, particularly because he was soon to be transitioning to the community and this would be a useful skill. At the same time, the ISP included action plans for assessment of three needs related to money management, but none of these had occurred.

12. The IDTs did not assertively address risk areas in a consistent manner. Examples included:
    - Individual #678 suffered a fractured clavicle after a fall, but the IDT had not obtained a required PNMT assessment to make recommendations related to her falls risk. Also, the IDT noted her high tolerance for pain and its possible impact on discovering injury, but did not integrate this into her PNMP regarding signs and symptoms related to falls or otherwise address it with an individualized support in her Integrated Health Care Plan (IHCP.)
    - At the time of last monitoring visit, the Monitoring Team was extremely concerned for Individual #140 related to her numerous health risks. At that time, 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 Monitoring Team found the IDT had not developed a plan for collecting the types of comprehensive data needed to determine and address the root causes. Further, the IDT needed 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. While it was positive that Individual #140's status had been much improved over the past nine months, the IDT had still not approached all of her health care needs in a comprehensive way. Examples included:
        - At the time of the last monitoring visit, documentation indicated, for many months, that she needed to be tested for Huntington's disease to rule it out as a cause for her frequent uncontrolled movements. The IDT still had not completed this at the time of the present visit.
        - The IDT had not obtained lactose intolerance testing as recommended to also rule out food allergies as a possible factor in her movement disorder.
        - Individual #140's weight often fluctuated dramatically between weekly weights, but the IDT had not met to discuss this concern or its root cause.
        - An MRI had indicated Individual #140 had free fluid in her pelvis and needed a urology consultation. The IDT had not obtained this.

- It was unclear why Individual #140 had recently been hospitalized for a UTI and dehydration, when she was supposed to have been receiving fluids enterally to ensure adequate hydration. Because of her cyclical history leading to frequent and lengthy hospitalizations, the IDT needed to meet to consider whether this was an early warning signal and identify any root cause that may have led to this latest episode.

- Individual #72's IDT had not obtained the recommended neurological evaluation of Arnold-Chiari formation, indicated as a potential cause for unsteady gait and resultant falls.

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 consistently well-integrated, also as described throughout this report. In addition to the examples provided in #12 above, other examples included:

- While it was positive the Center had taken initiative to access orientation and mobility (O&M) services for two individuals with sensory impairments, the coordination among the IDT, the Center's habilitation professionals and the O&M specialist was lacking. For example:
  - Individual #678's IDT had not met to consider an O&M assessment that indicated significant opportunity for increased independence following cataract surgery.
  - Individual #320's ISP included a goal to use a phone adapted for individuals with a visual impairment, but it had not been implemented. Per the QIDP, the phone had been delivered, but was pending programming by habilitation staff. When the Monitoring Team asked the habilitation department about this, they provided evidence the adaptive phone was, in fact, available on the home. Also, the O&M specialist entered progress notes that expressed ongoing frustration with the interdisciplinary process, without directly engaging the IDT to address this.
- Per her audiology assessment, Individual #678 had limited openings of the external auditory meatus bilaterally and recommended that a trial for open ear plugs be implemented to prevent collapsing of the bilateral ear canals, which may in turn cause conductive hearing impairment. The IDT did not develop an action plan.
- For Individual #320, the IDT had not identified and addressed the inconsistent approaches among staff to the use of gloves and whether they were being used to prevent self-injury or were simply a preference. It was positive the IDT acted immediately to revise the positive behavior support plan (PBSP) to clarify once the Monitoring Team brought this to their attention. Similarly, the behavioral health assessment (BHA) did not address her increasingly frequent behavior of dropping to floor and refusing to walk. The rationale provided was that she had not been injured and could be re-directed, but this disregarded the potential for future injury.
- For Individual #672, the IDT as a whole had not documented a thorough examination and discussion of all of the potential side effects of her psychotropic medications, including those identified by her mother/LAR during the IRRF discussion at her ISP annual meeting in August 2018, such as urinary retention and possible impact on her menses. At that time, the IRRF discussion documented the mother was choosing to withhold consent for psychotropic medications until her questions had been addressed. The IDT had not documented any follow-up or to ensure consent had been re-instated. In addition, the QIDP did not know that Individual #672 had a counseling plan with specific counseling goals; it was concerning that the IDT was not aware counseling had been suspended for more than two months despite a significant need. If the IDT had been aware, they may have been able to assist the counselor to modify the counseling techniques to better address Individual #672's 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:

- Two people had individualized action plans in this area. Both Individual #72 and Individual #678 had action plans for participation in community church activities, but neither had had any implementation.
- Individual #140 had one broad action plan to continue family visits and community outings if healthy, but with no consideration for community integration.
- Individual #599's action plans indicated he would have community trips twice a month, with no specific purpose or methodology for participation and/or integration delineated; another action plan under relationships indicated only that he would take community trips with peers. Neither had an implementation plan. Per data provided by the Center, he had participated in a total of five community outings in the last six months.
- Individual #672's action plans in this area were limited to scheduling outings so she could walk in community and go to restaurants. The action plans did not address community integration.

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 for Individual #678 had identified a creative personal goal to volunteer as member of the Center's praise team. This was consistent with her interests and preferences. It was unfortunate the IDT did not develop specific action plans to affect this.
- Assessment information indicated Individual #672 had interests in being a mail carrier on campus, which was consistent with her preferences, and that she had also stated an interest in working at the country store, which was also consistent with her preferences for a quiet setting. The IDT did not integrate these interests into her action plans. IDT members did not have knowledge of this information even though it was available in her assessments.
- Since the last review, and as previously reported, Individual #72 continued to refuse work, but the IDT determined the goal to be an office assistance remained an interest of his. They hadn't developed any action plans for exploration of related opportunities. The action plan to be assessed for supported employment for the clerk job had also not occurred.

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, particularly for meaningful day activity that addressed their needs and preferences.

On a positive note, at the time of the last monitoring visit, the Monitoring Team found that the IDTs did not place significant focus on skill acquisition. While this remained an area of need, this group of individuals generally did have more SAPs. Similarly, the Monitoring Team also found last time that IDTs did not ensure action plans were implemented frequently enough to result in functional engagement to meet personal goals and needs; while this was also an area of continued need, there was improvement.

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. For example, the BHA for Individual #678 identified the lack of guardianship as a primary barrier to community transition, but the IDT did not develop a corresponding action plan.
- As described above, the IDT had not obtained needed assessments and evaluations for Individual #140 to aid in an effort to

determine the root cause of her movement disorder. This was a primary barrier to returning to baseline functioning.

- The IDT lacked an assertive approach to addressing employment and engagement barriers for Individual #72. For example, at the time of last year's visit, the Monitoring Team had noted the lack of implementation of the action plan to develop a rewards chart to reinforce work attendance and participation. The QIDP monthly reviews indicated this had still not been formally implemented. Instead, several members of the IDT had informally implemented it and considered it to be unsuccessful, but provided no data that would demonstrate its efficacy or lack thereof.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports, although some improvement was noted.

- SAPs were improved, overall, but many continued to lack key elements for measurability.
- Similarly, the previous monitoring report noted that IDTs relied on service objectives (SOs) or other staff actions for much of ISP implementation, but rarely developed SOs with specific implementation methodologies and required data collection. The Monitoring Team found some improvement in the construction of SOs as well.
- Living options action plans for increasing individual and LAR awareness of community settings had no related measurable outcomes.

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

Summary: The ISP document and the annual meeting observed for Individual #72 met criteria with all of the indicators of this outcome. This was good to see and demonstrated that Richmond SSLC has the capacity to meet these indicators for all individuals. The indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 140	320	672	72	678	599			
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).	50% 3/6	0/1	1/1	1/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1				1/1					
21	The ISP included the opinions and recommendation of the IDT's staff members.	33% 2/6	0/1	0/1	0/1	1/1	1/1	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 options.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1			

	community).										
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1				1/1					
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	100% 1/1				1/1					
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Three of six ISPs (for Individual #320, Individual #672 and 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:

- The IDT for Individual #678 lacked a basis for determining preference and had not provided for living options awareness.
- Individual #140's IDT indicated that she would live in an environment that supported her needs and safety, but did not describe her individualized preferences.
- Individual #599's IDT indicated his preferences were unknown, but had not implemented living options action plans to increase awareness across the previous year.

20. The Monitoring Team attended the annual ISP meeting for Individual #72 while onsite. His preference was clearly stated and was determined in an adequate manner.

21. Two of six ISPs (for Individual #678 and Individual #72) 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 exception was for Individual #672, whose vocational assessment did not meet criterion.
- 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 example:
  - Individual #140's ISP did not document a medical recommendation or statement.
  - For Individual #599, the ISP did not include statements and recommendations from medical or psychiatry.
  - For Individual #672, the psychiatrist was present at the ISP meeting, but the narrative did not document his statement and recommendation.

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. Two of six individuals (Individual #672, Individual #72) had a thorough examination of living options based upon their preferences, needs, and strengths. Otherwise, the ISPs did not reflect a robust discussion of available settings that might meet individuals' needs.

24. Three of five ISPs (for Individual #678, Individual #599, and Individual #672) 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. Another individual, Individual #72, had been referred and also met criterion. ISPs that did not meet criterion, for Individual #140 and Individual #320, did not identify the lack of individual awareness as an obstacle, but should have.

25 and 27. The Monitoring Team attended the annual ISP meeting for Individual #72 while onsite. The IDT discussed whether barriers to transition existed and determined the transition was proceeding as expected.

26. None of five individuals who were not referred had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. Individual #72 was referred at the time of the annual ISP and the IDT met frequently throughout the ensuing year to identify and address barriers to transition. His ISP was the one that met criterion with this indicator.

28. One of six ISPs, for Individual #72, included individualized and measurable plans for education, which were developed and revised as needed once his referral meeting was held following the ISP. The remaining ISPs had action plans that were limited to group home tours, provider fairs, and annual living options information, none of which had individualized action plans, with measurable outcomes or implementation methodologies.

29. Six of six individuals had obstacles identified at the time of the ISP.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: Individuals participated in their ISPs. This has been the case for the past two reviews, too. Therefore, indicator 33 will be moved to the category of requiring less oversight. 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 plans in a timely manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	320	672	72	678	599			
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	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

	knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).										
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 consistently implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

33. Five of six individuals participated in their ISP meetings. Individual #140 did not, at the request of her LAR.

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 #678, the SLP did not attend, nor did the representatives from nutrition or the day program. She had needs in all of these areas. For example, the SLP assessment indicated she could benefit from continued training with the AAC (Talkable II) and that it should be available for use throughout the day. It would have been important for the SLP to participate in the discussion and the development of specific action plans to integrate how and when the AAC could be used. As another example, Individual #678 had recent changes to her diet due to unplanned weight loss, so the nutrition staff would have also been needed.
- The primary care practitioner (PCP) did not attend the ISP annual meeting for Individual #140, despite the many significant medical problems that had occurred during the months immediately preceding.
- The SLP for Individual #599 did not attend, but he had significant communication needs and direct therapy. No habilitation therapist attended despite his ongoing falls.

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

Summary: Full sets of assessments were not determined for the individuals, though the IDTs did do a better of obtaining those assessments that they had deemed as necessary. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	140	320	672	72	678	599			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	67% 4/6	1/1	1/1	1/1	0/1	0/1	1/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for none of six individuals. Examples included:

- Individual #140's IDT did not request a BHA, but she had a PBSP.
- For Individual #599, the grid of required assessments in his ISP preparation document included only an SLP assessment.
- Individual #672's IDT did not request a nutritional assessment, but she was significantly overweight, with diagnoses including hypertension and obesity.

36. Four of six ISPs met criterion for arranging for and obtaining needed, relevant assessments prior to the IDT meeting. This was improvement from the previous monitoring visit. Those that did not meet criterion included:

- Several of Individual #678's assessments indicated an audiology assessment was due in April 2018, but there was no evidence provided that the IDT had obtained it, nor did they discuss and action plan to obtain it. In addition, the Center provided an FSA summary, but the actual tool had not been completed.
- As reported at time of last site visit, Individual #72's IDT did not request a comprehensive falls analysis, but should have.

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

Summary: Although scores were low for these indicators, as detailed in the comments below, various progress was observed. The indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 140	320	672	72	678	599			
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, the Center had evidenced some improvement in the consistent implementation and monitoring of ISP action steps, but additional improvement was still needed. The QIDP department continued to develop strategies and systems for enhancing QIDP performance overall. For example, the QIDPs now met on a weekly basis for training and information sharing. There was also an emphasis on improving tracking and follow-up of ISPA action steps, which had yielded some early positive results. More work remained necessary in this area, as further explained below, but it was a good initiative.

37. There were some positive examples of IDTs using data to make decisions about revising the ISP. There was also improvement in the review of SAP data and completion of consequent revisions. This was not yet consistent, however. For example:

- For Individual #678, it was positive the IDT had used behavioral data related to ingestions to regularly consider reduction in her level of supervision. Valid and reliable data were not otherwise available for most action plans, though, and the IDT did not use data consistently in other her ISPA. For example, the IDT did not track weight data for discussion between May 2018 and October 2018, although she was continuing to lose weight.
- For Individual #599, the QIDP did not report any data for many action plans in September 2018 and October 2018.
- For Individual #320, the QIDP monthly reviews included many broad assessments of progress that appeared to be of the cut

and paste variety. For example, for an action plan to improve behavior by at least 50% at day program, the QIDP monthly review repeated the same statement for months that indicated she had good days and bad days, but rates appeared to be declining. No specific data were offered.

38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. This continued to reflect 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 Monitoring Team was able to attend and observe Individual #72's annual ISP meeting onsite and was impressed with the QIDP's preparation. The meeting began with his favorite music videos and snacks, which created a relaxed environment as well as camaraderie between Individual #72 and the IDT. The QIDP had obviously spent a good deal of time with Individual #72 exploring his preferences and goals and helping him get ready to participate – and even co-facilitate – his meeting. The QIDP provided a meeting guide that summarized his progress over the past year and new interests in each goal area. As a result of these strategies, the goals and action plans the IDT developed clearly represented his personal preferences.

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: 672	320	388	678	599	535	758	133	542
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	50% 9/18	1/2	1/2	1/2	1/2	0/2	1/2	1/2	2/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #672 – constipation/bowel obstruction, and fractures; Individual #320 – falls, and skin integrity; Individual #388 – urinary tract infections (UTIs), and choking; Individual #678 – skin integrity, and osteoporosis; Individual #599 – constipation/bowel obstruction, and seizures; Individual #535 – UTIs, and other: hypothermia/hypothyroidism; Individual #758 – falls, and choking; Individual #133 – gastrointestinal (GI) problems, and cardiac disease; and Individual #542 – constipation/bowel obstruction, and falls].

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 #758 – falls, and Individual #133 – GI problems.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the

IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #672 – constipation/bowel obstruction; Individual #320 – skin integrity; Individual #388 – choking; Individual #678 – skin integrity; Individual #535 – other: hypothermia/hypothyroidism; Individual #758 – choking; Individual #133 – GI problems, and cardiac disease; and Individual #542 – constipation/bowel obstruction.

Psychiatry

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

Summary: Richmond SSLC appeared poised to move forward regarding the development of psychiatric indicators and goals, but had not yet done so. That is, to choose relevant psychiatric indicators for decrease and for increase, to put them into goals that are in the ISP/IHCP, and to collect data on these indicators. The temporary absence of an onsite psychiatry lead may hamper efforts in the short term. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

At Richmond SSLC, there was some progress in many of the sub-indicators. With the impending return of the lead psychiatrist, the Monitoring Team expects that the Center will move forward in developing indicators, goals, and data systems.

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

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

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

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

The Monitoring Team looks for:

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

4a. Seven of the individuals had at least one goal for reduction, that is, all except Individual #320 and Individual #72. Two individuals, Individual #140 and Individual #314, had specific indicators to increase, the other seven did not.

4b. Documentation that clearly described the relationship between the psychiatric indicator to decrease and the individual's diagnosis was present for four individuals, Individual #218, Individual #139, Individual #140, and Individual #543. The derivations of the indicators for increase from the psychiatric diagnoses were not specified.

4c. For the indicators for decrease, the indicator was described and specified in observable terminology for Individual #543. For the indicators for increase, none were described with enough observable terminology so that they could be reliably measured and tracked.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for one individual (Individual #543). For psychiatric indicators for increase, the criteria met for none of the individuals. Overall, criteria were met for all three sub-indicators for both types of psychiatric indicators for none of the individuals.

5. Psychiatric goals:
The Monitoring Team looks for:

d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

5d. A goal for the indicator to decrease was documented for Individual #218, Individual #139, and Individual #314. For the other six individuals, in response to a document request, the Center produced an addendum to each of their most recent CPE updates that identified a goal, which stated, in general, that the individual "will remain psychiatrically stable for the next 12 months with no inpatient psychiatric hospitalizations." Individual #139 also had this goal in his document. These goals did not meet any of these criteria and, thus, were scored zero. There were no goals for the psychiatric indicators to increase.

5e. The type of data and how it was to be collected was not specified in a functional manner for any of the individuals. There was no definition of the type of data that would be required to track positive indicators.

Thus, for indicators for reduction, both sub-indicators were met for none of the individuals. For indicators for increase, the two sub-indicators were met for no individuals. Overall, criteria were met for both sub-indicators for both types of psychiatric indicators for no individuals.

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

6f. The goals for reduction for Individual #218 and Individual #672 were mentioned in the ISP, but were not in the format of an IHCP. The goals for indicators to increase did not appear in the form of IHCP goals.

6g. The goals for Individual #218 were discussed in the most recent quarterly review based on a decrease in frequencies, but there was no formalized goal to modify. The goals for increase had not been developed and, thus, could not be modified.

Thus, for indicators for reduction and increase, indicators 6f and 6g were not met for any individuals.

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

7. The data related to the goals for decrease could not be considered adequate to summarize their status and make treatment modifications due to the deficiencies described above. The lack of measurable goals for increase made it impossible to reliably

summarize an individual's progress or lack of progress.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.												
Summary: Due to sustained high performance on CPE content, indicator 14 will be moved to the category of requiring less oversight. The same might happen for indicator 16 after the next review if high performance is sustained. The same individual (Individual #140) did not meet criteria for both indicators. Indicator 16 will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	89% 8/9	1/1	1/1	0/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 14. The content of the CPEs was comprehensive and contained the required information for all of the individuals, except Individual #140. 16. The psychiatric diagnoses were consistent in the medical, behavioral health and psychiatric sections of the record for all the individuals, except Individual #140.												

Outcome 5 – Individuals' status and treatment are reviewed annually.												
Summary: Performance scores were about the same as last time, with the exception of indicator 18. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
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).	100% 6/6		1/1	1/1			1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	89% 8/9	1/1	1/1	1/1	0/1	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.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	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	0/1	0/1	1/1	0/1	0/1

Comments:

18. The information contained in the CPE updates for the six individuals was comprehensive and met the content requirements. (Individual #218 and Individual #298 had been admitted with in the past year and did not require an update; Individual #314 did not have one completed at all).

19. The CPEs and CPE updates were prepared and submitted to the ISP team in a timely manner at least 10 days prior to the ISP for all of the individuals, except Individual #314 who did not have a CPE update.

20. The psychiatrist attended the ISP for four of the individuals in the review group: Individual #139, Individual #140, Individual #672, and Individual #72. The Center produced documentation indicating that the IDT had indicated that the psychiatrist did not need to attend the other ISPs based on discussions at the ISP preparation meeting (i.e., three months prior to the annual ISP meeting). Review of the documentation from those ISP preparation meetings indicated that they did not contain any rationale for those decisions, nor was there any evidence of direct contact with the psychiatrists concerning the decision about their attendance. The decision that the psychiatrist does not need to attend the ISP should be supported by a clinically based rationale.

21. The ISP met the content requirements for one of the individuals, Individual #672. The Monitoring Team observed the ISP for Individual #72 on 12/5/18. The conduct of the meeting was supportive of Individual #72 and created a positive atmosphere. The psychiatrist did attend the meeting. The deficiencies included the absence of a discussion of the status of his neurological consultations and evaluations. In addition, there was no empirical justification for the statement that his current pharmacological treatment represented the most effective, least intrusive interventions.

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: Risk-benefit discussion and information was again in the consent forms. This was the case for all individuals this review and the past three reviews, too, with an exception in June 2017. Therefore, indicator 30 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.										
30	A risk versus benefit discussion is in the consent documentation.										
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
32	HRC review was obtained prior to implementation and annually.										
Comments: 30. A risk benefit discussion was present for each medication.											

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 continued to engage in activities to collect PBSP data and to increase the likelihood that those data were reliable. Seven of nine met criteria with indicator 5. This was good to see. Continued attention is needed and even though there was continued stable performance, this indicator will remain in active monitoring given the scores for this and the last review were 78% and 67%, respectively.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.											
3	The psychological/behavioral goals/objectives are measurable.											
4	The goals/objectives were based upon the individual's assessments.											
5	Reliable and valid data are available that report/summarize the individual's status and progress.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1

Comments:
5. Seven individuals had evidence of interobserver agreement (IOA) and data collection timeliness (DCT) assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. At the time of the document request for this onsite review, Individual #320 did not have an IOA or DCT assessment in the last 12 months, and Individual #543's most recent DCT level was below 80%. The establishment of reliable PBSP data should be a priority for the behavioral health department.

Note: In the last monitoring report, the Monitoring Team commented on the need for additional attention to the rumination behavior of Individual #241. The Center's behavioral health services director and the individual's IDT provided an update to the Monitoring Team. A variety of actions had been taken and there were some positive outcomes seen, especially regarding an increase/maintenance of desired weight gain.

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

Summary: Individual #218 and Individual #298 did not have functional assessments. Both were new admissions to Richmond SSLC.			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: Individual #218 and Individual #298's PBSPs were still initial plans, and they were missing some components. They should have been updated at the time of this review.			Individuals:									
#	Indicator	Overall Score										

13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
14	The PBSP was current (within the past 12 months).	
15	The PBSP was complete, meeting all requirements for content and quality.	
Comments:		

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

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.										
Summary: Medical Department staff should continue to focus on ensuring the timely completion of annual medical assessments. Since 2017 or early 2018, PCPs had not completed interim medical reviews for many of the individuals reviewed. The Monitoring Team raised this same issue in the last report, and Center staff apparently had not corrected it. This issue needs to be corrected as soon as possible. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that	78%	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

	is completed within 365 days of prior annual assessment, and no older than 365 days.	7/9									
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. Fifteen of the 17 IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

For a number of individuals, PCPs had not completed interim medical reviews since 2017 or early 2018 [e.g., Individual #672, Individual #320, Individual #678 (while the Monitoring Team was on site, Center staff produced a review completed after the Tier II document request was submitted), Individual #599, Individual #535, and Individual #133]. This issue needs to be corrected as soon as possible.

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	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 Individual #388's AMA included all of the necessary components, and addressed the individual's 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, social/smoking histories, past medical histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included complete interval histories, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include as applicable, family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #672 – other: hypertension, and respiratory compromise; Individual #320 – gastrointestinal (GI) problems, and diabetes;

Individual #388 – constipation/bowel obstruction, and seizures; Individual #678 – GI problems, and cardiac disease; Individual #599 – diabetes, and medication side effects/interactions; Individual #535 – osteoporosis, and other: hypothyroidism; Individual #758 – other: anemia, and osteoporosis; Individual #133 – other: iron deficiency anemia, and GI problems; and Individual #542 – GI problems, and seizures].

As noted above, the ISPs/IHCPs reviewed often did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. In addition, for many individuals, PCPs had not conducted recent interim reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: As indicated in the last several reports, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
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	2/2	0/2	0/2	0/2	0/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	12% 2/17	0/2	0/1	0/2	0/2	0/2	2/2	0/2	0/2	0/2

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #672 – other: hypertension, and respiratory compromise; Individual #320 – GI problems, and diabetes; Individual #388 – constipation/bowel obstruction, and seizures; Individual #678 – GI problems, and cardiac disease; Individual #599 – diabetes, and medication side effects/interactions; Individual #535 – osteoporosis, and other: hypothyroidism; Individual #758 – other: anemia, and osteoporosis; Individual #133 – other: iron deficiency anemia, and GI problems; and Individual #542 – GI problems, and seizures).

The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #388 – constipation/bowel obstruction, and seizures; and Individual #542 – seizures.

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 following individual's ISPs/IHCPs defined the frequency as six months: Individual #535 – osteoporosis, and other: hypothyroidism.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Individuals reviewed frequently did not have annual dental exams completed within 90 days of the ISP meeting, which impacted the availability of updated information in the annual dental summaries that IDTs used for planning purposes. However, improvement was noted with regard to the quality of dental exams. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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, this indicator moved to the category requiring less oversight.									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	33% 3/9	0/1	1/1	0/1	0/1	1/1	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, this indicator moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments: a. Individuals reviewed frequently did not have annual dental exams completed within 90 days of the ISP meeting. This negatively impacted scores related to the quality of annual dental summaries (Indicator c). Without updated information from a recent exam, the IDTs did not have updated information with which to make decisions at the ISP meetings.

b. It was positive that for eight of the nine individuals reviewed, the dental exams included all of the required components. The exam that did not meet criteria was missing:

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

c. As discussed above, a number of individuals did not have the benefit of dental summaries updated with recent information. In addition to ensuring Dentists complete exams close to the time of the annual summary, areas on which the Center should focus include:

- Dental care recommendations; and

- Dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.

Summary: For eight out of nine individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. For seven of the nine individuals, nurses completed quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: a.i. and a.ii. Most of the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments. The exception was for Individual #758 for whom no annual nursing assessment was submitted (i.e., the document submitted that was marked as an annual only covered the quarterly period between 3/1/18 and 6/1/18).

With regard to quarterly nursing record reviews and physical assessments, examples of problems included:

- May and June 2018 were not included in the quarterly assessments for Individual #672.
- For Individual #678, it was not until 11/5/18, that the RN Case Manager completed the assessment for the dates of 5/3/18 to 9/1/18 (which was not a quarterly period).

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions. Improvement is also needed with regard to the details of physical assessments, including, for example, weights, and fall risk assessments. In addition, Individuals:

when individuals experience changes of status, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.											
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual receives a quality annual nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	33% 3/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual receives a quality quarterly nursing record review.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	56% 5/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

g.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/12	0/1	0/2	0/1	0/2	0/2	0/1	0/1	0/1	0/1

Comments: a. As discussed above, Center staff did not submit an annual record review for Individual #758. It was positive that the annual nursing record reviews for the remaining eight individuals included the following:

- Active problem and diagnoses list updated at time of annual nursing assessment (ANA);
- List of medications with dosages at the time of the ANA;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

Most included:

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

The components on which Center staff should focus include:

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

b. For a number of individuals reviewed, RN Case Managers had not included weights for the year. At times, information was cut off of the documents, so the Monitoring Team could not determine if a full assessment was completed.

c. and f. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #672 – constipation/bowel obstruction, and fractures; Individual #320 – falls, and skin integrity; Individual #388 – UTIs, and choking; Individual #678 – skin integrity, and osteoporosis; Individual #599 – constipation/bowel obstruction, and seizures; Individual #535 – UTIs, and other: hypothermia/hypothyroidism; Individual #758 – falls, and choking; Individual #133 – GI problems, and cardiac disease; and Individual #542 – constipation/bowel obstruction, and falls).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for about a quarter of the risk areas reviewed, nurses included status updates in annual assessments, including relevant clinical data (i.e., Individual #678 – skin integrity, and osteoporosis; Individual #535 – UTIs; and Individual #133 – 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.

Nurses also included necessary updates in the most recent quarterly assessments for: Individual #678 – osteoporosis, Individual #599 – seizures, Individual #535 – UTIs, Individual #758 – falls, and Individual #542 – falls. However, nurses then did not analyze the information to determine whether the individuals were better, worse, or their status had remained the same.

d. It was positive that for the nine individuals, all of the quarterly nursing record reviews included the following:

- Active problem and diagnoses list updated at time of the quarterly assessment;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Immunizations;
- Consultation summary;
- Lab and diagnostic testing requiring review and/or intervention; and
- Tertiary care.

Most, but not all of the quarterly nursing record reviews included:

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

The components on which Center staff should focus include:

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

e. For Individual #672, no quarterly physical assessment was submitted. For other individuals for whom problems were noted, the physicals did not include weights or falls assessments.

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

- An IPN, dated 10/5/18, indicated that according to a direct support professional, Individual #672 hit herself in the nose and had blood on her nose and hands. The nurse did not conduct and/or document an assessment of the individual's nares, mental status, cognition, or visual field, or to determine whether or not she had a headache.
- A nursing IPN, dated 7/5/18, at 5:28 p.m., noted Individual #320 fell while getting off a van and landed on her "butt and hit head." Based on the documentation submitted, the nurse did not conduct initial neurological checks to establish a baseline, which would have been especially important since the note indicated that the individual was "ambulating with change in gait noted at this time." In the note, the nurse did not provide any further description of the change in gait. Nurses did not conduct follow-up assessments until 7/6/18, at 9:44 a.m. Moreover, this second IPN was identical to the one discussed above, as was the IPN on 7/6/18, at 7:44 p.m., and 7/8/18, at 2:52 p.m., and 10:02 p.m. Nurses included no mental status or neurological assessments in the IPNs.
- An IPN, dated 9/28/18, noted swelling to Individual #320's right cheek. The nurse described no further assessment in the IPN, even though the note indicated "pain related to dental infection." The nurse conducted and/or documented no assessment of the individual's teeth, gums, or oral mucosa.
- For Individual #388, an IPN, dated 6/7/18, at 1:33 p.m., related to a UTI and Stage IV pressure ulcer to the sacrum did not describe a complete nursing assessment for odor of the urine, amount of urine in the bag and overall output, any abdominal or suprapubic distension or pressure/pain, guarding, fluid intake, blood in the urine, appearance and skin assessment of the urostomy stoma, or an assessment of the pressure wound.
- For Individual #678, nurses did not document assessments of the skin issues to her toes, making it impossible to determine if the individual experienced any status changes.

- According to an IPN, dated 7/5/18, at 6:07 p.m., a direct support professional reported a large knot to Individual #678's right shoulder and swelling to her right index and middle finger. The nurse did not conduct and/or document any pain assessment or assessment of range of motion, or skin temperature, or any assessment of her fingers.
- In an IPN, dated 7/9/18, a nurse noted Individual #599 was given a rectal suppository for no bowel movement for 48 hours. The nurse did not conduct and/or document an assessment prior to the administration of the pro re nata (PRN, or "as needed") medication, and the nurse did not document follow-up in the IPNs regarding the effectiveness of the PRN.
- On 8/20/18, no nursing IPNs were found when Individual #599 transferred to the hospital due to seizure activity.
- An IPN, dated 10/19/18, noted Individual #535's urine culture demonstrated bacteria. However, the nurse did not note the specific organism(s) to determine if hygiene issues could have been a possible cause of the UTI, which then should have resulted in a focus on staff training and monitoring the individual's hygiene care. Also, the nurse included no assessment of fluid intake in the IPN.
- An IPN, dated 7/11/18, indicated that Individual #758 was found on the floor with a swollen nose and bleeding from her right elbow. The nurse's assessment did not include a mental status exam, a determination of the individual's ability to breathe through her nose, any indication of whether or not the individual had bruising to her face or visual problems, or an initial neurological check.
- A nursing IPN, dated 7/16/18, indicated that Individual #133 had urinated on herself, and was very weak and refusing to stand. The nurse's assessment did not include the individual's response to pain; neurological checks; the individual's respiration status, skin color, and temperature; the rate and quality of her pulse; or information regarding what she was doing prior to the status change.
- An IPN, dated 7/27/18, at 6:02 a.m., noted Individual #542 lost his balance and hit "bottom to bare floor." Nurses provided no other details, such as the exact time and location of the fall (i.e., a PCP IPN, dated 7/28/18, noted "around 0400"), or what he was doing at the time of the fall. Nurses did not conduct and/or document an assessment of mental status, or range of motion.

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

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

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	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).	0/18									
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. Overall, the IHCPs failed to include nursing interventions to address individuals' needs.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: It was positive that as needed, Registered Nurses (RNs) completed Post Hospitalization Reviews for the individuals reviewed, and the PNMT discussed the results. In comparison with previous reviews, this was a significant improvement. Improvements are needed with regard to the timely referral of individuals to the PNMT, and/or the PNMT making self-referrals of individuals who meet criteria. When referrals occurred, the PNMT conducted timely reviews for the individuals the Monitoring Team reviewed, but the quality of the reviews needed improvement. The quality of PNMT comprehensive assessments for the two individuals varied considerably, but neither identified a comprehensive set of recommendations to address the individuals' needs and the underlying etiologies of their PNM issues. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6	N/A	N/A	0/2	0/1	1/1	0/1	N/A	1/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 4/6			2/2	0/1	1/1	0/1		1/1	

c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 2/4			0/2	N/A	1/1	N/A		1/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6			0/2	0/1	1/1	0/1		1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 4/4			2/2	N/A	1/1	N/A		1/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6			0/2	0/1	0/1	0/1		0/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2			N/A	0/1	N/A	0/1		N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4			0/2	N/A	0/1	N/A		0/1	

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

- From 10/24/17 to 11/1/17, Individual #388 was hospitalized for a fever and UTI with a Stage 2 pressure ulcer. Documentation indicated that the pressure ulcer worsened to a Stage 3 in the hospital. On 11/1/17, his IDT referred him to the PNMT for the Stage 3 wound, and on 11/7/17, the PNMT initiated a review. PNMT minutes stated that no assessment was needed and his new wheelchair possibly caused the pressure ulcer. The PNMT offered no recommendations other than to reassess pressure mapping of the wheelchair and assess his positioning for enteral nutrition.

  In the next review, dated 8/8/18, in response to a referral on 8/6/18, the PNMT stated that during the past month, Individual #388 had several hospitalizations, most recently from 8/1/18 to 8/3/18 for pneumonia. He returned to the Center with a wound vac for treatment of the sacral wound. Other hospitalizations occurred on 7/18/18, for sepsis, a UTI, and a Stage IV sacral wound; and on 7/26/18, for pneumonia and a Stage IV sacral wound. It was unclear why the IDT did not make a referral or the PNMT did not make a self-referral sooner. Even with the re-hospitalizations, the PNMT should have begun a record review. His health had declined, and his physical condition also declined, and he was weakening. For example, he now required assistance from staff for transfer and ambulation with an Arjo walker. He was now dependent for mobility and was using a wheelchair. The PNMT stated that it agreed with the IDT on the current action plan to address the pneumonia and the sacral wound, so no other PNMT assessment was needed. Given this individual's multiple PNM issues, a sacral wound that

continued to worsen, and his overall worsening condition, the rationale was unclear for the PNMT's decision not to conduct an assessment.

In its comments on the draft report, the State sought to provide clarification and stated: "The PNMT works closely with IDT. For Individual #388, the IDT had developed an action plan, with the PT, RT, and SLP, addressing his PNM issues. PNMT agreed with the IDT's action plan; therefore, the IDT did not need PNMT's further involvement (TX-RI-1812-II.010), page 9." Without conducting further review/assessment, the PNMT did not have the basis, nor did it provide sufficient clinical justification for its decision not to become involved.

From 8/13/18 to 8/22/18, the individual was hospitalized for fever, emesis, and the Stage IV wound, and from 8/27/18 to 9/4/18, he was hospitalized again due to pneumonia. On 8/23/18, the IDT made a referral, but returned to the hospital before the PNMT conducted a review. On 9/5/18, the PNMT conducted a review due to pneumonia and the Stage IV sacral wound, UTI, and sepsis. He had had the Stage IV wound for some time. For this review, the PNMT essentially copied information from the previous one. The only difference was to request a Grand Round to discuss the individual's healthcare issues. Again, the PNMT concluded that no assessment needed. On 9/12/18, the Grand Rounds occurred. Following that, the PNMT conducted no follow-up.

In its comments to the draft report, the State disputed the finding for Indicator b, and stated: "There were 2 individuals (#678 & #535) not referred to PNMT but other [sic] 3 individuals (#388, #599 & #133) were referred to PNMT." Indicator b relates to the timeliness of the referral, and as articulated in the Monitoring Team's comments in the draft report, the referral was not timely. Outcome 1, Indicator b.i addresses whether or not a referral occurred (regardless of timeliness), and the Monitoring Team had assigned that indicator a positive score for this individual in the draft report.

In its comments on the draft report, the State requested the following clarification: "Two PNMT Reviews were submitted for #388 (TX-RI-1812-II.010). Please clarify score; why is it N/A?" To clarify, the Indicator reads: "If only a PNMT review is required…" This individual did not only require a PNMT review, he required a full assessment. As indicated in the draft report, the PNMT did not conduct one.

- On 7/2/18, Individual #678 tripped over a wheelchair, hit her head on a door, and sustained a fracture of the mid-clavicle with displacement. This is a long bone fracture, and warranted at least a PNMT review. The Monitoring Team found no evidence of a PNMT review.
- On 5/3/18, Individual #599 went to the ED, and was admitted for lethargy and unresponsiveness. According to a chest x-ray on 5/4/18, he was diagnosed with aspiration pneumonia. On 5/14/18, the PNMT RN made a timely referral to the PNMT in relation to aspiration pneumonia, and on 5/14/18, the PNMT initiated assessment. On 6/11/18, the PNMT completed the assessment.
- Individual #535 had a Stage 2 pressure ulcer with delayed healing, but the IDT did not refer him to the PNMT, and the PNMT did not make a self-referral. More specifically, on 6/23/16, a Stage 2 pressure ulcer was identified on the individual's coccygeal area. Different documentation identified different dates for the resolution of the pressure ulcer: a PCP progress note identified the date as 6/11/18, but the TX-RI-1812.IV-1.20 document identified the date as 7/24/18. Regardless, given the lengthy healing period of approximately a year, the PNMT should have reviewed/followed Individual #535. The individual had a tilt-

in-space wheelchair with a custom-molded positioning system. On 11/20/17, the seat cushion was replaced with a Roho cushion after pressure mapping revealed a lot of high pressure areas on the molded cushion. Given that the initial wound in 2016 was related to an improperly positioned cushion, it was concerning that the IDT did not closely monitor and make changes to the custom molded system, as needed, when the ulcer did not heal. At the time of his OT/PT assessment in June 2018, he continued to use the Roho cushion. His time in the wheelchair was limited to mealtimes and one hour after each meal. He had an alternating air pressure mattress and a positioning program to reduce/relieve pressure on the sacral area.

In its comments on the draft report, the State disputed this finding, and provided the following in way of clarification: "Individual #535 was on the skin integrity database indicating the wound was healed. This explained that he was not referred to PNMT." Unfortunately, the State's comments did not provide information or citations to documents to explain the discrepancy between the State's assertion that the "wound was healed" and the dates and specific documentation that the Monitoring Team cited in the draft report that showed that the length of healing was approximately one year.

- Although the presenting problem timeline section of the PNMT assessment did not include this information, it appeared that on 7/29/18, Individual #133 vomited, and refused lunch. Before she went to the hospital, an occult blood test was positive. In addition, the Registered Dietician (RD) section of assessment stated that she had a couple of episodes of emesis with dark brown color. From 7/29/18 to 8/3/18, she was hospitalized for a GI bleed, and received two units of blood due to a hemoglobin of 7.3, which increased to 9.0 after the transfusion. The admitting chest x-ray showed patchy pneumonia in the right lung base. The physician noted aspiration with mild right lower lobe pneumonitis. Another EGD, completed on 8/1/18, "found EKG pad but no sign of bleeding." Other documentation indicated she had previously ingested a wire lead (i.e., according to a nursing IPN, dated 7/23/18, staff recovered a telemetry lead from her stool.) On 8/3/18, she was discharged with continued intravenous (IV) antibiotics in the Infirmary until 8/5/18. On 8/8/18, a PNMT referral and assessment were initiated. The PNMT completed the assessment timely. The quality of the assessment is discussed below.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. In its comments on the draft report, the State sought to provide clarification and stated: "The PNMT Assessment on Individual #133 had an electronic signature page with PNMT member names and verified date (TX-RI-1812-II.010), page 13." The list of PNMT members provided for Individual #133 was similar to that provided for other individuals. According to the "signature" and time stamp, the PT entered the list of names. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism in place to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of participants that the State references in its comment without those participants having any role in the process or even knowing that they are listed as participants. Other entries in IRIS provide a "signature" of sorts, because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. Given the ongoing challenges with IRIS related to the inability to have more than one user "sign" a document, the State should propose a mechanism to allow this verification (i.e., allowing one user to simply include the names of "team members" at the bottom of the report does not suffice).

h. As noted above, Individual #388 should have had a comprehensive PNMT assessment, but did not. The following summarizes some of the strengths and weaknesses noted with the two assessments that the PNMT completed:

- Individual #599's met criteria with regard to most of the sub-indicators. However, the recommendation section did not

address findings from other sections of the report. As a result, the PNMT did not provide the individual's IDT with a comprehensive set of recommendations to address his needs. For example, the PNMT identified his sedentary lifestyle, fluid intake, and potentially medications as underlying causes of constipation, which in turn was an underlying cause of pneumonia. However, the PNMT did not offer recommendations to address these potential etiologies.

- Individual #133's PNMT assessment met very few of the criteria. Some of the problems noted included:
  - The PNMT provided a limited discussion of the individual's history, diagnosis, and their impact on PNM supports.
  - Although the PNMT identified problems with pica, they did not discuss what behavioral supports were in place to address it. More specifically, on 7/16/18, she was hospitalized, during which time, she ingested an EKG lead. On 7/22/18, she passed the lead on, and on 7/23/18, she was discharged. Staff believed she might have ingested something else in the ambulance (i.e., a KUB showed a foreign object). As discussed above, on 7/29/18, she had episodes of constipation and coffee ground emesis leading to a second hospitalization due to a GI bleed and aspiration pneumonia. On 7/29/18, an x-ray confirmed the diagnosis of enteritis. Another EGD, completed on 8/1/18, "found EKG pad but no sign of bleeding." Given that the PNMT concluded that the etiology of the aspiration pneumonia was the ingestion of foreign objects with emesis, coordination and integration of behavioral supports in the PNMT assessment and related recommendations would have been essential to addressing her PNM needs.
  - The PNMT provided no discussion of the potential impact of medications on her supports, or if she presented with any side effects.
  - The PNMT did not observe her in bed "as she likes to sit on her recliner during her break time." Rather than conduct an observation during her natural time in bed, the PNMT relied on staff report of her position.
  - The PNMT rated the effectiveness of her supports using limited data to support their conclusions.
  - The PNMT offered no recommendations for interventions or goals/objectives to prevent recurrence. Again, this would have required integration with Behavioral Health Services staff.

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

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

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
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.	44% 4/9	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #672 – GI problems, and circulatory; Individual #320 - choking, and fractures; Individual #388 – aspiration, and skin integrity; Individual #678 – choking, and fractures; Individual #599 – falls, and aspiration; Individual #535 – aspiration, and skin integrity; Individual #758 – choking, and falls; Individual #133 – falls, and aspiration; and Individual #542 – choking, and fractures.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "encourage heart healthy activity and level," "encourage walking," etc.).

c. All individuals reviewed had PNMPs and/or Dining Plans. It was positive that the PNMPs for Individual #678, Individual #535, Individual #758, and Individual #133 included all of the components necessary to address the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Risk levels related to supports and individual triggers;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Bathing instructions;
  - Included toileting/personal care instructions;
  - Handling precautions or moving instructions; and
  - Complete communication strategies.

- As applicable to the individuals, most, but not all of the PNMPs reviewed:
  - Were reviewed and/or updated within the last 12 months. On the first day of the review, the Monitoring Team member observed Individual #388. Reportedly, Habilitation Therapy staff had updated his positioning instructions and staff were supposed to be implementing the revised positioning instructions, and the use of the wound vac had been discontinued. However, these revisions were not reflected in the PNMP in his Individual Notebook. For all individuals, but especially for an individual with such complex needs, the PNMP should always be up-to-date and available in the Individual Notebook for staff reference;
  - Included photographs;
  - Included complete descriptions of assistive/adaptive equipment;
  - Included mealtime instructions; and
  - Included medication administration instructions.
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Oral hygiene instructions.

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

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	672	320	388	678	599	535	758	133	542
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1			0/1			N/A			

Comments: a. and b. While return to oral intake might not be possible for Individual #388, the IDT had not specifically justified the continued medical necessity of the tube, and no discussion was found in his ISP/IRRF/assessments to show consideration of movement along the continuum to oral eating and/or data to show why it was not possible.

Individual #535 currently ate orally (i.e., in June 2017), and took his medications orally. Documentation described the tube as being

used on a PRN basis if he ate less than 50% of his meal. In the IRRF, the IDT identified that he was at high risk for aspiration due to the existence of the tube, but did not discuss the risks/benefits of leaving it in place or removing it. Although he had returned to oral intake, the documentation did not include a plan to assist in ensuring that this occurred methodically and safely.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments needs improvement. Overall, the quality of the OT/PT assessment updates required substantial improvement. The remaining indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	56% 5/9	1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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;	N/A									

	▪ 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.										
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following concerns were noted:

- For Individual #388, the OT/PT completed the assessment on 1/31/18, for an ISP meeting on 2/12/18. The State disputed this finding, and stated: "ISP: 2/2/18, OT/PT Update was verified 1/17/18 (TX-RI-1812-II.090), more than 10 working days prior to the ISP." The Lead Monitor reviewed the documents, and confirmed that according to Document #TX-RI-18.12-II.001, the "ISP Meeting Date" was 2/12/18, and according to Document #TX-RI-1812.090, the signature date was 1/31/18. Further, review of the body of the assessment showed the OT and PT both made numerous content entries into the document through 1/31/18.
- Individual #678's annual update was timely, but no evidence was found of a review or further assessment after her fall on 7/2/18, with an acute clavicle fracture.
- Individual #535's annual update was timely, but no evidence was found of additional review related to the increase in his falls in July/August.
- On 8/15/18, the OT/PT completed Individual #133's assessment for an ISP meeting held on 8/23/18. The State disputed this finding, and stated: "ISP: 8/23/18, OT/PT Update was verified 8/6/18 (TX-RI-1812-II.090), more than 10 days before the ISP." The Lead Monitor reviewed the documents, and confirmed that according to Document #TX-RI-18.12-II.001, the "ISP Meeting Date" was 8/23/18, and according to Document #TX-RI-1812.090, the signature date was 8/15/18. Further, according to time-stamped entries, the OT and PT made all content entries into the document on 8/15/18.
- Based on the State's comments, the Monitor made corrections from 0s to 1s to two scores (i.e., Individual #672, and758).

e. All of the individuals reviewed had updates. Overall, the OT/PT updates required substantial improvement. That being said, most, but not all met criteria, as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

The Center should focus most on the following sub-indicators:

- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- 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;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	25% 3/12	0/1	0/2	0/1	0/1	0/1	1/1	1/2	0/2	1/1
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.	N/A									

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

b. Simply including a chart of the IDT's "approval" of various plans, including the PNMP did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements.

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

Communication

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

Summary: Problems were noted with the timeliness of a number of communication assessments reviewed. In addition, significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	44% 4/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
b.	Individual receives assessment in accordance with their	67%	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

	individualized needs related to communication.	6/9									
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/6	N/A	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1

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

- Center staff did not submit a previous assessment for Individual #672, so it was unclear whether or not a screening met her needs.
- Individual #320's last communication assessment was completed in 2016, and at that time, the SLP did not provide clinical justification for not completing a comprehensive assessment. The AAC "evaluation" that year consisted of the SLP presenting devices to her while she was in bed and reporting that she did not engage. She also was wearing gloves required by her PBSP. The SLP did not collaborate or document collaboration with BHS to determine if the gloves could be removed for the assessment. More recently, according to her ISP, she was demonstrating the use of switches for other indications, and this was identified as a strength. An updated comprehensive assessment was needed to identify her communication strengths and needs, and to offer the IDT updated recommendations.
- On 1/31/18, the SLP completed an assessment for Individual #388 for an ISP meeting held on 2/12/18.
- On 6/6/18, the SLP completed an assessment for Individual #678 for an ISP meeting held on 6/14/18. The State disputed this finding, and stated: "ISP: 6/14/18, Communication Update verified 5/25/18 (TX-RI-1812-II.079), more than 10 working days before the ISP." The Lead Monitor reviewed the documents, and confirmed that according to Document #TX-RI-18.12-II.001, the "ISP Meeting Date" was 6/14/18, and according to Document #TX-RI-1812.079, the signature dates for two SLPs were 5/31/18, 6/6/18, and 6/9/18. Further, according to time-stamped entries, the SLPs made content entries into the document between

5/31/18 and 6/9/18. Therefore, the finalization date was actually 6/9/18.

- Individual #535's comprehensive assessment in 2017 did not address his needs. The IDT was attempting to teach him to activate a switch. The SLP made no reference to this. He should have had another assessment in 2018, but did not.
- On 8/22/18, the SLP completed an assessment update for Individual #133 for an ISP meeting held on 8/23/18.

c. Individual #672's screening, the assessor did not state whether or not an assessment was necessary, and if not, why.

d. As noted above, the Center did not submit an assessment for Individual #672, and Individual #320 should have had a comprehensive assessment, but did not. Individual #758's assessment did not meet criteria for any of the sub-indicators.

e. Overall, the communication updates were of poor quality. The Center should focus on improving performance with all of the sub-indicators:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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	44% 4/9	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1

	clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/7	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	38% 3/8	N/A	N/A	0/1	0/2	2/2	N/A	0/1	1/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Problems varied with regard to descriptions of individuals' communication skills and needs in their ISPs. Examples included a lack of description of the individual's use of an AAC device, strategies from the SLP assessment were not included or inconsistent with the information in the ISP, and a lack of a description of how others should communicate with the individual.

b. Simply including a chart of the IDT's "approval" of various plans, including the Communication Dictionary did not provide evidence of what the IDT reviewed, revised, and/or approved. Therapists should work with QIDPs to make improvements. In addition, for two individuals (i.e., Individual #599, and Individual #535) discrepancies within the documents submitted made it difficult to determine whether or not they had needed Communication Dictionaries.

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: There was improvement in some aspects of this outcome. First, all individuals had at least one SAP. This was good to see, however, on the other hand, all of these individuals could have benefited from additional skill acquisition opportunities. Six of the individuals had two SAPs, and two of the individuals had one SAP. There was an increase in the percentage of SAPs for which there were reliable data. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	71%	1/1	2/2	1/2	3/3	1/1	0/2	1/2	2/2	1/2

		12/17									
3	The individual's SAPs were based on assessment results.	82% 14/17	1/1	2/2	2/2	3/3	0/1	0/2	2/2	2/2	2/2
4	SAPs are practical, functional, and meaningful.	71% 12/17	1/1	1/2	2/2	2/3	0/1	1/2	1/2	2/2	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	76% 13/17	1/1	0/2	2/2	2/3	1/1	2/2	1/2	2/2	2/2

Comments:

1. All individuals had skill acquisition plans (SAPs). This represents a dramatic improvement from the last review when 56% of individual's had SAPs.

The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs to review for Individual #543, Individual #72, Individual #672, Individual #320, Individual #140, and Individual #139, and one SAP available to review for Individual #298 and Individual #218, for a total of 17 SAPs for this review.

Thus, although it was good to see an improvement in that there were one or more SAPs for each individual each of these individuals had numerous skill deficits that could have benefited from additional skill acquisition opportunities. The Center should continue to look at the role that SAPs can play in each individual's overall treatment program and ISP.

2. Individual #543's brush his teeth and Individual #140's sign thirsty SAPs were judged to not be measurable because the objectives were not operationally defined and, therefore, were not measurable. Individual #672's state her schedule SAP, and Individual #320's dressing and brush her teeth SAPs were scored as not measurable because they did not specify the number of prompts acceptable to attain the objective.

3. Individual #298's FSA indicated that could independently prepare a simple meal. Individual #320's SAP baseline indicated that she could brush her teeth with verbal prompts (the same level in her SAP objective). Additionally, her FSA was blank, so it was not clear that her dressing SAP was based upon assessment results.

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 #672's remain at work SAP), or SAPs that were not clearly related to the individual's ISP vision statement (e.g., Individual #139's brush his teeth SAP).

Although Richmond SSLC has more work to do to ensure that SAPs are meaningful and practical, this represents an improvement from the last review when 55% of SAPs were scored as meaningful to the individual.

5. Individual #672's state her schedule SAP, and Individual #139's brush his teeth and wash his hands SAPs did not have interobserver agreement (IOA) demonstrating that the data were reliable. Individual #314's make a smoothie SAP did have documentation of a recent integrity assessment, 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. This is another indicator that is much improved from last review when 36% of SAPs were documented to have reliable data.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

Summary: With the exception of the one missing FSA, performance improved on these indicators, though indicators 11 and 12 needed additional improvement. Given sustained high performance over this and the previous three reviews, indicator 10 will be moved to the category of requiring less oversight. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	139	140	314	298	320	672	72	543
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	67% 6/9	0/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	44% 4/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1

Comments:

10. Individual #320's FSA was blank

11. There was no documentation that FSAs, PSIs, and vocational assessments were available to the IDT at least 10 days prior to the ISP for Individual #298, Individual #314, or Individual #218.

12. Individual #320, Individual #672, Individual #72, and Individual #543'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, 34 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, eight other indicators were added to this category, in restraints, psychiatry, medical and pharmacy.

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

In psychiatry, once Richmond SSLC routinely obtains reliable data for psychiatric indicators, then progress can be determined.

In behavioral health, four individuals were rated as having met their goals/objectives and/or making progress (because they met criteria indicator 5 and the data showed progress). Two of these individuals (Individual #140, Individual #72) were, therefore, deemed to not require a deeper review. Of the five individuals who were not rated as making progress, two (Individual #139, Individual #672), met criteria for all of the other indicators in psychology/behavioral health. Thus, these two individuals, although not making progress, were deemed to be receiving psychology/behavioral services and supports as per the monitoring tool.

Acute Illnesses/Occurrences

When there were frequent occurrences of crisis intervention restraints, the Center maintained and/or improved on most of the required review aspects. Some additional attention is required.

Psychiatrists were available for interim and urgent psychiatric consultations in-between the quarterly psychiatric reviews.

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Richmond SSLC

review, the Center was in the initial stages of implementing the revised acute care plan template/process. Center staff should continue to work with State Office to correct the issues with this critical nursing function.

Numerous problems were noted with regard to PCPs' assessment and follow-up of acute issues addressed at the Center. This is an area on which Center staff should focus. Since the last review, improvements were noted with regard to PCP's assessment or documentation of acute issues requiring ED visits or hospitalization. However, PCPs did not yet consistently complete and/or document follow-up on these issues. In addition, PCPs often did not attend post-hospitalization meetings to assist the IDTs in developing follow-up medical and healthcare supports to reduce risks and enable early recognition of problems to the extent possible.

Based on the one dental emergency reviewed, the Dentist provided the individual with timely dental assessment, and determined treatment was not necessary. Pain assessment and management, and documentation of it are areas on which the Center should focus.

Implementation of Plans

In psychiatry quarterly reviews were done timely, documentation was complete, and clinics were observed to contain the required content. The integration between psychiatric services and behavioral health services was extensive as evidenced by the cross references in their respective documentation. The psychiatrists routinely attended the neurology clinics that were held onsite every other Tuesday with the neurologist. They attended the clinics for every individual they followed, regardless of whether the medications were for dual use.

There were some deficiencies in the timelines of the MOSES and AIMS monitoring for medication side effects as well as the timely review of those documents by the prescriber. The polypharmacy meeting schedule should be adjusted to ensure that individuals undergoing medication changes are reviewed more frequently than annually. There was empirical justification for medication regimens and tapering plans.

Behavioral assessments and PBSPs were consistently timely and complete. Although Richmond SSLC still has work to do to ensure the data are reliable and PBSPs are implemented as written, there was improvement from the last review. Behavioral Health staff need to ensure that when PBSP objectives are achieved, new objectives are established, and that progress notes document actions to address the lack of expected progress.

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. As a result, individuals remained at significant risk.

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

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCPs generally reviewed the consultations and indicated agreement or disagreement, wrote IPNs that included the required components, and ordered agreed-upon recommendations. This resulted in three indicators moving to the category requiring less oversight. During this review, the Center also sustained progress with regard to providers reviewing consultations timely.

Since the last review, some improvement was noted with regard to the provision of dental treatment to the individuals reviewed, but more work is needed.

Improvement is needed with regard to the quality of the Quarterly Drug Regimen Reviews (QDRRs), particularly with regard to the review of lab results. Based on the individuals reviewed, providers consistently reviewed QDRRs timely.

Adaptive equipment observed was in good working order. Proper fit often was still an issue, though. As the Monitoring Team discussed with staff on site and indicated in its exit notes, therapists should also consider the appropriateness and fit of the beds for individuals with bed positioning concerns. When the Monitoring Team member discussed this with the group of OTs and PTs, they agreed that the bed proportions were disproportionate for many individuals, but they had not raised the issue internally. It might be helpful to obtain a consultation from the State Office Discipline Lead, or therapists from other SSLCs.

Based on observations, there were still numerous instances (37% of 88 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Although in some homes, staff did well implementing Dining Plans, in other homes, problems with Dining Plan implementation placed individuals at significant risk, as did problems with positioning. 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.

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: This outcome applied to four individuals. For one (Individual #298), an IDT was not conducted after more than three restraints. Behavioral health services and IDTs should make sure that this review always occurs. For the other individuals, the meeting discussion topics regarding possible maintaining variables met criteria for indicator 23 for this review and for the previous three reviews, and in addition, IDTs reviewed and revised PBSPs as required for indicator 29 (with one exception at the last review for both indicators). Therefore, indicators 23 and 29 will be moved to the category of requiring less oversight. The discussion regarding environmental variables (indicator 21) was not yet occurring as required for all individuals, and CIPs were not developed as required. Therefore, indicators 21 and 25 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	139	314	298	672					
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: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	67% 2/3	1/1	1/1		0/1					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents,	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

	2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?										
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 3/3	1/1	1/1		1/1					
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	50% 2/4	0/1	1/1	0/1	1/1					
26	The PBSP was complete.	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.	100% 3/3	1/1	1/1		1/1					

Comments:

18-29. This outcome and its indicators applied to Individual #139, Individual #314, Individual #298, and Individual #672.

18-19. Individual #298 had six restraints in June 2018, however, there was no documentation that his IDT met to review more than three restraints in 30 days.

21. For Individual #672, ISPAs documented a discussion of potential setting events. For Individual #314, the ISPA identified anxiety around family visits as an antecedent to her dangerous behavior that provoked restraint. This was more clearly a psychological (i.e., anxiety) issue, or the scheduled family visit was more of an immediate trigger to her dangerous behavior. Individual #139's ISPA ISPA identified inconsistent staff as an setting event to his target behavior (though this might be more considered to be an antecedent). Individual #298 did not have an ISPA addressing more than three restraints in a rolling 30-day period.

23. Individual #139 and Individual #672's ISPAs included a discussion of potential consequences that affected their restraints, and a plan to address them. Individual #314's ISPA indicated that her IDT concluded that consequences did not affect her restraints. Individual #298 did not have an ISPA addressing more than three restraints in a rolling 30-day period.

25. Individual #139 and Individual #298 did not have a CIP. Individual #672 also did not have a CIP, however, the Monitoring Team

was provided a rationale for why the IDT determined that Individual #672's more than three restraints in 30 days represented an isolated event and, therefore, this indicator was scored 1 for her.

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: Once Richmond SSLC routinely obtains reliable data for psychiatric indicators, then indicators 8 and 9 can be assessed by the Monitoring Team. Similarly, indicators 10 and 11 can then be assessed, too. That being said, the Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 8. As described above the psychiatric team had not yet developed functional goals. Accordingly, it was not possible to determine if an individual was making progress.											

9. Due to these deficits, goal/objectives could not be updated.

10. Although there were no functional goals, there was evidence that the psychiatric team did respond when there were clinical indications that an individual's psychiatric status was deteriorating. The related documentation appeared in the quarterly psychiatric reviews as well as Integrated Progress Notes (IPNs) that documented urgent/interim psychiatric consultations that were performed in-between quarterly reviews.

11. These notes also document the implementation of the clinical recommendations.

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:			Individuals:									
#	Indicator	Overall Score										
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.											
Comments:												

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly reviews were done timely, documentation was complete, and clinics were observed to contain the required content. With sustained high performance, these indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	1/1 100%						1/1			

Comments:

33. The quarterly reviews for each individual were completed in a timely manner.

34. The documentation in the quarterly reviews was thorough and contained the required content.

35. The psychiatric clinic for Individual #320 was observed by the Monitoring Team on 12/5/18. The required team members were present and participated in the meeting. The behavioral health services staff initially presented the data through the end of the prior month, but when the psychiatrist inquired about the most recent data, for December 2018, he was able to both present and discus this information.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Performance maintained at a mediocre level. Perhaps some clerical assistance could help ensure that these assessments get completed and reviewed by the prescriber as required. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	56% 5/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments:

36. The MOSES and AIMS were performed and reviewed in a timely manner for Individual #140, Individual #314, Individual #298, Individual #320, and Individual #72. They were completed on time for Individual #218, Individual #543, and Individual #672, but were not reviewed by the prescriber within the required time frame. Individual #139 was an individual for whom the evaluations were not completed or reviewed in a timely manner.

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	218	139	140	314	298	320	672	72	543
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									

Comments:

40. The dosages of the psychiatric medications did not suggest that the goal of treatment was to sedate the individuals.

41. There was no indication that medications were being used for punishment or as substitute for treatment.

42. There was a treatment program in the record of each individual.

43. The facility does not use 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 reviews continued at Richmond SSLC. As part of these reviews, there was empirical justification and tapering plans (or rationales). This has been the case for this and for the previous two reviews, too. Therefore, indicators 44 and 45 will be moved to the category of requiring less oversight. Indicator 46 will remain in active monitoring. Some individuals need to have more frequent polypharmacy reviews.

#	Indicator	Overall Score	Individuals: 218	139	140	314	298	320	672	72	543
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	44% 4/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1

Comments:

44. The polypharmacy meeting that took place on 10/18/18 was observed. Individuals that were not reviewed in that meeting were discussed with the team after the meeting. There was clinical justification for the current psychotropic medications for all of the individuals in the review group.

45. The psychiatric team was able to describe the prior and current efforts to taper medications or the rationale for why they were, or were not, being challenged at this time.

46. One hundred and forty-four of the individuals who resided at the facility were prescribed psychotropic medications. Sixty-six of these (46%) were prescribed medications that met the criteria for polypharmacy. The polypharmacy committee met monthly with a goal of reviewing every individual whose medications met the criteria for polypharmacy. Individuals who are actively undergoing medication changes should be reviewed quarterly. The review of the polypharmacy committee data indicated that the frequency of reviews for Individual #139, Individual #140, Individual #314, Individual #298, and Individual #672 did not meet this criterion.

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: Four individuals were rated as having met their goals/objectives and/or making progress (because they met criteria indicator 5 and the data showed progress). Two of these individuals (Individual #140, Individual #72) were, therefore, deemed to not require a deeper review. This was good to see. The other two of these four individuals did not meet criteria with ensuring assessments were used to develop goals and/or that updated objectives were made (Individual #298, Individual #314).

Of the five individuals who were not rated as making progress, two (Individual #139, Individual #672), did meet criteria for all of the other indicators in outcomes 1 and 2 (indicators 1-9) and all indicators met criteria in the deeper review (see the remainder of this report's psychology/behavioral health sections). Thus, these two individuals, although not making progress, were deemed to be receiving psychology/behavioral services and supports as per the monitoring tool.

These indicators remain in active monitoring.

Individuals:

#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
6	The individual is making expected progress	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	25% 1/4	0/1			0/1				1/1	0/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 4/4	1/1	1/1					1/1		1/1
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 #72, Individual #298, Individual #140, and Individual #314 were scored above as making progress toward their PBSP target behavior objectives. Individual #320's PBSP data indicated progress, however, because her data were not demonstrated as reliable (indicator 5), this indicator for her was scored as 0. The remaining individuals were judged to not be making progress.

7. Individual #72 achieved his SIB objective and a new objective was established. Individual #543 achieved his elopement objective in May 2018, however, no new objectives (or rationale why the objective would be maintained) was presented. Similarly, Individual #314

achieved her elopement and property destruction objectives in October 2018, however, no new objectives were established. Individual #218 achieved her property destruction objective in May 2018, however, no new objective was established.

8. It was encouraging to find that all individuals that were not making progress had progress notes that included actions to address the absence of progress. This represented an improvement from the last review when 50% of the individuals not making expected progress, had identified corrected actions.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	There was a PBSP summary for float staff.											
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:												

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

Outcome 8 – Data are collected correctly and reliably.											
Summary: Richmond SSLC continued to show progress in indicator 30, scoring higher than in previous reviews. Although still more work is needed, it was good to see this continued progress. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
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.										
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	57% 4/7	1/1	1/1		0/1	1/1	0/1	1/1		0/1
Comments: 30. Established frequencies of DCT were not achieved for Individual #543. Additionally, Individual #314 did not have IOA assessed in the last quarter. Finally, there were no IOA or DCT measures in the last year for Individual #320. Although Richmond SSLC still has work to do to ensure the data are reliable and PBSPs are implemented as written, this represents an improvement from the last review when 44% of individuals had achieved their established goal frequencies and levels od IOA, DCT, and treatment integrity.											

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	672	320	388	678	599	535	758	133	542
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	interventions.										
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #672 – other: hypertension, and respiratory compromise; Individual #320 – GI problems, and diabetes; Individual #388 – constipation/bowel obstruction, and seizures; Individual #678 – GI problems, and cardiac disease; Individual #599 – diabetes, and medication side effects/interactions; Individual #535 – osteoporosis, and other: hypothyroidism; Individual #758 – other: anemia, and osteoporosis; Individual #133 – other: iron deficiency anemia, and GI problems; and Individual #542 – GI problems, and seizures). IDTs had not developed clinically relevant, achievable, and measurable goals/objectives.

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

Outcome 4 – Individuals receive preventative care.

Summary: Two of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until performance improves, and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, when reviewing metabolic as well as endocrine risks, practitioners need to correctly calculate the individual's level or risk.

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	86%	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1

		6/7									
	iii. Breast cancer screening	50% 2/4	N/A	1/1	N/A	0/1	N/A	N/A	1/1	0/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	56% 5/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
	vi. Osteoporosis	88% 7/8	N/A	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	60% 3/5	0/1	0/1	N/A	1/1	N/A	N/A	1/1	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.	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	

Comments: a. The following problems were noted:

- For Individual #672, Center staff did not submit a pap report. An IPN mentioned a pap test that occurred in 2017.
- For Individual #320, the last pap occurred on 8/15/13. If human papillomavirus (HPV) testing was completed, the next one would have been due in 2018, but if not, it was due sooner.
- In 2017, Individual #678 had a mammogram, and the recommendation was to follow up in 2018, but no documentation showing follow-up was submitted. In addition, a hearing screening, dated 4/20/17, indicated mild to moderate hearing loss with a recommendation to return in a year. Center staff did not submit documentation of follow-up.
- On 6/1/17, hearing tests for Individual #599 were inconclusive. The recommendation was to have auditory brainstem response (ABR)/otoacoustic emission (OAE) testing and also to return in one year. Follow-up was not found. In addition, documents submitted indicated that a DEXA scan was not applicable, even though he received anti-epileptic drugs (AEDs), highly associated with the development of osteoporosis.
- On 6/7/18, Individual #535's hearing screening was inconclusive and recommended ABR/OAE testing, but follow-up was not found.
- On 2/17/16, Individual #133 had her last mammogram. Of note, on 3/29/18, she had an eye exam. On 7/16/18, the IDT sent the PCP an email asking for a second opinion regarding cataract surgery. No second opinion consult was found in the records.
- For Individual #542, on 9/3/13, a colonoscopy showed worms, and a polyp was removed. The pathology of the polyp was not documented. The gastroenterologist recommended a repeat colonoscopy in five years, but this was not done.

  In addition, audiological testing, on 10/8/15, recommended ABR to determine his hearing sensitivity to facilitate a better plan for possible auditory habilitation and to improve his functional communication at least for basic needs. Evidence to show completion of this testing was not found, or an explanation for why it was not done.

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

Although for some individuals reviewed, PCPs had done this, for some individuals, the Clinical Pharmacist and/or PCP had not identified the correct level of risk (e.g., for metabolic syndrome).

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	672	320	388	678	599	535	758	133	542
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									

Comments: a. None

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

Summary: Numerous problems were noted with regard to PCPs' assessment and follow-up of acute issues addressed at the Center. This is an area on which Center staff should focus. Since the last review, improvements were noted with regard to PCP's assessment or documentation of acute issues requiring ED visits or hospitalization. However, PCPs did not yet consistently complete and/or document follow-up on these issues. In addition, PCPs often did not attend post-hospitalization meetings to assist the IDTs in developing follow-up medical and healthcare supports to reduce risks and enable early recognition of problems to the extent possible. The remaining indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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.	18% 2/11	1/2	0/1	1/1	0/1	0/1	0/2	0/1	N/A	0/2
b.	If the individual receives treatment for the acute medical issue	27% 3/11	1/2	0/1	1/1	0/1	0/1	1/2	0/1		0/2

	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.										
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	80% 8/10	1/2	N/A	2/2	N/A	2/2	N/A	1/2	2/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4	1/1		2/2		N/A		0/1	N/A	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 8/8	1/1		2/2		1/1		2/2	2/2	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	17% 1/6	N/A		0/2		1/2		N/A	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.	56% 5/9	1/2		2/2		1/2		0/1	1/2	

Comments: a. For eight of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including: Individual #672 (drooling and slurred speech on 7/13/18, and nasal fracture on 10/5/18), Individual #320 (skin lesion on 5/8/18), Individual #388 (conjunctivitis on 10/9/18), Individual #678 (clavicle fracture on 7/5/18), Individual #599 (drowsiness on 10/2/18), Individual #535 (seizure on 10/17/18, and UTI on 10/17/18), Individual #758 (agitation on 7/23/18), and Individual #542 (leg erythema on 5/23/18, and knee effusion on 7/11/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #672 (nasal fracture on 10/5/18), and

Individual #388 (conjunctivitis on 10/9/18).

b. For Individual #672 (nasal fracture on 10/5/18), Individual #388 (conjunctivitis on 10/9/18), and Individual #535 (UTI on 10/17/18), the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problems until the acute problems resolved or stabilized.

The following provide examples of concerns noted:

- On 7/13/18, at approximately 10:37 a.m., nursing staff documented that the psychiatrist ordered stat drug levels of ammonia and Valproic acid (VPA) due to Individual #672 having slurred speech and drooling. The nurse did not notify the PCP and no documentation was found to show that a medical provider conducted an evaluation. At around 4:15 p.m., nursing staff documented that the VPA level was not available to the Infirmary staff, and the psychiatrist/PCP would be notified when it was available. The next day, on 7/14/18, at approximately 11:00 a.m., nursing staff notified the psychiatrist of the results. The psychiatrist gave no new orders. Nursing staff did not document any assessments related to the individual's drooling and slurred speech. It also was not clear why the PCP was not notified of these findings. In the IPNs reviewed, there was no documentation from any medical provider regarding the lab results.
- On 5/8/18, the PCP evaluated Individual #320 for a report of a skin lesion to her forehead and left eyebrow. The exam was pertinent for scabs and scars on the forehead. There was an open skin lesion above the left eyebrow with scant serous drainage that was surrounded by induration and erythema; there was no abscess or purulent drainage. The PCP's physical exam did not describe the size of the open lesion or the size of the induration and erythema that surrounded the lesion. The plan was to apply mupirocin ointment twice a day for seven days and use warm compresses three times a day for five days. The PCP did not schedule any plan for or document any follow-up.
- On 7/5/18, the Registered Nurse Case Manager (RNCM) reported in the morning meeting that on 7/2/18, Individual #678 tripped and hit her head. It was further stated that medical monitoring was not implemented. After the morning meeting, nursing staff implemented medical monitoring and neurological checks. In a separate nursing IPN, dated 7/5/18, nursing staff reported that the individual had a large knot on her right shoulder and swelling of the right index and middle fingers. Nursing staff notified the PCP who gave orders to obtain stat x-rays. The individual was referred to sick call in the morning. On 7/6/18, the PCP evaluated the individual and documented visible displacement of the right mid-clavicle with bruising. The x-rays showed a fracture. The plan was to use a sling, give Motrin for pain, and refer the individual to orthopedics. The PCP did not document any follow-up for this acute injury.
- On 10/2/18, the PCP evaluated Individual #599 for reports of drowsiness, weakness, and refusal to eat breakfast. There were no other complaints. The PCP documented that the individual ambulated independently into the exam room and was alert upon examination. The individual's blood pressure was 133/79, and the exam was unremarkable. The plan was to obtain labs and a chest x-ray to rule out an infectious etiology as the cause of the change in mental status. The PCP indicated that monitoring would continue and follow-up would occur for the labs. No follow-up assessment or documentation was found.

  Again, on 10/6/18, the individual was referred to sick call. The PCP documented that the individual was found in bed and did not get up for breakfast. It was also documented that the head-of-bed (HOBE) was not properly elevated as required as part of aspiration precautions. Per the PCP, the exam was normal and medical monitoring was to continue. The results of the labs, mentioned on 10/2/18, were not discussed.

- On 10/17/18, the PCP documented that the previous night, Individual #535 had a 20-second seizure. The physical exam was unremarkable; however, the PCP did not document a neurological exam. The plan was to check a phenobarbital level and a urinalysis to rule out a UTI. The PCP did not document any follow-up assessments.

  On 10/24/18, the PCP documented that the previous night, the individual was admitted into the Infirmary due to the need to administer intravenous (IV) antibiotics for a UTI. There was no documentation of the results of the other labs that were discussed in the note, dated 10/17/18. On 10/26/18, and 10/29/18, the PCP saw him again, and reported he was doing well. On 10/30/18, Individual #535 was discharged from the Infirmary.
- On 7/23/18, the PCP documented an evaluation of Individual #758 due to reports of multiple bruises to her back and arms secondary to aggressive behavior. The PCP documented bruises at various stages of healing on the individual's arms and back. The plan was to obtain labs to rule out a medical cause for the increased agitation and possibly to refer her to neurology/psychiatry for evaluation for possible dementia. The PCP set forth no specific plan for follow-up, though.

  The PCP did not conduct any follow-up for this issue. On 7/27/18, the PCP evaluated the individual for a new complaint of scalp hematoma and laceration. At that time, the individual's white blood cells (WBCs) and platelets were documented as normal. There was also no follow-up for this laceration.
- On 5/23/18, the PCP documented an evaluation of Individual #542 for left leg redness and a reopened left leg wound. The exam described "profuse redness to L lower leg below knee and some redness to R lower leg." There was also a superficial lesion on the left lower extremity that measured 1.5 centimeters (cm) by 1.5 cm, and was scabbed over. The diagnosis was "erythematous condition, unspecified." The plan was to use compression stockings and treat the wound with Bactroban. The PCP did not schedule follow-up, even though the diagnosis was not clear.

  On 6/1/18, the PCP saw Individual #542 again, because the redness on the right leg worsened. The plan was to continue compression stockings. Given that the leg redness worsened, closer follow-up likely was warranted. Additionally, given the progression of the condition, evaluation/consultation with a physician might have been indicated.

  On 6/5/18, the PCP noted the wound was healed, but the individual was not wearing the stockings. On 7/9/18, he was seen for a new lesion on the left shin.

  On 7/11/18, the PCP again evaluated Individual #542 due to the OT reporting that his right knee was swollen, warm, and red. He did not complain of pain, but it was noted that he received Ativan and acetaminophen/hydrocodone daily, which could mask both pain and fever. The assessment was right knee effusion and the plan was to check labs and x-rays and rule out an infectious process.

  Given the fact that the Advanced Practice Registered Nurse (APRN) considered an infectious process, there should have been an immediate work-up, and the APRN probably should have consulted a physician. Joint infections are medical emergencies that warrant prompt intervention to prevent sepsis and joint destruction. The PCP did not document a follow-up assessment. On 7/16/8, the PCP noted in an addendum that the labs were normal.

On 8/9/18, the PCP documented that on 7/27/18, there was an attempt to do a computed tomography (CT) scan, and the individual's knee was unremarkable.

c. For five of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #672 (psychosis on 8/17/18, and abscess/cellulitis on 9/28/18), Individual #388 (pneumonia on 7/26/18, and aspiration pneumonia/sepsis on 8/1/18), Individual #599 (pneumonia on 5/3/18, and status epilepticus on 8/20/18), Individual #758 (nasal hematoma on 7/11/18, and cardiac arrest on 9/1/18), and Individual #133 [gastrointestinal (GI) bleed on 7/16/18, and aspiration pneumonia on 7/29/18].

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #672 (abscess/cellulitis on 9/28/18), Individual #599 (pneumonia on 5/3/18), and Individual #133 (GI bleed on 7/16/18).
- On 8/17/18, nursing staff documented that at 8:00 p.m., the psychiatrist ordered a transfer of Individual #672 to the ED. There was no documentation to show that the physician or nurse communicated necessary clinical information to the ED staff. The individual was evaluated in the ED, and on 8/18/18, at 7:45 a.m., she returned to the Center. The diagnosis was psychosis. The Medical Director and psychiatrist were notified of her return to the Center. However, there was no documentation to show that a medical provider evaluated her upon her return to the Center. The ED records documented several abnormal diagnostics, including a chest x-ray that showed two adjacent less than 5 millimeter (mm) nodular densities in the left lung, and the hemoglobin (Hb) and hematocrit (HCt) were low at 11.1 and 32.3. Medical staff addressed none of these findings in the IPNs.
- Individual #388's IDT did not meet to specifically discuss the two hospitalizations for pneumonia. Given his complex medical needs, his IDT, with the leadership of the PCP, should have reviewed and revised, as necessary his IHCPs.
- On 8/20/18, the PCP documented receiving a call at around 6:25 a.m., with a report that Individual #599 had a seizure that lasted more than five minutes and he was transferred to the hospital. The individual was admitted to the intensive care unit (ICU) with status epilepticus, respiratory failure, and sepsis. He required intubation and mechanical ventilation. On 8/24/18, he was discharged.

  On 8/22/18, the IDT held an ISPA meeting to discuss the hospitalization, but no PCP attended. Based on the documentation, it was not clear when a neurological consult would occur following this individual's status epilepticus and resulting hospitalization, intubation, etc.

  On 8/25/18, the PCP evaluated the individual. Records should have noted that in May, Keppra was discontinued due to aggression. However, during the hospitalization, he was restarted on Keppra due to the diagnosis of status epilepticus. The PCP did not comment on mental status or a neurologic exam in the assessment. On 8/26/18, the PCP saw him again. Neither of the two notes discussed follow-up with his regular neurologist, and in the records submitted, there was no neurology consult completed after this hospitalization.
- On 7/11/18, the PCP documented that Individual #758's wheelchair flipped over and the individual fell and had swelling to her nasal bridge. At 3:47 p.m., the PCP was notified of the individual's injuries, but did not assess the individual. There was an attempt to obtain x-rays, and when this was not successful, she was transferred to the ED. On 7/12/18, the PCP saw her, and

noted that a CT of the cervical spine, and head showed no acute abnormality. The diagnoses were forehead hematoma and nasal contusion. There was no additional follow-up.

- For Individual #758, on 9/1/18, nursing staff documented that: "Infirmary nurse… RN called and notified of critical lab value on BUN [blood urea nitrogen] -60 @1214. On call NP [nurse practitioner]… was called and informed at 1218 of the critical lab and she said due to the CKD [chronic kidney disease] stage to follow up with PCP on Tues, Problem not resolved." At around 1:25 p.m., staff reported that the individual was on the sofa unresponsive and unconscious. The events that occurred were not entirely clear. It appeared that the nurse on the scene left the individual to get an automated external defibrillator (AED) and reported that a faint pulse was palpated. Emergency Medical Services (EMS) found no pulse and started cardiopulmonary resuscitation (CPR). Hospital records documented that she was found with no pulse. She coded twice in the ED, and the family decided to sign a do not resuscitate order (DNR). At 5:57 p.m., she died.
- Although on 7/30/18, Individual #133's IDT held a post-hospitalization ISPA meeting to address her hospitalization on 7/16/18 for sepsis, syncope and hypotension, the PCP was not present. The discharge diagnoses were not clearly stated in the PCP's IPN. An esophagogastroduodenoscopy (EGD) was performed due to a suspected GI bleed, and showed an esophageal hiatal hernia, but no bleeding was found. According to a nursing IPN, dated 7/23/18, staff recovered a telemetry lead from her stool. A KUB (i.e., abdominal x-ray) done at the Center showed a possible foreign body. On 7/25/18, the PCP documented that the follow-up KUB was pending. On 7/26/18, the PCP assessed the individual after discharge from the Infirmary and noted that she had no problems. The follow-up KUB was negative for a foreign body. Of note, nursing documented in an IPN that staff in the x-ray department stated that two KUBs were done and "did not show anything." The documenting nurse indicated that the IDT would be notified by email. Staff should be aware that the staff in the x-ray department are not licensed to interpret x-rays, and information relayed to the IDT should come from the physician's reading of the x-ray.

  On 7/29/18, the PCP documented that he received an after-hours call that Individual #133 had dark brown emesis that tested positive for occult blood. She was referred to the ED for evaluation, admitted, and on 8/3/18, discharged back to the Center.

  On 8/4/18 (i.e., Saturday), there was no PCP note. On 8/5/18, the PCP evaluated the individual. Per the PCP assessment, she was diagnosed with a right lower lobe pneumonia, possibly aspiration. The PCP did not mention that the individual received a blood transfusion, but this information was found in the ISPA, dated 8/2/18. The PCP also did not mention that on 8/1/18, an EGD was done, but this was found in the ISPA. Per hospital documentation, on 8/1/18, an EGD was done, and an electrocardiogram (EKG) pad was found in her stomach and she had a significant hiatal hernia.

  The plan was to continue antibiotics and order a baseline KUB to assess for a foreign body. On 8/6/18, the PCP saw the individual again. On 8/7/18, the PCP documented a post-infirmary assessment. This IPN included documentation of pertinent labs. The individual had hypokalemia and the plan was to replace the potassium and recheck. Antibiotics would be continued for treatment of pneumonia and the complete blood count (CBC) would be rechecked.

  On 8/2/18, the IDT met to discuss Individual #133's ingestion of the EKG leads. There was no PCP present. The individual's history of having a blood transfusion, and an EGD on 8/1/18 with retrieval of an EKG lead was not documented in the PCP's post-hospital assessment. The ISPA also did not show that the IDT adequately discussed the diagnosis of aspiration pneumonia.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCPs generally reviewed consultations and indicated agreement or disagreement (Round 12 – 85%, Round 13 – 100%, and Round 14 – 94%), wrote IPNs that included the required components (Round 12 – 85%, Round 13 – 100%, and Round 14 – 82%), and ordered agreed-upon recommendations (Round 12 – 100%, Round 13 – 93%, and Round 14 – 94%), Indicators a, c, and d will move to the category requiring less oversight. It was good to see timely review of consultations. If the Center sustains this performance, after the next review, Indicator d might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	94% 16/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	0/1	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	94% 16/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	0/1	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	82% 14/17	1/2	2/2	2/2	2/2	2/2	2/2	2/2	0/1	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	94% 16/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	0/1	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #672 for neurology on 6/8/18, and podiatry on 5/15/18; Individual #320 for optometry on 6/7/18, and podiatry on 8/21/18; Individual #388 for wound care on 9/20/18, and eye on 10/25/18; Individual #678 for orthopedics on 10/22/18, and gastroenterology (GI) on 10/19/18; Individual #599 for eye on 6/7/18, and neurology on 5/22/18; Individual #535 for podiatry on 10/16/18, and GI on 6/7/18; Individual #758 for hematology on 5/8/18, and GI on 8/29/18; Individual #133 for ophthalmology on 10/5/18; and Individual #542 for neurology on 8/14/18, and orthopedics on 6/22/18.											

a. and b. For most of the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements, and completed these reviews timely. The exception was the consultation for Individual #133 for ophthalmology on 10/5/18, for which Center staff did not submit the consultation, but only submitted the IPN.

c. Exceptions were the consultations for: Individual #672 for neurology on 6/8/18, for which the PCP quoted the text of the discharge instructions rather than provide a summary of the consult and the plan stated in the consult; Individual #133 for ophthalmology on 10/5/18, for which Center staff did not submit complete information; and Individual #542 for orthopedics on 6/22/18, for which the PCP did not provide a valid reason for the consultation (i.e., "Fu").

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 the consultation for Individual #133 for ophthalmology on 10/5/18, for which Center staff did not submit complete information.

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

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

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
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.	39% 7/18	1/2	1/2	1/2	1/2	0/2	1/2	1/2	0/2	0/1

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #672 – other: hypertension, and respiratory compromise; Individual #320 – GI problems, and diabetes; Individual #388 – constipation/bowel obstruction, and seizures; Individual #678 – GI problems, and cardiac disease; Individual #599 – diabetes, and medication side effects/interactions; Individual #535 – osteoporosis, and other: hypothyroidism; Individual #758 – other: anemia, and osteoporosis; Individual #133 – other: iron deficiency anemia, and GI problems; and Individual #542 – GI problems, and seizures).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #672 – respiratory compromise, Individual #320 – GI problems, Individual #388 – seizures, Individual #678 – GI problems, Individual #535 – osteoporosis, Individual #758 – other: anemia, and Individual #542 – seizures. The following provide examples of concerns noted:

- Individual #672's goal was to maintain a blood pressure less than 140/90. This individual was 35 years old, and the PCP should review current guidelines related to the management of hypertension to determine if this is an appropriate blood pressure goal. She was monitored for evidence of target organ damage. She was treated with enalapril 20 mg daily and was

prescribed a heart healthy diet. However, she had chronic hyponatremia that was attributed to the use of Depakote. Therefore, she received daily salt tablets. Providing additional salt adversely affects the management of hypertension. There was no documentation that a nephrology evaluation had occurred, and there also was no documentation that the hyponatremia was reported as a potential adverse drug reaction.

- Individual #320's IDT rated her at low risk for diabetes. In addition, according to the risk assessment in the AMA, the individual met one of the criteria for the diagnosis of metabolic syndrome: treatment of dyslipidemia. However, this individual was at increased risk due to a strong family history of diabetes mellitus, treatment with Zyprexa, and the diagnosis of hyperlipidemia. Additionally, the individual received two medications used to treat hypertension. Lisinopril was prescribed for cardiomyopathy, and propranolol was prescribed for a psychiatric indication. The individual remained normotensive on these two medications, suggesting that she might actually have elevated blood pressures. The blood pressure of 138/82 documented in the AMA was actually consistent with hypertension. Therefore, the risk for metabolic syndrome might be higher than assessed.
- Per the AMA, Individual #388 was diagnosed with constipation that was treated with daily docusate, lactulose, and pro re nata (PRN, or "as needed") suppositories. According to the AMA, non-pharmacologic treatment was also implemented, but no specific information was provided.
- Individual #678 was diagnosed with dyslipidemia. According to the AMA, she was treated with Lipitor, fish oil, and cholestyramine, and the lipid values were within normal limits. The PCP noted that she did not have metabolic syndrome. However, she was treated for hyperlipidemia. Cardiology documented that she had primary hypertension with blood pressures well controlled on metoprolol. Cardiology also noted that the individual's fasting blood sugar was 139 and an A1c would be obtained. The A1c was 5.5, which was at the upper normal range.
- According to the AMA, Individual #599 did not have metabolic syndrome. However, the AMA failed to discuss the risk for metabolic syndrome. The individual received a second-generation antipsychotic that increased risk. Moreover, the records documented numerous blood pressures that were greater than 130/85. The PCP had not completed any interim medical reviews, or addressed the recent elevations in blood pressure.
- Per the AMA, Individual #599 had chronic mild thrombocytopenia, which was likely medication-induced. He was asymptomatic. There was no referral to hematology for evaluation. As discussed elsewhere, there was no report of a potential ADR based on the thrombocytopenia.
- Per the AMA, Individual #535's hypothyroidism was diagnosed based on the thyroid stimulating hormone (TSH) level, which was repeated every six months. The AMA implied that he had symptoms of hypothyroidism, such as weight gain, decreased appetite, dry skin, constipation, and bradycardia. It was not clear if those symptoms resolved with treatment.
- In 2008, Individual #758 was diagnosed with osteoporosis. She was treated with Prolia, Vitamin D, and calcium. In August 2017, her last DEXA scan showed improving scores. Per the AMA, completed on 11/29/17, she would be referred to endocrinology for evaluation regarding implementing a drug holiday. There was no evidence that the endocrine evaluation was done.
- Individual #133 was diagnosed with iron deficiency anemia. Per the AMA, since 2016, the individual had been treated with iron supplementation. The AMA did not include the important information that in July 2018, she was hospitalized twice due to hematemesis, or that she had an EGD done while hospitalized (i.e., on 7/16/18). On 7/29/18, she was hospitalized again for evaluation of possible hematemesis. Again, on 8/1/18, an EGD was done and showed no active bleeding. The plan at discharge was to obtain a small bowel follow-through after the nausea and emesis had resolved. There was no evidence that this was

done, even though there was no clear explanation for the decrease in her hemoglobin and the iron deficiency.

Per the AMA, dated 8/15/18, she had GERD based on EGDs done in 2012 and 2015. She was treated with esomeprazole and had supports that included GERD precautions with elevation of HOB. No aspiration was noted based on a Modified Barium Swallow Study (MBSS). She was prescribed a regular diet with GERD precautions. However, the AMA did not discuss the hospitalizations or the EGDs that were done during the hospitalizations. The EGD showed a hiatal hernia (new diagnosis).

- On 9/3/13, Individual #542 had a colonoscopy completed. The exam was pertinent for the presence of worms in the colon and removal of a cecal polyp. The GI recommendation was to repeat the colonoscopy in five years. The AMA did not include any discussion of the diagnosis of a colon polyp or the related pathology report, and there was no documentation that a follow-up study was completed.

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

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	86% 6/7	N/A	0/1	2/2	N/A	N/A	2/2	1/1	N/A	1/1

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the action steps assigned to the PCPs generally were implemented.

Pharmacy

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

Summary: N/R

#	Indicator	Overall Score	Individuals: 672	320	388	678	599	535	758	133	542
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 Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.										

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given that during this review and the past two reviews, psychiatrists completed timely reviews of QDRRs for individuals prescribed psychotropic medications (Round 12 – 100%, Round 13 – 100%, and Round 14 - 100%), Indicator c.ii will be placed in the category requiring less oversight. Improvement is needed with regard to the quality of the QDRRs, particularly with regard to the review of lab results.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	33% 6/18	2/2	2/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	89% 16/18	2/2	2/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	67% 4/6	N/A	0/2	N/A	N/A	2/2	N/A	2/2	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										

	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	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% 8/8	2/2	2/2	N/A	N/A	2/2	N/A	2/2	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 15/15	2/2	2/2	2/2	2/2	2/2	N/A	1/1	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.	N/R									

Comments: b. For a number of individuals, the Clinical Pharmacist had not addressed abnormal lab values in the QDRR reports, or made recommendations that were not consistent with generally accepted practice. A few examples included:

- For a few individuals with anemia (e.g., Individual #542, Individual #133, Individual #535, and Individual #388), the Clinical Pharmacist recommended iron panels. The algorithm for the evaluation of anemia takes into consideration values other than the hemoglobin and hematocrit. The Clinical Pharmacist should state the hemoglobin and hematocrit values and additional information, such as the red blood cell (RBC) indices. The evaluation and decision to obtain other studies is made after review of the indices and a peripheral blood smear. An iron panel is not indicated for every individual with anemia.
- For Individual #542, the carbon dioxide level (CO2) came back elevated, but the Clinical Pharmacist did not comment on this as a possible medication induces issue.
- For Individual #678, the Clinical Pharmacist commented that the white blood cell (WBC) and RBC counts were depressed. There was no comment regarding a potential relationship to medication use.

The Clinical Pharmacist stated that Individual #320 met zero out of five criteria for metabolic syndrome. This was inaccurate. The individual was treated with atorvastatin for hyperlipidemia. Additional consideration should be given to the fact that she is normotensive while receiving Lisinopril and propranolol, which both decrease blood pressure.

The Clinical Pharmacist stated Individual #599 met one criteria for metabolic syndrome: blood pressure (greater or equal to 130/180 or treated for hypertension). However, the individual did not have a diagnosis of hypertension, but was treated with a high dose of clonidine for a psychiatric indication (as opposed to high blood pressure). Based on review of IView documentation, he had several blood pressure readings greater than 130/80.

- In its comments on the draft report, the State disputed this finding, and stated: "On QDRR completed 9/12/18, the clinical pharmacist noted the individual appears to have met one out of five criteria for metabolic syndrome: Blood pressure (greater or equal to 130/85 or treated for hypertension). The clinical pharmacist was referring to the blood pressure readings (134/77; 120/70; 130/76), not treatment for blood pressure. In addition, the clinical pharmacist stated pharmacological treatment for the blood pressure does not appear to be necessary per JNC8 guidelines based upon the blood pressure readings as the target goal is less than 140/90. (TX-RI-1812-II.009 page 10 of 48)."
- The State is correct that the individual did not have a diagnosis of hypertension. The intent of the Monitoring Team's comment

was for the Clinical Pharmacist to recognize that the individual's blood pressures were elevated (>130/80), even though he was receiving a substantial dose of clonidine, which can drop an individual's blood pressure. Consideration should be given to the fact that the individual might have hypertension.

For Individual #599, the Clinical Pharmacist recognized the individual was prescribed polypharmacy for psychotropic drugs, but did not comment on it.

For Individual #542, the Clinical Pharmacist discussed the reaction between hydrocodone and lorazepam, but made no formal recommendation. The Center for Disease Control (CDC) has issued specific warnings about the danger of using opioids and benzodiazepines. The Clinical Pharmacist should have made a formal recommendation to monitor for the potential side effects.

- In its comments on the draft report, the State disputed this finding, and stated: "On QDRR completed 9/19/18, the clinical pharmacist noted what side-effect to watch closely for – "shallow breathing and sedation" in the clinical findings section based upon the drug-drug reaction (TX-RI-1812-II.009 page 13 of 39)."
- The Clinical Pharmacist did note under the interaction section that the individual should be watched for shallow breathing and sedation. However, the CDC makes a specific recommendation to "avoid prescribing opioid medications and benzodiazepines concurrently." Given the well-documented risk of concurrent use of benzodiazepines and opioids, the Clinical Pharmacist should have made a specific recommendation regarding the continued use of this drug combination. If the decision was that this was necessary, there should be a plan in place to address the respiratory depression in the event that it occurred. There was no discussion of having a reversal agent immediately available in the event of respiratory depression.

c. For the individuals reviewed, it was good to see that prescribers reviewed QDRRs timely, and documented agreement or provided a clinical justification for lack of agreement with the Pharmacist's recommendations.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	N/A	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% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7		0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments: a. and b. Individual #672's IDT rated her at low risk for dental, and Individual 133 was edentulous. However, they were part of the core group, so full reviews were conducted. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

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

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

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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)								N/A	

Comments: Individual #133 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: Since the last review, some improvement was noted with regard to the provision of dental treatment to the individuals reviewed, but more work is needed. The remaining indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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.	75% 6/8	1/1	0/1	0/1	1/1	1/1	1/1	1/1	N/A	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	63% 5/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1		0/1
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.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	1/1		1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	50% 1/2	N/A	N/A	N/A	0/1	N/A	1/1	N/A		N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										

Comments: a. through f. Individual #133 was edentulous.

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

Summary: Based on the one dental emergency reviewed, the Dentist provided the individual with timely dental assessment, and determined treatment was not necessary. Pain assessment and management, and documentation of it are areas on which the Center should focus.

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A						N/A			
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1						0/1			

Comments: a. through c. through c. On 7/17/18, a direct support professional reported that Individual #535's tooth came out during dental care. The PCP saw the individual and referred him to the Dental Clinic. The Dentist was able to perform a limited exam, and stated that the missing tooth appeared to be #20, and that no further treatment was indicated. The individual was scheduled for TIVA on 7/25/18. In the documentation provided, the Dentist did not discuss pain management.

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	672	320	388	678	599	535	758	133	542
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/2			0/1			0/1			
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2			0/1			0/1			
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2			0/1			0/1			

Comments: a. For the two applicable individuals, IDTs did not include measurable suction tooth brushing strategies/plans in their ISPs/IHCPs.

b. Based on documentation submitted, for the two individuals, staff implemented some suction tooth brushing, but because IHCP did not include measurable action steps, the Monitoring Team could not determine whether or not they received what they needed. Of concern, during the course of the year, Individual #388 was rated as having fair/poor oral hygiene, and Individual #535 was consistently rated as having poor oral hygiene. This called into question the reliability of the data, and/or the quality of the technique staff used.

c. Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." Although it appeared that Dental Department staff conducted some monitoring of staff's implementation of suction tooth brushing for quality, ISP action plans did not define the frequency expected to meet the individuals' needs. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient.

d. QIDP reports did not include specific data, and analysis of the data. Moving forward, specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset is needed on the number of such events during which the individual completed the expected duration of suction tooth brushing (e.g., of the 60 completed sessions, in 12 sessions the individual completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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	0%									

	nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.										
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the Richmond SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.										

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	672	320	388	678	599	535	758	133	542
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #672 – constipation/bowel obstruction, and fractures; Individual #320 – falls, and skin integrity; Individual #388 – UTIs, and choking; Individual #678 – skin integrity, and osteoporosis; Individual #599 – constipation/bowel obstruction, and seizures; Individual #535 – UTIs, and other: hypothermia/hypothyroidism; Individual #758 – falls, and choking; Individual #133 – GI problems, and cardiac disease; and Individual #542 – constipation/bowel obstruction, and falls). For these individuals' risk areas, IDTs had not developed clinically relevant, measurable goals/objectives.

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

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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	0/1	0/2	0/2	0/1	0/2	0/1	0/1	0/2	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	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 generally was 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. As illustrated below, a pervasive problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- From the ISPAs provided (e.g., on 10/8/18), Individual #672 experienced changes in her mood and affect, with increasing periods of agitation resulting on 10/2/18, in a fracture to her nasal bone from hitting herself and running into a wall. However, it did not appear that the IDT conducted a comprehensive analysis to address the following issues:
    - According to the ISPA, dated 9/5/18, her day "is not full of meaningful activities that could help distract her from obsessing about a family visit or a phone call."
    - Episodes of hyponatremia;
    - Sleep issues related to her sleep apnea;
    - A lack of regular documentation regarding her mood and mood cycles (i.e., she was diagnosed with Bipolar Disorder 1 manic with Psychotic Features);
    - Restraint episodes;
    - Episodes of increased aggression and self-injurious behavior (SIB);
    - An unsteady gait, and pain related to degenerative joint disease, callouses to her feet, and menses;
    - Her mother and father's declining health; and
    - Based on documentation in the IRRF, poor fluid intake placing her at higher risk for falls.

  The lack of a comprehensive analysis of these and other factors placed Individual #672 at continued risk for harm.
- The ISPA, dated 7/9/18, indicated that staff noted transfers for Individual #320 were becoming difficult due to her weight gain, and that while staff are to walk in front of her with the individual's hands on staff's hips, Individual #320 was leaning backwards. This caused concerns with regard to potential back injuries for staff and potential falls for the individual. In the ISPA, dated 10/4/18, the IDT noted similar concerns. On 7/5/18, the individual had already fallen while getting out of a van and landing on her buttocks and hitting her head. The ISPA, dated 7/9/18, indicated that her weight was above her estimated desired weight range (EDWR) by 23 pounds. However, the following issues were noted:
    - The ISPAs, dated 7/9/18, 10/4/18, and 11/1/18, did not show that the IDT actually took any steps to address her weight issues.
    - According to the ISPA, dated 10/4/18, the Orientation and Mobility (O&M) Specialist indicated that there was poor communication between the IDT and the Specialist regarding the completion of action steps as well as the individual's travel procedure. The ISPA indicated that the "modifications currently in place were to accommodate the staff from previous techniques," but she would be re-assessed during travel "for her maximum preference and safety." This statement was concerning, and it was unclear why the IDT had not requested a re-assessment sooner, since her fall occurred on 7/5/18.
    - The ISPA, dated 11/1/18, did not indicate whether or not the O&M Specialist completed the reassessment or why staff

requested a walker assessment. In addition, during this meeting, the IDT discussed the issues of needing to re-in-service staff regarding proper scooping of food, and the possibility that staff were providing her snacks when she was not engaging in SIB. However, when the IDT met in July 2018, when weight was clearly an issue related to her ambulation, the IDT had not addressed these issues.

Based on the documentation provided, since her fall on 7/5/18, the IDT took little to no action, leaving her at risk for further falls.

- From the nursing documentation provided, it was not possible to tell whether Individual #320's skin condition related to her SIB was better or worse. Tracking was not found to show whether or not she wore gloves at all times, except for bathing, nor was monitoring documented to show the gloves' effectiveness. The IPNs, nursing annual and quarterly assessments, the IRRF, the IHCP, and the ISPAs included little to no information about the gloves, calling into question the justification for the ongoing, regular use of the gloves.
- With regard to infections for Individual #388 that included hospitalizations for UTIs on 10/14/17, 2/14/18, and 8/13/18; ED visits for UTIs on 5/14/18, and 5/28/18; sepsis on 7/18/18, 8/13/18, and 8/27/18; pneumonia on 7/26/1; a fever on 8/1/18; and on-going infections to his sacral Stage 4 pressure wound:
  - No evidence was found that the Infection Control Nurse was involved in his case;
  - The ISPAs did not indicate that his IDT completed a "root cause analysis," including a review of all infections to identify causes and potential opportunities for cross contamination;
  - Based on the Monitoring Team's observations, staff were not following universal precautions;
  - Staff were not maintaining documentation of his daily intake and output;
  - Staff did not maintain documentation to show changes of the drainage bag every three days;
  - Nurses did not complete regular urinary assessments; and
  - Nursing staff/the IDT did not maintain a clear clinical timeline of his health issues (e.g., UTIs, skin breakdown, weight loss, kidney stones, anemia, osteomyelitis), and related treatments.
- Although at the time of the onsite review, Individual #388 received nothing-by-mouth (NPO), the documentation in the IRRF and nursing annual assessment noted he experienced several vomiting episodes, which placed him at risk for choking. He had some ability to reposition himself. However, due to his sacral wound, he was confined to bed, and had few approved options for positioning. Based on review of the ISPAs and IHCP, his IDT had not developed a plan that addressed what staff should do in the case of a vomiting episode to prevent choking and aspiration. The "15 Minute Positioning Checklist Sheet," for 12/3/18, clearly noted at the top: DO NOT POSITION ON HIS BACK. Position him only on semi right or semi left side lying." It was very concerning to note that staff had positioned him in the supine position frequently during the day, and staff had left some of the times on the sheet blank.
- Individual #678 had experienced three fractures, including her right clavicle, when she was young (i.e., no age provided in the AMA); the right fourth finger in 2017; and the right clavicle, on 7/2/18. She had a diagnosis of osteopenia, and from the documents provided, she ambulated independently. Based on the documents submitted, the IDT had not put weight-bearing programs in place to potentially improve her DEXA score, or at the very least, prevent worsening of the osteopenia to osteoporosis.
- Based on the ISPA, dated 9/7/18, and the nursing annual and quarterly assessments, it was unclear how many of Individual #599's falls were due to seizure activity and how many were not. Based on the documentation provided, his IDT had conducted no analysis of his seizures or falls, despite the fact that his falls were increasing (i.e., 5/18/18, 7/20/18, 8/4/18, 8/20/18,

8/28/18, and 8/29/18, according to Document Request IV.1-20). In addition, he had a history of a traumatic brain injury (TBI), which placed him at higher risk of sustaining additional head injuries. It was concerning that during the 9/4/18 ISPA meeting, the IDT concluded the following without conducting a comprehensive review of his falls: "At this time the team does not feel that any additional supports are necessary. Due [sic] to the falls being related to aggression and uncontrollable variables." In addition, although the documentation indicated that he only had two seizures during the review period (i.e., from 5/3/18 to 8/20/18), both were significant in that they resulted in hospitalizations. There was no indication that the IDT met to try to identify possible issues related to his elevated Dilantin levels (e.g., possible dehydration, medication interactions, medication variances), and to identify potential patterns and trends related to his seizure activity in comparison with constipation episodes or other health/behavior issues.

- Based on the documentation provided, Individual #535's IDT had not reviewed and analyzed the potential causes or etiologies of his recurring UTIs (e.g., lack of fluid intake, poor hygiene habits, unable to empty bladder, etc.). In addition, the IDT had not reviewed the organisms found in the urine cultures, which would help to identify possible interventions to prevent further UTIs to the extent possible.
- The IDT had not conducted a comprehensive assessment to address Individual #758's increase in falls (i.e., 5/31/18, 6/2/18, 6/4/18, and 7/11/18) and other health and behavioral issues, such as analysis of information related to her:
    - Vision issues;
    - Chronic Kidney disease;
    - Episodes of constipation;
    - Acute infections such as UTIs;
    - Increases in aggression and peer-to-peer aggression incidents;
    - Sleep issues;
    - Anemia;
    - Changes in mental status;
    - Dehydration;
    - Fluid intake; and
    - Abnormal lab values

  Such analysis would be necessary to determine whether or not any patterns or trends existed, and if so, whether or not one or more issues were impacting her falls.
- Individual #133's IDT met in response to hospitalizations on 7/16/18, for hypotension, sepsis, and syncope, and again on 7/29/18, after two episodes of coffee ground emesis and diagnoses of a GI bleed, anemia, and right lower lobe pneumonia, including the need for a blood transfusion, with constipation noted during both episodes. However, her IDT did not initiate interventions for regular nursing assessments of blood pressures, gait, energy level, sleep, visual acuity, mood, fluid intake, or constipation. Moreover, an ISPA, dated 7/31/18, noted her vision was getting worse and staff had observed her "feeling around the room;" an ISPA, dated 8/23/18, noted a 9.4-pound weight loss in three months; an ISPA, dated 9/11/18, noted that her "unsteadiness is due to poor vision;" and an ISPA, dated 10/23/18, noted she fell three times in October 2018. However, the IDT still did not revise her IHCP to include needed nursing interventions. In addition, based on the documents submitted, it was unclear what symptoms, if any, nursing staff were monitoring in relation to her cardiac status and abnormal echocardiogram (ECG).
- There was no indication that the IDT held on-going meetings regarding Individual #542's change of status, on 4/17/18, related

to the removal his left hip prosthesis with suspected osteomyelitis; the need for "accurately logged "sleep data per the AMA, dated 4/18/18; or the increased risk for constipation due to the use of pain medication. Other complicating factors included his diagnosis of osteoporosis, his past femur fracture in 2011, frequent indications of pain, and a decrease in mobility resulting in more frequent use of a wheelchair, after sustaining a fall on 7/28/18.

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

Summary: For at least the two previous reviews, as well as this review, the Center did well with the indicator related to nurses administering medications according to the nine rights. However, given the importance of this indicator to individuals' health and safety, it will continue in active oversight until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement.

Some of the problems noted included medication nurses not adequately assessing individuals' positions for medication administration, not following infection control procedures, and incorrect placement of the stethoscope for assessing individuals' lung sounds in the different lobes. During some medication observations, medication nurses gave lengthy "presentations" that seemed rehearsed and were not representative of a typical medication pass. This appeared to agitate some individuals. In addition, during the medication passes the Monitoring Team observed, the Center's nurse observer did not address the issues identified. Considerable work and mentoring is needed regarding medication administration procedures.

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R						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% 7/7	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	75%	N/A	N/A	1/1	N/A	0/1	1/1	1/1	N/A	N/A

	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.	3/4									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	20% 1/5	N/A	N/A	1/2	N/A	N/A	N/A	N/A	0/2	0/1
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	71% 5/7	1/1	1/1	0/1	1/1	1/1			0/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	71% 5/7	1/1	1/1	0/1	1/1	1/1			0/1	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	N/R									

	status is immediately reported to the practitioner/physician.										
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #672, Individual #320, Individual #388, Individual #678, Individual #599, Individual #133, and Individual #542.

During some medication observations, medication nurses gave lengthy "presentations" that seemed rehearsed and were not representative of a typical medication pass. This appeared to agitate some individuals. In addition, during the medication passes the Monitoring Team observed, the Center's nurse observer did not address the issues identified. Based on these observations and other issues discussed below, considerable work and mentoring is needed regarding medication administration procedures.

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

d. The following concerns were noted:

- The nurse assessed Individual #388's lungs sounds, but did not correctly place the stethoscope for either anterior or posterior lung sounds. In addition, the individual started to cough repeatedly after staff rolled him on his right side. The medication nurse should have initiated a full respiratory assessment (i.e., not just lung sounds). The medication nurse indicated that the PCP came to assess him.
- Individual #599 was at high risk for aspiration, but his IDT had not included respiratory assessments in his IHCP.
- In August 2018, Individual #133 had aspiration pneumonia, but her IDT had not modified her IHCP to include regular lung assessments. During the Monitoring Team's observation, the medication nurse completed lung sounds, but did not correctly place the stethoscope, and she did not listen to the individual's lungs after administering medications. The individual was coughing during medication pass, and the medication should have completed a full respiratory assessment (i.e., not just lung sounds).
- Individual #542 began coughing after drinking juice, but the nurse did not stop to conduct a respiratory assessment, including checking his lung sounds.

f. The following problems were noted:

- Individual #388's's bed was in the correct position, but the individual was not correctly positioned, until the direct support professional pulled him up in bed. The medication nurse did not use the PNMP pictures to validate the individual was in the correct position.
- The medication nurse asked Individual #133 to stand to receive her medications. She was very unsteady on her feet, and since 5/15/18, she fell at least seven times. The PNMP instructed the nurse to be at eye level or below when administering

medications. The individual was coughing during medication pass, and since she was struggling to keep her balance while standing and coughing all while swallowing her medications, she was at higher risk of aspiration. The medication nurse overfilled the spoon with pudding, again putting the individual at higher risk for aspiration.

g. For five of the seven individuals observed, nursing staff followed infection control practices. The exceptions were for:

- For Individual #388, the medication nurse did not wear gloves or sanitize her hands after contact with the individual and before touching medications.
- For Individual #133, the medication nurse touched the powdered medication in the cup.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Continued improvement is needed with regard to individuals being referred to the PNMT, when needed. Overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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;	8% 1/12	0/2	0/2	N/A	0/1	0/1	0/1	0/2	1/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/2	0/2		0/1	0/1	0/1	0/2	0/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/2		0/1	0/1	0/1	0/2	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2	0/2		0/1	0/1	0/1	0/2	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/2		0/1	0/1	0/1	0/2	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have										

	taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 4/6	N/A	N/A	2/2	0/1	1/1	0/1	N/A	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6			0/2	0/1	0/1	0/1		0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6			0/2	0/1	0/1	0/1		0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6			0/2	0/1	0/1	0/1		0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/6			0/2	0/1	0/1	0/1		0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6			0/2	0/1	0/1	0/1		0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #672 – GI problems, and circulatory; Individual #320 - choking, and fractures; Individual #678 – choking; Individual #599 – falls; Individual #535 – aspiration; Individual #758 – choking, and falls; Individual #133 – falls; and Individual #542 – choking, and fractures.

a.i. and a.ii. The IHCP that included a clinically relevant, and achievable goal/objective was for: Individual #133 – falls (i.e., using her mobility cane to ambulate). Unfortunately, the goal/objective was not measurable, and the QIDP summaries provided no data or analyses related to its implementation.

b.i. The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included for: Individual #388 – aspiration, and skin integrity; Individual #678 – fractures; Individual #599 – aspiration; Individual #535 – skin integrity; and Individual #133 - aspiration.

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

- On 7/2/18, Individual #678 tripped over a wheelchair, hit her head on a door, and sustained a fracture of the mid-clavicle with displacement. This is a long bone fracture, and warranted at least a PNMT review. The Monitoring Team found no evidence of a PNMT review.
- Individual #535 had a Stage 2 pressure ulcer with delayed healing, but the IDT did not refer him to the PNMT, and the PNMT did not make a self-referral. More specifically, on 6/23/16, a Stage 2 pressure ulcer was identified on the individual's coccygeal area. Different documentation identified different dates for the resolution of the pressure ulcer: a PCP progress note identified the date as 6/11/18, but the TX-RI-1812.IV-1.20 document identified the date as 7/24/18. Regardless, given the lengthy

healing period, the PNMT should have reviewed /followed Individual #535.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

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

Individuals:

#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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.	13% 1/8	N/A	N/A	0/2	0/1	1/2	0/1	N/A	0/2	N/A
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. Many of the PNM action steps that were included were not measurable. In addition, monthly integrated reviews often only included statements such as "ongoing," or "continues in place," without specific information or data about the status of the implementation of the action steps.

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

- Individual #388 had five hospitalizations related to pneumonia and/or the pressure wound (i.e., on 10/24/17, for fever, UTI,

and the wound; on 7/18/18, for sepsis, UTI, and the wound; on 7/26/18, for pneumonia and the wound; on 8/1/18, for pneumonia and the wound; on 8/13/18, for fever, emesis, and the wound; and on 8/27/18, for pneumonia and the wound). While the IDT held ISPAs, they generally reacted to issues, but did little to identify the etiologies of the issues, including recurrent UTIs, pneumonia, and the non-healing wound. On 7/26/18, the IDT identified unresolved pneumonia as a problem, and cited a possible cause as emesis, but they did not discuss how to remedy this concern or to determine why he had emesis.

As discussed with staff on site, the elevated portion of Individual #388's bed was very short for his trunk, which made positioning him difficult. Other individuals had similar beds. When the Monitoring Team member discussed this with a group of OTs and PTs, they agreed that the bed proportions were disproportionate for many individuals, but they had not raised the issue internally. As indicated in the Monitoring Team's exit comments, for a couple of individuals reviewed (i.e., Individual #388 and Individual #535), bed positioning and wheelchair use/positioning needed immediate review. The Monitoring Team recommended obtaining a consultation from the State Office Discipline Lead, or therapists from other SSLCs.

- Based on the Center's response to Document Request #TX-RI-1812-IV.1-20, on 5/18/18, 7/20/18, 8/4/18, 8/20/18, 8/28/18, 8/29/18, Individual #599 fell. On 6/20/18, the IDT met in relation to his PNMT assessment for aspiration/constipation. They made brief mention of his fall risk with recommendations to participate in programming with fewer individuals and to replace his existing shoes with regular tennis shoes by 7/20/18, to which IDT agreed. On 8/21/18, the IDT met to discuss falls. On 8/28/18, after a fall, the IDT determined he was wearing his old shoes, and indicated they were waiting for the PT to come put his new tennis shoes on him. Clearly, this necessary action had not been completed by 7/20/18, which was the deadline the IDT set. In addition, without conducting a full analysis of the information, the IDT attributed a number of his falls to seizures and to aggression. They did not discuss alternative plans to address seizures or his safety, and stated that he had a PBSP for aggression so there was no need to do anything further there either.
- For Individual #535's Stage 2 pressure ulcer, the IDT did not meet frequently. In fact, during the year in which he had the non-healing wound, the IDT only documented three ISPA meetings. At the ISPA meeting, dated 2/14/18, the IDT discussed a problem with nurses reportedly not using the wound care supplies that the wound care specialist recommended. In terms of ongoing preventative measures, on 9/18/18, the IDT met, and discussed another problem with his mattress beeping, indicating low pressure. The IDT agreed to order a new mattress, and assigned the nurse to complete the task by 9/21/18. Documentation of a subsequent meeting on 10/2/18, seemed to suggest the task had not been completed, but at the time, it was determined that a different mattress was available on campus and he would not have to wait for it to be shipped. The Monitoring Team found no documentation of follow-up to confirm he received the new mattress, and that it was effective.
- On 5/15/18, 6/27/18, 7/14/18, 8/21/18, 10/14/18, 10/20/18, and 10/22/18, Individual #133 fell. On 10/23/18, her IDT held an ISPA meeting. The only action steps the IDT agreed upon were to keep the area clear for ambulation, for staff to monitor her during ambulation per the PNMP, and for staff to intervene right away when she jumped up. In October, two of three falls were related to her tripping over someone's legs and wheelchair. The other resulted in her falling to her knees, but the IDT did not identify the circumstance. On 9/11/18, the PT discharged her from direct therapy, but the ISPA provided no evidence of follow-up to address the increase in falls in October. The Orientation and Mobility (O&M) specialist did not participate in the ISPA meeting. The IDT did not document discussion of the effectiveness of the sighted guide techniques, even though staff were with her for at least two of the falls.

c. Although Individual #599's IDT met with the PNMT to discuss his discharge, the group did not modify his IHCP to incorporate the

recommendations and goals/objectives.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Although in some homes, staff did well implementing Dining Plans, in other homes, problems with Dining Plan implementation placed individuals at significant risk, as did problems with positioning. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, the need for skill acquisition, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	63% 55/88	
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.	43% 3/7	

Comments: a. The Monitoring Team conducted 88 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during four out of 15 observations (27%). Staff followed individuals' dining plans during 50 out of 71 mealtime observations (70%). Staff completed transfers correctly during one out of two observations (50%).

The staff in certain homes (e.g., San Antonio, TJ6) did particularly well with the implementation of mealtime plans. These two homes accounted for 35 of the individuals that scored positively for the mealtime observations. Unfortunately, errors in PNMP implementation during mealtimes in other homes often placed individuals at risk (e.g., staff feeding individuals at too fast a pace, staff not intervening when individuals took large bites, etc.) or significantly limited their independence (e.g., feeding individuals who can eat with staff supervision).

Based on the Monitoring Team's observations, positioning is an area on which the Center should focus. The Monitoring Team observed some individuals in positions that required the Monitoring Team to request the intervention of Center staff. These types of situations placed individuals at increased risk for aspiration. For example:

- Individual #388's shoulders and head were slid down in the bed. Although the HOB was elevated, his chest was flat on the bed. His PNMP stated that staff should not place him on his back. When the Monitoring Team member came back the next day, a new plan was in his book that stated staff could place him on his back, but the clinical justification for this decision was unclear. However, as discussed with staff on site, the elevated portion of the bed was very short for his trunk, and this will likely present an ongoing problem for him.

- Individual #61 had a new G tube, placed on 6/15/18, due to pneumonia. He was observed lying down flat in bed. His one-to-one staff member could not explain why this was a problem.
- Individual #429 was observed with his head in hyperextension. He had very wet breath sounds and gurgling. The Monitoring Team member reported these concerns to the SLP who went to get the nurse.

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	672	320	388	678	599	535	758	133	542
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A			N/A			N/A			
Comments: a. Although Individual #535 returned to oral eating, his IDT had not developed a measurable plan.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1

		0/10									
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1

Comments: a. and b. Although Individual #678's had a goal/objective (i.e., ambulation program using a six-pound weighted belt for 15 minutes or less if unable to tolerate, five times per week for osteopenia management), it was not included in the ISP or incorporated through an ISPA. The same was true for Individual #542. Although Individual #758's ISP identified the need for programs for mobility and bilateral upper extremity range of motion, no goals/objectives were found to measure the success of the programs.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team conducted full reviews for all nine individuals.

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

Summary: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. These indicators will continue in active oversight.

			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/6	N/A	0/1	N/A	N/A	N/A	0/1	0/1	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.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	0/1

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

- For Individual #320, the QIDP integrated reviews included no reference to range-of-motion (ROM) exercises for her hands, and no reference to the outcomes of the O&M specialist's assessment or interventions.
- For Individual #535, documentation in the QIDP review for July 2018 indicated that he only tolerated a maximum of 30 minutes of the standing program. The QIDP indicated that the program was on hold and the QIDP would follow up with the PT. This statement was carried over every month through October (i.e., the last review submitted in response to the document request).
- For Individual #758, each monthly review submitted repeated the same narrative: "Unit ambulation program using a weighted belt for Osteoporosis management due to Osteopenia to L [left] hip. PT will assess for the appropriate weight (in pounds) for the weighted belt and will purchase for [Individual #758's] unit program." The QIDP monthly reviews provided no evidence of

implementation or documentation of progress. The PT's IPNs indicated that the individual was seen a few times to establish the proper weight for the belt, and this was accomplished on 3/9/18. It was unclear why the program was not implemented, and why neither the PT nor the QIDP follow-up to resolve the issue(s) preventing its implementation.

- Although the OT and PT wrote IPNs regarding the implementation of Individual #133's interventions (i.e., chest strap for remaining upright after meals, and gait training), the QIDP did not comment on them in the integrated reviews.
- The QIDP indicated that from June to August 2018, Individual #542 participated in his ambulation program, but the integrated reviews presented no data. In September 2018, this program that PNMP Coordinators had run was shifted to home staff, but the QIDP stated that they were not aware of this shift and requested in-service training. QIDP monthly reviews included no information related to this after September.

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

Summary: Improvement is needed with regard to the proper fit of adaptive equipment.

[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: 241	308	428	344	535	107	589	251	354
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 12/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	50% 6/12	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1

		Individuals:									
#	Indicator		378	621	388						
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1						
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	0/1						

Comments: b. The Monitoring Team conducted observations of 12 pieces of adaptive equipment. It was good to see that adaptive equipment observed was in proper working order.

c. Based on observation of Individual #241, Individual #428, Individual #344, Individual #535, and Individual #621 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #388's shoulders and head were slid down in the bed. Although the HOB was elevated, his chest was flat on the bed. As discussed with staff on site, the elevated portion of the bed was very

short for his trunk. 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, one indicator was moved to this category, in the area of engagement.

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

For the ISPs, Richmond SSLC had reliable data for six goals across the set of individuals in the review group. Although a small number, it was more so than ever before. Of these six goals, five were showing some progress. Richmond SSLC was not, however, taking action when goals were not progressing or not being implemented.

There were several improvements in SAP development and implementation since the last review. These include the number of individuals with SAPs, the practically of the SAPs, and the reliability of SAP data. Generally, there were improvements in the overall quality of SAPs and the majority of necessary SAP components were included in the majority of SAPs.

There was much improvement in the implementation of SAPs. Two-thirds were implemented correctly as written. Furthermore, staff and individuals were visibly comfortable during implementation and familiar with SAPs, indicating that SAPs are likely regularly implemented at Richmond SSLC. That being said, the SAP training sheets need to include more specific training instructions for the instructors, and ensure that meaningful SAP monitoring is occurring.

The Center regularly measured engagement and was now doing so during second shift and during weekends, too. The Center had goals for engagement. Observations at the Leon C home showed much improvement compared with the past few Monitoring Team reviews. This time, individuals were engaged in activities in the living room and the activity room.

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

ISPs

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

Summary: Richmond SSLC had reliable data for six goals across the set of individuals in the review group. Although a small number, it was more so than ever before. Of these six goals, five were showing some progress. Richmond SSLC was not, however, taking action when goals were not progressing. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 140	320	672	72	678	599			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	1/6	0/6	0/6	2/6	0/6	2/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/5	0/6	0/6	0/4	0/6	0/4			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/5	0/6	0/6	0/4	0/6	0/4			

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. A personal goal that meets criterion for Indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. With the exception of the six measurable goals with valid and reliable data identified above, it was not possible to evaluate progress. Therefore, no one had a comprehensive set of personal goals that met criterion for these indicators.

4. No one had a set of goals that met criterion, since the pre-requisite described above was not met.

For the six personal goals that did achieve this milestone, five also demonstrated that the individuals were making progress. These were the independence goal for Individual #140, the relationships and independence goals for Individual #599, and the leisure and living options goals for Individual #72. While none of the individuals were making progress in all of their personal goal areas, it was good to see the Center was improving in this area.

5. No one had a set of goals that met criterion, since the pre-requisite described above was not met. The Monitoring Team could only evaluate whether progress was being made, or not, for six goals. As indicated above, progress was documented for five of the six. The sixth was the relationships goal for Individual #678, for which progress was not being made.

6. Overall, no one had a full set of personal goals that could be evaluated for progress.

For Individual #678, whose compliant personal goal for relationships had not progressed, the QIDP had not taken steps to implement going out to eat with her special friend after receiving approval from volunteer services in July 2018.

7. No one had a full set of goals that met criterion for this indicator, since the pre-requisite described above was not met.

Five personal goals that did meet the pre-requisite criterion and were identified above as progressing. None had yet been met. It was positive, though, to see that the IDT for Individual #72 still met regularly to discuss any barriers and revise strategies for his living options goal. One personal goal met the pre-requisite criterion, but was not making progress, as described above for Individual #678. For this goal, activities and revisions had not been implemented.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	320	672	72	678	599			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. 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. 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 five of six individuals. It was positive, though, that many DSPs had good knowledge of individuals' preferences and there was also improved awareness of training for behavior plans.

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: More SAPs were progressing than in any previous reviews (in part because more SAPs now had reliable data, upon which a progress determination could be made). The other two indicators remained at about the same level of performance as at the last review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	218	139	140	314	298	320	672	72	543

		Score									
6	The individual is progressing on his/her SAPs.	56% 9/16	0/1	0/2	1/2	3/3	1/1	0/2	0/1	2/2	2/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	80% 4/5				1/1	0/1			1/1	2/2
8	If the individual was not making progress, actions were taken.	33% 1/3		0/2	1/1						
9	(No longer scored)										

Comments:

6. Nine SAPs (e.g., Individual #72's operate his karaoke player SAP) were rated as progressing. This represents a dramatic improvement from the last review when one SAP was judged to be improving. One of the 17 SAPs was not included in this indicator because there was insufficient data because the SAP had been recently implemented (Individual #672).

Some SAPs (e.g., Individual #140's play ball SAP) were not progressing. Other SAPs had reliable data, however, there was not enough data to determine progress (e.g., Individual #672's remain at work SAP). 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 #672's state her schedule SAP). Finally, some SAP data did indicate progress (e.g., Individual #320's dressing SAP), but were scored as not making progress because they were judged not to be practical (indicator 4).

7. Individual #314's make a smoothie SAP, Individual #72's prepare a pizza SAP, and Individual #543's brush his teeth and prepare a chili dog SAPS all achieved their objectives, and all four SAPs were moved to the next objective. Individual #298's meal preparation SAP also achieved an objective, however, a new objective was not introduced.

8. Individual #140's play ball SAP 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 #139 was not progressing on his brush teeth and wash hands SAPs and there were no actions to address his lack of progress.

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. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	139	140	314	298	320	672	72	543
13	The individual's SAPs are complete.	6% 1/17	0/1 7/10	0/2 16/20	0/2 18/20	0/3 26/30	0/1 8/10	0/2 12/19	1/2 17/18	0/2 15/20	0/2 16/20

Comments:

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

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

Although only Individual #672's remain at work SAP was judged to be complete, many of the SAPs contained the majority of the components. For example, at least 85% of the SAPs had a plan that included:

- a task analysis (when appropriate)
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- documentation methodology.

Regarding common missing components:

- The majority of SAPs instructed staff to train all steps in the task and subsequent objectives gradually reduced the intrusiveness of the prompts. For example, Individual #139's brush his teeth SAP had brush his teeth with physical prompts as objective 1, and objective 2 was to brush his teeth with gestural prompts, etc., culminating with objective 4 which stated he would brush his teeth independently. The instructions did not, however, indicate the specific steps of the task. The skill steps just included one step: brush teeth. The baseline, however, included seven steps starting with getting the toothbrush and ending with rinsing his mouth. Additionally, the sequence of prompting that staff should use was not clear. Should they start at the current objective level (e.g., physical prompting) or use gradual increasing of prompt level and starting by allowing Individual #139 to be independent on the task (as suggested in the "incorrect response" section of the SAP training sheet?
- Ensuring that individuals are motivated to complete SAPs is a critical training component and, therefore, it is important that efforts are made to ensure that potent reinforcers are provided following the successful completion of all SAPs. This type of individualization of reinforcement for correct SAP completion was apparent in some SAPs (e.g., Individual #140's sign drink SAP where correct responses were to be followed by praise and the opportunity to consume a drink). Many SAPs, however, merely included saying "good job," which may not function as a potent reinforcer for every individual (e.g., Individual #139's wash hands SAP).
- Some SAPs (e.g., Individual #320's dressing SAP) did not state the number of prompts that were acceptable
- Some SAPs (e.g., Individual #543's brush teeth SAP) did not include operational definitions of the target behavior

Outcome 5- SAPs are implemented with integrity.

Summary: There was much improvement in the implementation of SAPs. Two-thirds were implemented correctly as written. Furthermore, staff and individuals were visibly comfortable during implementation and familiar with SAPs, indicating that SAPs are likely regularly implemented at Richmond SSLC. Along those same lines, all SAPs had a schedule of treatment integrity checks. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 218	139	140	314	298	320	672	72	543

14	SAPs are implemented as written.	67% 4/6		1/1	0/1	1/1		1/1	0/1		1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	76% 13/17	1/1	0/2	2/2	2/3	1/1	2/2	1/2	2/2	2/2

Comments:
14. The Monitoring Team observed the implementation of six SAPs. Individual #139's make a sandwich SAP, Individual #314's make a smoothie SAP, Individual #320's brush her teeth SAP, and Individual #543's brush his teeth SAP were all implemented and scored as written. Individual #140's play ball SAP, and Individual #672's state her schedule SAP were not implemented as written. This represents another improvement relative to the last review when SAPs were not implemented as written for any of the individuals observed.

15. A schedule of SAP integrity collection and a goal level was established for all SAPs. These frequencies and levels of SAP integrity were not achieved for Individual #672's state her schedule SAP, Individual #314's make a smoothie SAP, and Individual #139's brush his teeth and wash his hands SAPs.

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

Summary: Performance remained about the same as at the last review. That is, about half of the SAPs were reviewed each month, and almost all SAPs had a graph that summarized data. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
16	There is evidence that SAPs are reviewed monthly.	47% 8/17	1/1	0/2	2/2	1/3	0/1	0/2	0/2	2/2	2/2
17	SAP outcomes are graphed.	94% 16/17	0/1	2/2	2/2	3/3	1/1	2/2	2/2	2/2	2/2

Comments:
16. Forty-seven percent of SAPs had a data based review in the QIDP monthly report (e.g., Individual #140's sign drink SAP). Some 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 #139's wash hands SAP), other reviews did not include current data (e.g., Individual #320's brush her teeth SAP). Finally, some SAPs were not reviewed (e.g., Individual #672's state her schedule SAP).

17. Graphs were made for every SAP (except Individual #218's).

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

Summary: The Center regularly measured engagement and was now doing so during second shift and during weekends, too. The Center had goals for

Individuals:

engagement for this review and for the previous two reviews. Therefore, indicator 20 will be moved to the category of requiring less oversight. The other indicators in this outcome will remain in active monitoring.											
#	Indicator	Overall Score	218	139	140	314	298	320	672	72	543
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #543, Individual #320, Individual #314) to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

Observations at the Leon C home showed much improvement compared with the past few Monitoring Team reviews. This time, individuals were engaged in activities in the living room and the activity room. Improvements were the direct result of staff and management actions taken since the last review.

19-20. Richmond SSLC tracked engagement in all residential and treatment sites. The engagement goal was individualized to each residence and day program site.

21. The facility's engagement data indicated that Individual #72 and Individual #140's residential sites did not achieve their goal level of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Same as the last two reviews, 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 Score	218	139	140	314	298	320	672	72	543
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	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	are established and achieved.	0/9									
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, none had established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. Richmond SSLC did not provide data regarding 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: No individuals at Richmond SSLC attended public school.			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	N/A									
Comments:											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									

d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through d. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed refused dental care.											

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: Individuals reviewed did not have clinically relevant, and measurable goals/objectives to address their needs for formal communication services and supports. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/10	N/A	0/1	0/1	0/2	0/2	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	30% 3/10		0/1	0/1	0/2	2/2	0/1	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/10		0/1	0/1	0/2	0/2	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10		0/1	0/1	0/2	0/2	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% 0/10		0/1	0/1	0/2	0/2	0/1	0/1	0/1	0/1
Comments: a. and b. Individual #672 had functional communication skills. She was part of the core group, so the Monitoring Team completed a full review. Although the SLP developed communication goals/objectives for Individual #678 that were measurable (i.e., using her Talkable device to request something to drink and to request music), her IDT had not integrated them into her ISP, and they were not clinically relevant. 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 #599 (i.e., using five signs, and using a picture-based AAC device; clinical										

relevance could not be determined due to issues with the quality of the assessment), and Individual #542 (i.e., making a request using a communication board or voice-output device; this was described as a goal carried forward from the last year, but the IDT/SLP provided no data to support its continued relevance).

c. through e. For Individual #599, the QIDP provided limited data or analysis in the monthly integrated reviews. No evidence was included of monitoring or review by the SLP. In addition, although direct therapy goals were listed in the monthly QIDP reviews, the QIDP indicated there was no evidence of implementation. The SLP submitted monthly IPNs, but these notes included no comparative data from month to month.

For the eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

Summary: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	672	320	388	678	599	535	758	133	542
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	N/A	N/A	0/2	0/2	N/A	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	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. For applicable individuals, evidence of implementation was not found.

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: Center staff need to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.	Individuals:

[**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	162	344	60	552	232	61	479	797	452
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	29% 4/14	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	15% 2/13	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
			Individuals:								
#	Indicator		218	599	738	319					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/2	1/1	0/1	0/1					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/2	N/A	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.	33% 2/6									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. At the time of the last review, no indicator was in the category of requiring less oversight. Based on information the Center provided, between the time of the Monitoring Team's last review and the Tier I document request, none of the individuals at Richmond SSLC transitioned to the community, and no post-move monitoring occurred. As a result, the outcomes and indicators in Domain #5 were not scored.

Four individuals, however, were in the active referral process. Two were likely to have CLDP meetings and transitions within the next couple of months.

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:			Individuals:									
#	Indicator	Overall Score										
1	The individual's CLDP contains supports that are measurable.	N/A										
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	N/A										
Comments:												

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary:			Individuals:									
#	Indicator	Overall Score										
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	N/A										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	N/A										
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	N/A										

	justification is provided as to why it is no longer necessary.											
6	The PMM's assessment is correct based on the evidence.	N/A										
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	N/A										
8	Every problem was followed through to resolution.	N/A										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A										
Comments:												

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary:			Individuals:									
#	Indicator	Overall 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.	N/A										
Comments:												

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A										
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	N/A										

	to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.											
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	N/A										
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A										
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A										
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	N/A										
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.	N/A										
19	Pre-move supports were in place in the community settings on the day of the move.	N/A										
Comments:												

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary:			Individuals:									
#	Indicator	Overall Score										
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	N/A										
Comments:												

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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