United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Remote Virtual Review: June 7-10, 2021

Date of Report: August 30, 2021

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Background

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

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

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

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

a. **Selection of individuals –** During the weeks prior to the review, the Monitoring Teams requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Teams attended various meetings via telephone, such as Center-wide meetings [e.g., morning medical, unit morning, Incident Management Review Team (IMRT), Physical and Nutritional Management Team (PNMT)], and individual-related meetings [e.g., Individual Support Plan meetings (ISPs), Core teams, Individual Support Plan addenda meetings (ISPAs), psychiatry clinics]. In addition, the Monitoring Teams conducted interviews of various staff members via telephone (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator). Also, the Monitoring Teams met with some groups of staff via telephone (e.g., Psychiatry Department, Behavioral Health Services Department). This process is referred to as a remote review.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
d. **Observations** – Due to the nature of the remote review, the Monitoring Team could not complete some observations (i.e., as discussed above, some observations of meetings were possible). As a result, some indicators could not be monitored or scored. This is noted in the report below.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will move to the category of requiring less oversight. At the next review, indicators that move to this category will not be monitored, but may be monitored at future reviews if the Monitor has concerns about the Center's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the Center's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

The Monitors and Monitoring Team members want to take this moment to recognize that the COVID-19 global pandemic has required Center staff to make some significant changes to their practices, and that the steps necessary to protect individuals and staff require substantial effort. The time since the pandemic began has undoubtedly been a challenging one at the SSLC and the other Centers, as it has been across the country. Throughout the course of the

week, we appreciated staff's willingness to share with us some of the ways that COVID-19 has impacted their work, and how life has changed for the individuals.

State Office shared a chart in which Center staff outlined activities that were put on hold, and provided information about how staff believe such changes potentially impacted the delivery of supports and services that the Settlement Agreement requires. In conducting the review and making findings, the Monitors have taken into consideration the impact COVID-19 might have had on the scores for the various indicators. In some instances, the Monitors have indicated that they were unable to rate an indicator(s) due to this impact.

The Monitoring Team's review identified the following protection from harm issues that require attention:

Pressure Injuries

- As indicated in the Monitors' Summary of Preliminary Findings, Center staff had identified concerns related to pressure injuries, and developed a plan of improvement (POI). Based on the Monitoring Team's review, these concerns continued to require attention. Given the nature of the Monitoring Team's review and role, the Monitoring Team did not request all of the documents necessary to determine the quality of the Center's efforts to remediate the ongoing discovery of pressure injuries for individuals supported at the Center. However, based on the information submitted, it was not clear that Center staff had systematically identified the potential root cause(s) of the problem, which is an essential step in the development and implementation of effective corrective actions. Overall, the Monitoring Team recommends that State Office consider using the resources of their recently-hired quality assurance/improvement technical assistance consultant to assist Richmond SSLC (and other Centers) to collect and use reliable pressure injury data, as well as other related data (e.g., monitoring/audit data); conduct analyses to the depth necessary, up to and including formal root cause analysis; and modify the POI, as needed. The following summarizes the Monitoring Team's comments based on its limited review of these concerns:
    - Based on the Monitoring Team's review of documentation related to individuals in the review group, as well as the skin integrity meeting minutes, a number of individuals at the Center experienced pressure injuries in recent months. More specifically, between 1/20/21 and 3/21/21, five center-acquired pressure injuries were identified (i.e., an additional three hospital-acquired pressure injuries were identified during this time period). Four of the five were Stage 3 pressure injuries, and the remaining one was unstageable.
    - Center staff indicated that about a year ago, they formed a special committee to develop an action plan around this issue. The Center submitted a copy of the plan. Clearly, many Center staff were involved in this interdisciplinary process, and staff had identified a number of action steps. Some action steps were

marked as completed, and others were in various stages of implementation. The committee appeared to meet frequently and provided status updates for each active action step. The following provide a few observations with regard to the POI:

- Many of the action steps were not measurable, and the POI did not include expected outcomes, which made it difficult for the committee to: a) know when action steps were complete; and 2) determine which action steps were effective at solving the problem they were designed to correct. The Monitoring Team's previous quality assurance/improvement reports provide a number of examples of the development of outcome measures to determine the efficacy of action steps within corrective action plans. Such measures would help the committee determine which action steps are effective, as well as which are not working, and need modification. As a couple examples:
    - A number of action steps related to training/re-training staff. The evidence required was usually listed as "in-service records." The action steps did not delineate which staff practices the training was designed to change, and with no required competency-check component, the committee would not have information to assist it in determining whether or not the training provided resulted in increased competency in specific areas. Similarly, no auditing was connected with these action steps to allow the committee to determine if staff practices changed.
    - One action step read: "Plan review." The meaning of this was unclear, and it was not measurable. In addition, the "evidence" for completion was listed as: "85% compliance with wheelchair & mattress monitoring via checklist and 85% compliance with positioning monitoring via checklist." Although this was written in more of an outcome format, it was not clear that an overall score of 85% with these monitoring/audit tools was discreet enough to ensure that the problems leading to individuals' pressure injuries were resolved. For example, were certain indicators on these tools more important than others? Was this an overall score for the Center, or were specific homes more problematic, and if so, what were their baseline scores? Although the comment section provided some additional details, more work was needed on the expected outcome(s) to assist the committee in determining whether or not needed changes occurred.
- The overall goal of the POI was not clinically sound, it was potentially unrealistic, and it set the occasion for important early indicators of more serious problems to be seen as negative outcomes. The goal read: "The Skin Integrity Committee will focus on reduction of new pressure wounds to 3 or less than 3 per month for the next reporting period. Nurses will report no

recurrent pressure wounds for individuals who have healed pressure wounds during next 3 month period." The first sentence of the goal did not recognize that the identification of Stage 1 pressure injuries, and even Stage 2 pressure injuries is an important indicator that surveillance systems are working, and that staff are identifying injuries at early stages. With treatment and needed changes to equipment, etc., often, these injuries can be reversed, and they do not progress to higher stages. That said, the goal potentially defines success as the identification, for example, of up to three Stage 3 or Stage 4 pressure injuries each month, which also is not clinically sound.

- As noted above, it was not clear that staff engaged in analysis to the depth necessary to determine what the most frequent root cause(s) of the facility-acquired and/or hospital-acquired pressure injuries were. Such analyses would allow the Center to focus its efforts in ways that are most likely to solve the problem. In the comments section for two of the action steps of the POI, staff documented discussions over the course of a year (i.e., from May 2020 through May 2021) about the potential need for "root cause analysis" (RCA) meetings. The intent seemed to be largely to do this for individuals with recurring wounds. The latest comment was as follows: "05/19/2021 - Discussed RCA for skin integrity issues but there is specific criteria to hold an RCA. May consider after reviewing historical list from [staff member]. Need to look at refresher training of staff, look at weight loss, seating systems, mold, and cushions… [Four staff]… to review info from other centers and make recommendations at next meeting."

  The identification of any Stage 3 or Stage 4 pressure injury is an indicator of problems with the provision of care, supports, and/or services. A formal root cause analysis would be warranted for any such occurrence. Given that between 1/20/21 and 3/21/21, five center-acquired pressure injuries were identified, four of which were Stage 3 pressure injuries, and the fifth being unstageable, should have resulted in root cause analysis.

  In addition, if this has not already occurred, both the State Office and Center Quality Assurance departments should play a role in aggregating and analyzing data related to skin integrity issues, including, but not limited to pressure injuries. For example, based on a review of available data, it appeared there was some correlation to certain homes. In addition, further inquiry is needed into the fact that during the time period in which these five pressure injuries were identified, staff identified no Stage 1 or 2 injuries. In other words, a problem might exist with current surveillance methods, because the identification once pressure injuries reached Stage 3 likely meant that staff missed earlier signs of problems, or staff failed to stage the injuries at an earlier

point. Questions need to be asked about whether direct support professionals know what to look for and report, and whether other disciplines are completing the necessary checks and assessments (e.g., nursing staff, Habilitation Therapy staff, as well as medical staff).

- As discussed below in the sections on physical and nutritional management (PNM), and Occupational and Physical Therapy (OT/PT), the proper fit of individuals' wheelchairs and their positioning in them was an ongoing problem. It is critical that Center staff look collectively at those individuals in the review group and others observed during the remote review to address wheelchair concerns, and that they also examine seating, bedtime, and leisure positioning, as well as transfers and bed mobility systemically to identify clues for how these activities might be impacting skin care and the occurrence of pressure injuries. At the time of the onsite review, a Monitoring Team member and the State Office Discipline Lead discussed these concerns. The State Office Discipline Lead indicated that State Office was developing a plan to assist Center staff with assessment and perhaps some additional focus on wheelchair design.
- As members of the larger allied health care team, nurses should have a defined role and responsibility for the ongoing assessment of individuals with skin integrity risk, as well as those with active skin integrity issues. The intensity of skin integrity nursing interventions should be data driven, taking into consideration, for example, individuals' risk ratings, as well as data that show which homes have the greatest problems with pressure injuries as well as other skin issues. For example, nurses should have a defined schedule for making observational rounds, such as during check-and-change activities, as well as bathing, especially for those individuals whose IDTs already have identified them as meeting criteria for medium or high risk of developing a pressure injury. In addition, as discussed in this report, improvements are needed with the nursing interventions included in acute care plans, as well as Integrated Health Care Plans (IHCPs) for individuals with medium and high skin integrity risk, as well as nursing staff's implementation of these interventions.

Conditions in Bathroom

- On 4/29/20, Individual #264 died after she fell in the bathroom and sustained a laceration to the back of her head, as well as a head injury, resulting in placement in the intensive care unit (ICU) with intubation and mechanical ventilation. On 5/10/21, the IDT held an individual support plan addendum (ISPA) meeting to discuss the fall that resulted in this serious injury and the individual's death. They discussed the resulting Unusual Incident Report (UIR), and the Center's Review Authority recommendations. This ISPA identified ongoing problems with the slippery nature of the shower areas in this individual's home. For example, the IDT documented an update, dated 5/12/21, which stated that the Residential Coordinator "followed up with staff to

see if we are still having issues in the bathrooms during showering and the staff reported the following: Bathroom floor [sic] are still very slippery and they have to put towels on the floor to help with how wet the floors get. They also reported it gets very foggy in there when bathing… Staff did report that the anti-slip agent helped some, but not very much. This is concerning due to the individual on the waiting list for [name of home] does not use a shower chair and she showers with minimal support. This poses a fall risk for any of the ladies that walk to/from the showering area…" As the IDT identified, these issues (i.e., the slippery nature of the shower floor, as well as staff placing towels on the floor) continued to present fall risks, which placed other individuals at risk of harm. It appeared the Review Authority was aware of the issues, and had made recommendations to try to resolve them. If Center staff have not yet effectively resolved the issue, they should do so as soon as possible.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at the Richmond SSLC for their assistance with the review. The Monitoring Team appreciates the assistance of the Center Director, Settlement Agreement Coordinator, and the many other staff who assisted in completing the remote virtual review activities.

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

This Domain contains 17 outcomes and 42 underlying indicators in the areas of restraint management, pretreatment sedation/chemical restraint, mortality review, and quality assurance.

- The Center achieved substantial compliance with many of the requirements of Section C of the Settlement Agreement. The exceptions are Section C.5 related to licensed health care staff's (nurses' and/or physicians') roles in the monitoring of all types of restraints, and physicians' roles in defining monitoring schedules, as needed; and Section C.6 related to assessments for restraint-related injuries, as well as monitoring of individuals subjected to medical restraint. The Monitoring Teams will continue to monitor these remaining areas for which Center staff have not obtained substantial compliance using the outcomes and indicators related to these subjects. With the understanding that these topics are covered elsewhere in the Settlement Agreement, the SSLC exited from the other requirements of Section C of the Settlement Agreement.
    - As a result, the Center exited from these parts of Section C of the Settlement Agreement. This resulted in the removal of 10 outcomes, and 20 underlying indicators.
    - Three indicators were added to the nursing restraint audit tool.
- The Center also achieved substantial compliance with the requirements of Section D of the Settlement Agreement.
    - As a result, the Center exited from this section of the Settlement Agreement. This resulted in the removal of 10 outcomes and 19 indicators.
- At the start of this review, no other indicators were in the category of requiring less oversight. Presently, no additional indicators will move to the category of less oversight.
- In sum, at the time of the next review, this Domain will include seven outcomes and 23 underlying indicators.

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>

For two of the six restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. The problems noted during the last review remained, though. When restraints occur, staff need to timely notify nursing staff. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; following the nursing guidelines for assessments following administration of chemical restraints; and following nursing guidelines for the assessment for and of injuries.

Other
For the planning and management of the need for pretreatment sedation, the Center met all criteria for one of the individuals. It now needs to do so for all individuals.

It was good to see that the Center completed three clinically significant DUEs. For the two for which follow-up was due, Center staff completed it.

Restraint

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

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

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

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: For two of the six restraints reviewed, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. The problems noted during the last review remained, though. When restraints occur, staff need to timely notify nursing staff. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; following the nursing guidelines for assessments following administration of chemical restraints; and following nursing guidelines for the assessment for and of injuries. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	139	108	448	449	537				
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	33% 2/6	1/1	0/1	1/2	0/1	0/1				
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	N/A									
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	N/A									
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A									
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	33% 2/6	1/1	0/1	1/2	0/1	0/1				
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	20% 1/5	1/1	0/1	0/1	0/1	0/1				

Comments: The restraints reviewed included those for: Individual #139 on 11/17/20 at 1:57 p.m. (18-minute multi-person arm neutralization); Individual #108 on 12/30/20 at 4:36 p.m. (chemical); Individual #448 on 3/2/21 at 3:08 p.m. (18-minute multi-person arm neutralization), and 11/2/20 at 3:45 p.m. (nine-minute physical restraint); Individual #449 on 11/26/20 at 2:10 p.m. (five-minute multi-person arm neutralization); and Individual #537 on 3/4/21 at 7:01 a.m. (one-minute arm neutralization of both arms).

a. through c. For Individual #139 on 11/17/20 at 1:57 p.m. (18-minute multi-person arm neutralization), and Individual #448 on

11/2/20 at 3:45 p.m. (nine-minute physical restraint), the nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects.

The following provide examples of additional findings:

- On 12/30/20, Individual #108 engaged in self-injurious behavior, as well as aggression, and property destruction. At 4:15 p.m., three staff brought him to the nurse's office. The individual initially refused vital signs, but the nurse documented his respirations. At 4:36 p.m., nursing staff administered a chemical restraint, which consisted of Haldol 5 milligrams (mg) intramuscular (IM). Nursing staff did not follow the nursing guidelines for assessments following the administration of the chemical restraint. For example, the nurses only documented attempts to assess vital signs at 4:15 p.m. (i.e., prior to administration of the chemical restraint), 5:00 p.m. – refused, so only respirations; 7:00 p.m. – refused, so only respirations; and 11:00 p.m. – no vital signs. Nursing staff should have conducted assessments every 15 minutes for two hours, every 30 minutes for one hour, every two hours for four hours, and every four hours for a minimum of 24 hours. In addition, in the documentation submitted, the nurse did not document the site of the injection.
- For Individual #448's restraint on 3/2/21 at 3:08 p.m. (18-minute multi-person arm neutralization), the nurse did not initiate an assessment until 4:15 p.m. According to the IPN, staff did not notify the nurse of the restraint until 4:07 p.m. It was positive that the nurse completed a full set of vital signs, and documented the individual's mental status. Nursing IPNs, dated 3/2/31, at 4:15 p.m., and 4:45 p.m., included identical information for the objective assessment section. The nurse identified an area of redness on the individual's right lower arm. The injury report indicated that the probable cause of the injury was the personal restraint. Neither IPN included measurements of the reddened area(s). In the later IPN, the nurse did not indicate whether or not the "mild redness" was fading.
- For Individual #449's restraint on 11/26/20 at 2:10 p.m. (five-minute multi-person arm neutralization), it was positive that a nurse initiated a timely assessment, and documented vital signs. IView entries did not include a mental status assessment. An IPN, dated 11/26/20, at 3:35 p.m., stated that the individual was awake, alert, and oriented to baseline, but did not describe the individual's baseline. In the IPN, the nurse also noted scratches on the individual's left palm and shoulder with mild redness and "mild opening noted on the affected area." The nurse did not document the provision of any basic first aid, such as cleaning the wounds with soap and water. Nursing staff did not initiate the nursing guidelines for skin integrity issues. For example, IView entries, dated 11/26/20, at 2:30 p.m., 3:30 p.m., and 3:37 p.m. did not include descriptions of the skin impairments. The next IPN, dated 7:27 p.m., did not include a complete description of the injuries, and only stated: "…no redness, swelling, but mild scratches still noted on the effected [sic] areas of the left hand and shoulder…"
- On 3/4/21, Individual #537 was sitting on the couch and began scratching and hitting her face. Staff attempted to block, but she then began repeatedly punching her face/head with both fists. At 8:10 a.m., staff notified the nurse. The individual refused assessments. The nurse did not assess her respirations, which would not require the individual's cooperation. The nurse noted some superficial scratches on the individual's forehead and the tip of her nose. The nurse noted no bleeding, bruises, swelling, redness, or signs and symptoms of pain. The individual also refused any treatment for the scratches. IView entries, dated 3/4/21, at 4:48 p.m., included the first set of vital signs. Given the self-injurious behavior in which the individual engaged leading up to the restraint, nursing staff should have included a pupillary assessment as part of the neurological assessment, but this was not found in the IView entries.

Abuse, Neglect, and Incident Management

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

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

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.

Summary: For the four individuals reviewed who required either TIVA/general anesthesia or pre-treatment sedation during the last six months, the Center did not provide documentation to show they ensured all required criteria were met. In addition, State Office had not issued, and the Center had not implemented preoperative assessment guidelines and procedures to identify and address risks, including perioperative management. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments: a. For two individuals, the Monitoring Team reviewed the use of total intravenous anesthesia/general anesthesia (TIVA/GA) for the completion of dental treatment.

- Based on a documentation submitted, on 3/10/21, Individual #264 was administered TIVA/general anesthesia. The documentation submitted showed that Center staff confirmed informed consent and nothing by mouth (NPO) status, provided an operative note that defined procedures completed and assessment, and documented pre-operative/procedure vital signs. The documentation also indicated the primary care practitioner (PCP) completed the medical clearance form issued by state office. However, it documented that the last EKG, completed on 4/10/20, was reported as normal, but the PCP approved the

administration of TIVA prior to obtaining a needed updated EKG. In addition, as discussed in previous reports, the Center's policies with regard to criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure; however, an individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on the completion of perioperative evaluations for non-cardiac surgery. Given the risks involved with TIVA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

- Based on review of the dental IPNs submitted, on 5/5/21, Individual # 227 was administered TIVA/general anesthesia for the completion of her annual dental examination and x-rays. The available IPNs reviewed indicated the presence of an operative note that defined procedures completed and assessment, and documented pre-operative/procedure vital signs. Otherwise, Center staff did not submit any supporting documentation to confirm they followed proper procedures (i.e., their response to the Monitors' Tier II document request indicated she did not receive this service).

In addition to these two individuals, for Individual #344, the documentation submitted in response to the Monitors' Tier I document request indicated that on 12/16/20, he was administered TIVA for periodontal therapy. However, in response to the Monitors' Tier II document request, Center staff did not submit any other related documentation for review (i.e., their response to the Monitors' Tier II document request indicated he did not receive this service).

b. The Monitoring Team reviewed the use of oral pre-treatment sedation for two individuals.
   - Based on review of the IPNs submitted, on 3/3/21, at 5:39 a.m., Individual #344 was administered oral pre-treatment sedation (i.e., Ativan) for completion of his annual dental examination, prophylaxis, and x-rays. Center staff did not document taking vital signs prior to administration of the medication. The only other vital signs Center nursing staff documented occurred at 7:00 a.m. and 9:00 p.m. on that date. The Center did not otherwise submit any of the other documents to confirm they followed proper procedures. As noted above, their response to the Monitors' Tier II document request indicated he did not receive this service.
   - Based on review of the dental IPNs submitted, on 2/26/21, Individual #112 was administered oral pre-treatment sedation (i.e., Ativan) for completion of dental restorations. The documentation submitted showed that Center staff confirmed NPO status, provided an operative note that defined procedures completed and assessment, and documented pre-operative/procedure vital signs. However, the documentation did not evidence that the Dentist or PCP determined the medication and dosage range with the input of the interdisciplinary committee/group or obtained informed consent.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227

a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	0/2	N/A	N/A	N/A	N/A

Comments: a. Of note, as part of the Tier I document request, the Monitoring Team requests a: "List of individuals who have had pretreatment sedation, with the following information (a) identify if PTS was for dental or medical, (b) what it was for (e.g., routine cleaning, hip surgery)…" Although the Center provided a list, these instances of the use of pre-treatment sedation with Individual #78 were not included on the list. Moreover, in response to the Tier II document request, Center staff indicated this individual had no medical pre-treatment sedation. Based on review of other documents, the Monitoring Team member identified these administrations of medical pre-treatment sedation:

- On 4/26/21, at 8:30 a.m., she received 2 milligrams (mg) of Ativan for a mammogram. The mammogram was not completed, because the transportation vehicle did not show up.
- On 4/29/21, nursing staff documented that the individual was scheduled to receive her COVID-19 vaccine at 9:15 a.m. At 9:30 a.m., the ambulance was scheduled to transport the individual for a computed tomography (CT) scan of the abdomen with intravenous (IV) sedation.

  Per IView documentation, the individual received her initial COVID-19 vaccination at 9:30 a.m. At 10:05 a.m., a nurse documented the individual's vital signs. The next set of vital signs were timed at 1:45 p.m., upon the individual's return from the outpatient diagnostic center. It was not clear why the decision was made to have the individual receive the initial COVID-19 vaccination, and shortly thereafter be transported off campus to complete a CT scan with IV sedation.

Center staff did not provide evidence of informed consent for either instance. They also did not provide evidence that the PCP determined the medication and dosage range with input of the interdisciplinary committee/group.

For both, it was positive that nurses documented the completion of pre- and post-procedure vital sign assessments.

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: All indicators were met for one of the two individuals to whom these indicators were applicable. Thus, Richmond SSLC demonstrated that it can meet criteria, but now needs to do so for all individuals. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 273	787	346	549	344	122	510	497	195
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 1/2			0/1	1/1					
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b)	50% 1/2			0/1	1/1					

	determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.											
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 1/1				1/1						
4	Action plans were implemented.	100% 1/1				1/1						
5	If implemented, progress was monitored.	100% 1/1				1/1						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	100% 1/1				1/1						

Comments:
1-6. This outcome and its indicators applied to Individual #346's pretreatment sedation for dental procedures on 12/15/20, and Individual #549's pretreatment sedation for off-campus TIVA on 1/21/21.

1. Available documentation for Individual #346's pretreatment sedation only included nursing notes.

2. There was no available evidence indicating that Individual #346's IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.

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	378	527	192	264						
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	0%	0/1	0/1	0/1	0/1						

	training/education/in-service recommendations identify areas across disciplines that require improvement.	0/4									
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% 0/2	N/A	0/1	0/1	N/A					

Comments: a. Since the last review, 13 individuals died. The Monitoring Team reviewed four deaths.

- On 9/1/20, Individual #379 died at the age of 44 with causes of death listed as pending as of 5/12/21.
- On 9/25/20, Individual #378 died at the age of 70 with cause of death listed as sepsis.
- On 12/4/20, Individual #162 died at the age of 52 with causes of death listed as listed as pending as of 5/12/21.
- On 12/4/20, Individual #29 died at the age of 71 with causes of death listed as multisystem organ failure, and septic shock.
- On 12/29/20, Individual #483 died at the age of 66 with cause of death listed as Hepatosplenic T-cell lymphoma with metastasis to lung.
- On 1/17/21, Individual #73 died at the age of 69 with causes of death listed as septic shock, and multisystem organ failure.
- On 1/19/21, Individual #621 died at the age of 66 with cause of death listed as COVID-19.
- On 2/2/21, Individual #527 died at the age of 65 with cause of death listed as complication of COVID-19.
- On 2/5/21, Individual #169 died at the age of 60 with causes of death listed as severe septic shock, multisystem organ failure, and respiratory/liver failure.
- On 2/18/21, Individual #48 died at the age of 58 with causes of death listed as septic shock, and respiratory failure.
- On 4/7/21, Individual #651 died at the age of 55 with causes of death listed as pending as of 5/12/21.
- On 4/13/21, Individual #192 died at the age of 69 with causes of death listed as aspiration pneumonia, and severe dysphagia.
- On 4/29/21, Individual #264 died at the age of 63 with cause of death listed as blunt trauma of head with subdural hematoma.

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

- According to nursing documentation, on 4/20/21, at 5:45 p.m., a direct support professional (DSP) discovered Individual #264 "in shower area on her own." The individual was sitting upright on the shower floor with bleeding noted to her posterior scalp. The bleeding was controlled with pressure. The nurse notified the PCP, who ordered transfer to hospital.

  On 4/21/21, at 9:54 a.m., a nurse added an addendum that the PCP was notified of the injury and ordered that the individual be sent out if bleeding persisted. Upon assessment, nursing determined that bleeding had stopped and there were no other changes. Therefore, staff did not call 911. Staff transferred the individual to the hospital in a Center van. At 6:30 p.m., on 4/20/21, the on-call PCP documented that the individual was transferred to the ED for evaluation of a bleeding laceration. There was no additional documentation from the PCP.

According to mortality documentation, a computed tomography (CT) scan showed a right-sided complex subdural hematoma with mass effect and shift of midline. She was transferred due to the need for a higher level of care. Upon arrival at the ED, she was intubated. A repeat CT showed brain herniation and the injury was determined to be irreversible with an extremely poor prognosis. Palliative care was provided, and on 4/29/21, the individual died.

The only recommendation generated by the clinical death review was to in-service PCPs on subdural hematomas. As discussed in various sections of this report, the Monitoring Team identified a number of problems with the provision of her supports, services, and treatment. Issues such as the following should have been identified and addressed through the mortality review process in order to improve services for other individuals the Center supports:

- In the Clinical Death Review, the Medical Director noted that the individual's preventive care was up-to-date. The State Office template specifically states: "Note if anything was missed and the reason." The Medical Director documented neither of the two deficiencies in preventive care:
  - On 3/2/16, she completed her last mammogram. During interview, the PCP reported: "She was past due for her mammograms for a number of years." There was no further explanation for this deficiency.
  - On 8/20/18, an audiological exam showed she had moderate to severe hearing loss. The recommendation was to return in one year. Per the PCP, she returned in 2019 for ear irrigation, but did not have a repeat audiological assessment.
- Starting in 2015, the individual had a history of abnormal gait and falls. A neurologist and a movement disorder specialist evaluated her. In April 2018, a CT scan showed normal pressure hydrocephalus (NPH). In June 2018, following placement of a ventriculoperitoneal (VP) shunt, her gait improved and falls decreased. According to the AMA, the movement disorder specialist continued to follow the individual with the last appointment being completed on 7/2/19. The May 2020 evaluation was rescheduled due to pandemic precautions. The last neurosurgery follow-up appointment was on 1/9/19. The recommendation was to follow-up in one year. Per PCP documentation in the discussion section of the AMA: "She is past due for her neurosurgery follow-up." The documentation submitted provided no evidence that the IDT met to conduct a risk-benefit assessment of proceeding or not moving forward with a neurosurgery consult. Per the Medical Director's comments in the Clinical Death Review "without the current status of her VP shunt, it could be speculated that without a proper working shunt, her gait would be affected."
- Similarly, the nursing clinical death review was incomplete, and did not provide evidence to substantiate the "yes" response to the question: "Was care appropriately provided and were plans followed as written, based on evidence data?"; or the "no" response to the question: "Are there additional or alternate supports or services that could have improved the overall care of the individual?" The following describe some, but not all of the concerns that the Monitoring Team identified with regard to the nursing supports provided to the individual:
  - No physical assessment was completed to correspond with her annual record review, dated 7/4/20.
  - Quarterly record reviews were due in October 2020, January 2021, and April 2021. The Center submitted quarterly record reviews dated 12/31/20, and 5/13/21.
  - For Individual #264, the PCP provided a blood pressure parameter of 150/90. On the following dates and times, the individual's blood pressure was out of this range, but nursing staff did not complete timely reassessments: 2/24/21, at 1:43 p.m.; 2/25/21, at 11:25 a.m.; and 2/25/21, at 7:15 p.m.
  - On 3/21/21, Individual #264's PCP increased the dose of one blood pressure medication and added another

due to uncontrolled blood pressure. On 3/10/21, she also had an abnormal electrocardiogram (EKG). However, based on the ISPAs submitted, her IDT did not hold a CoS meeting. No evidence was submitted to show that the IDT reviewed her IHCP or its implementation, and/or made changes as needed. The IHCP was deficient in a number of ways; for example, it included no preventative interventions.

- The death review from Habilitation Therapy offered no recommendations. Some of the issues that the Monitoring Team identified included:
  - Individual #264 required total assistance, but the toileting/personal care instruction section of her PNMP said: "communication instructions, delete if N/A."
    - According to the Habilitation Therapy death review, she required staff assistance for bathing (total), dressing, grooming (total), hygiene, and toileting (total) for safety and thoroughness of the tasks. She was to transfer to the bathroom with her helmet, and gait belt with stand by assistance. Then, she was to transfer to a shower chair for bathing/showering. On the day of the most recent fall, there was some indication that she slipped on water. Her helmet was on, but not strapped, the right elbow pad was on, but the left was not. It was unclear whether or not her knee pads were present. The floors in the bathroom were slippery with low ventilation to aid in drying. The report stated that staff would reapply anti-slip coating. Reportedly, the DSP was in restroom with Individual #264 and another individual. Individual #264 stayed and went to shower. The DSP heard noise and checked. She was undressed and on the floor.
  - Her IHCP for falls included none of the components necessary for a quality IHCP, and it did not meet her needs.
  - On 5/10/21, the IDT held an ISPA meeting to discuss the fall that resulted in this serious injury and her death, the resulting Unusual Incident Report (UIR), as well as Review Authority recommendations. This ISPA identified ongoing problems with the slippery nature of the shower areas in this individual's home. For example, the IDT documented an update, dated 5/12/21, which stated that the Residential Coordinator "followed up with staff to see if we are still having issues in the bathrooms during showering and the staff reported the following: Bathroom floor are [sic] still very slippery and they have to put towels on the floor to help with how wet the floors get. They also reported it gets very foggy in there when bathing… Staff did report that the anti-slip agent helped some, but not very much. This is concerning due to the individual on the waiting list for [name of home] does not use a shower chair and she showers with minimal support. This poses a fall risk for any of the ladies that walk to/from the showering area…"
  - In its comments on the draft report, the State provided the following clarification: "For individual #264, Record Request TX-RI-2106-II.106b, pg. 5. There [sic] were two other recommendations also documented in the clinical death review report.
    1. … safety modifications such slip resistant floors can help with falls.
    2. Have an alert system to notify staff that an individual has entered the bathroom to ensure safety. This can be discussed in the administrative death reviews if it is a viable option."

    Based on the Monitoring Team's review of the clinical death review committee's findings and recommendations, the group did discuss the two issues noted in the State's comments. However, the recommendation section did not include recommendations to address them. The administrative death review

did include the following recommendation: "Follow-up floor protection in 3 showers and ventilation." No recommendation related to an alert system was found." As noted in the draft report, it did not appear that the efforts thus far to address the slippery floors had been successful.

- Individual #378 was missing preventative care, including the Shingrix vaccine and HIV testing. The clinical death review mentioned only the Shingrix vaccine. The medical death review included no recommendations. This was a missed opportunity to correct similar issues for other individuals.
- For Individual #527:
    - It was positive that the nursing review included recommendations to address: 1) the lack of an acute care plan to address his unresolved diagnosis of COVID-19; and 2) the lack of IHCP updates for most of his risk areas for the 2020 ISP year. However, the administrative death review did not include the two nursing recommendations.
    - According to the review of nursing services, on 1/15/21, the individual received the COVID-19 vaccine. At 11:37 a.m., nursing staff took his vital signs, which showed a temperature of 102.2. The other vital signs were not documented in the death review. The exact time of the vaccination was not documented. This was important information that should have been clearly documented. The nurse notified the PCP of the elevated temperature. The nursing review did not document the PCP's response to the elevated temperature, and what, if any, action was taken. On 1/16/21, nurses took vital signs, but it was noted that the nurses did not enter vital signs into IView as per the guidelines. The nursing death review further documented that the on-call PCP documented at 6:00 a.m., that nursing staff called to report that the individual had a temperature of 102, blood pressure of 98/59, and oxygen saturation of 90%. The on-call PCP told the nurse to send the individual to the ED for evaluation. Per the nursing review, there were conflicting dates in the PCP documentation regarding the transfer date. According to nursing documentation, on 1/17/21, the licensed vocational nurse (LVN) reported that the individual was having mild congestion and abnormal vital signs. Vital signs entered into IView at 3:51 a.m., included a temperature of 101.6, and at 5:43 a.m., a blood pressure of 98/59 and a temperature of 102.3. At 5:52 a.m., the PCP was notified of abnormal vital signs and requested a non-emergency transport to the ED. At 7:13 a.m., the nurse activated 911 due to deterioration of the individual's respiratory status. The individual was admitted to intensive care unit (ICU) with COVID-19 disease, respiratory distress, and congestive heart failure (CHF).

      On 1/26/21, the individual returned to the Center. Nursing staff documented the times that the Physical and Nutritional Management Team (PNMT) nurse, Habilitation Therapy staff, and speech language pathologist (SLP) saw the individual (i.e., all on 1/27/21). Nursing did not document the time of the PCP assessment on 1/27/21. According to the nursing review, the PCP entered an addendum on 1/28/21, for a 1/27/21 visit. The time of this addendum was not provided. On 1/28/21, at 4:00 a.m., the individual experienced respiratory distress. The on-call PCP was notified, and the individual was transferred to the ED. The individual was intubated and mechanically ventilated. On 2/1/21, a do not resuscitate order (DNR) was implemented, and on 2/2/21, the individual expired.

      The status of vaccination with Shingrix was unclear. The clinical death review noted: "contraindicated with fludrocortisone?" This should have been reviewed and clarified.
    - This individual had multiple chronic conditions including chronic obstructive pulmonary disease (COPD), hyperlipidemia, epilepsy, dementia, and CHF. He also had Down syndrome. According to the medical review, the

individual was in generally good health until 1/17/21, when he began having fever, shortness of breath, and hypotension and was sent to the ED for evaluation. This statement was not consistent with the narrative documented in the nursing review. The medical review did not address the nursing documentation that there was a temperature of 102.2 on 1/15/21, or that the PCP was notified of the elevated temperature. There was no discussion of the fact that nursing staff documented discrepancies in dates of the PCP documentation. This was important information in understanding the individual's course of illness, and should have been reviewed and clarified as part of the mortality review process.

Precise information also was needed to determine what if any role the vaccination played in this illness. It appeared that there was evidence of illness starting on 1/15/21, with a documented temperature of 102.2, but there was no documentation of how this was addressed. Again, knowing the exact time of vaccination was important in determining if it played any role if the individual's change of status. According to the nursing review, upon return to the Center, there were issues related to documentation, in that a PCP addendum was made on 1/28/21, for a 1/27/21 assessment.

In light of all of the nursing death review documentation related to discrepancies in time, events, and documentation, none of these issues were reviewed or clarified in the clinical death review meeting. The clinical death review actually stated under the review of acute care that the individual was sent to the ED on 1/16/21. A preponderance of the documentation indicated that the individual was transferred and hospitalized on 1/17/21.

The medical services review as well as the clinical death review failed to adequately review the medical care and sequence of events leading up to the individual's hospitalization on 1/17/21. There should have been a thorough evaluation of the timelines related to the onset of symptoms and treatment, and a determination should have been made regarding the appropriateness of the interventions. There was no evidence that this occurred. Early identification of COVID -19 symptoms is integral in determining what therapeutic options are available.

- For Individual #192:
  - According to the Habilitation Therapy death review, on 3/12/21, the individual had redness around both heels. PT added heel protectors. On 3/16/21, the individual was seen in sick call, at which time, she was diagnosed with a Stage 2 pressure injury with Stage 1 over the adjacent areas. The record noted that on 3/19/21, the wound nurse reported that the individual had a Stage 3 pressure ulcer. On 4/3/21, the PT observed the individual's air mattress was unplugged. The nursing death review did not address the pressure injuries, including efforts to identify root causes. The nursing review offered no recommendations.
  - On 10/5/19, the individual entered hospice. Prior to that time, she had a number of preventive care services that had not been completed as required.

    The data for the review of Medical Services appeared to be largely extracted from the AMA. Per this review, on 3/24/11, the individual had a colonoscopy that was incomplete and required a barium enema. The recommendation was to repeat the screening in five years. On 7/24/17, an attempt was made to perform a colonoscopy, but it was unsuccessful due to a poor preparation. The documents reviewed did not provide any information on what was done to complete the study after the failed attempt, and prior to implementation of the DNR/Hospice status. A similar

concern was noted with regard to obtaining mammography. On 8/9/17, the study was not able to be completed, but the AMA only stated will repeat with sedation. There was no documentation of this repeat attempt. The individual also did not receive the Shingrix vaccine. These gaps in preventive care were not discussed in the clinical death review, and there were no medical recommendations. The Medical Director reported during interview that Center staff recognized the problems with preventive care, and a plan of improvement (POI) had been developed to address this issue.

e. At times, the discipline-specific mortality reviews included recommendations that were not carried forward into the administrative or clinical death reviews without explanation. For example, in relation to Individual 192's death, Habilitation Therapy staff recommended that nursing staff assist in checking for correct positioning of individuals during medication administration times. However, this recommendation was not carried forward, and, therefore, was not tracked.

Some improvement was noted with regard to mortality committee writing recommendations in a way that ensured that Center practice improved. For example, a recommendation read: "Infirmary and Unit RNs will be retrained on the ACP [acute care plan] Development and Initiation for Hospital Transfer/Return to facility to ensure care plans are initiated for acute issues upon return from hospital to infirmary and/or unit." This recommendation resulted in an in-service training, but the Clinical Death Review Committee also appropriately required monthly audits for three months to make sure nurses developed acute care plans and implemented them.

However, other recommendations did not follow this format. For example, another recommendation was: "For medical conditions that are not recommended for further intervention… it should be documented that the IDT is in agreement to [sic] that decision…" The Monitoring Plan column simply stated "AMA," and the evidence of completion was a sign-in sheet. This did not provide evidence that the PCPs met with the IDTs of individuals in this category to confirm their agreement with the PCPs' recommendations.

The documentation the Center provided made it difficult to determine whether or not, and when a mortality review recommendation was considered closed. Specifically, the charts that listed the recommendations did not include a column to indicate the date on which the recommendation was initiated and a date on which it was closed, or to provide a "pending" status update.

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

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.	
Summary: For the one individual in the review group for which Center staff identified a potential ADR, they did so timely. However, for another individual, the Clinical Pharmacist identified a possible ADR as part of the process of completing	Individuals:

the QDRR, but based on documents submitted, they did not report it. For the one ADR reported, the Pharmacy and Therapeutics Committee (P&T) thoroughly discussed it. Center staff did not submit documentation to show what and when clinical follow-up action occurred.											
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	ADRs are reported immediately.	50% 1/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2					0/1			0/1	
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	50% 1/2					1/1			0/1	
d.	Reportable ADRs are sent to MedWatch.	0% 0/1					N/A			0/1	

Comments: a. through d. For Individual #78, on 11/19/20, an ADR form, identified and reported sedation as a possible ADR. The description of the event was documented as "Per [psychiatrist] on 11/19/20 'Staff were reporting that [Individual #78] was unsteady and sedated from her meds.' 12/28/20 Psych clinic note reported the individual tolerated dose decrease." The treatment was a reduction in the dose of lorazepam.

The documentation for this ADR raised questions. It appeared that the Pharmacist completed their review and the data were entered into the form on 1/13/21, almost two months after the ADR occurred. As noted above, the Pharmacist referenced information from a psychiatric clinic that occurred on 12/28/20.

The ADR form includes a section for the physician response review. The physician is required to provide comments and indicate the date the assessment was completed. The physician did not complete this section of the form and it was blank. The Center did not submit any documentation from the prescribing physician regarding the possible ADR and the treatment that was implemented. According to documentation on the form, the dose of Ativan was reduced. It was not clear when that dose reduction occurred.

On 2/10/21, the ADR was reviewed in the Pharmacy and Therapeutics Committee meeting. The minutes documented that the psychiatric clinic note, dated 2/3/21 (which was not submitted), reported that the individual appeared to be less sedated and other medications could contribute to sedation. The committee concluded that this was not a true ADR. The psychiatrist responsible for medication management was not present at the meeting.

In Individual #544's QDRR, dated 4/28/21, the recommendations included a comment that the individual's anemia might be associated with donepezil, but there was no actual recommendation related to evaluation of the anemia. The individual's follow-up complete blood count (CBC) demonstrated a decrease in hemoglobin from 12 to 9.3. The Clinical Pharmacist noted that anemia is a listed possible ADR with donexepril. Based on the documentation submitted, the Clinical Pharmacist did not report this possible ADR.

In its comments on the draft report, the State disputed these findings and stated:

> The monitor states that the clinical pharmacist noted that anemia is a listed possible [sic] ADR with Donepezil. The source of this statement was from a previous QDRR dated 11/2019, over one year from the QDRR referenced in the comment. Lab discussions from 2019 were carried over to subsequent QDRRs for historical reference and not pertinent to the quarter being reviewed. When reporting CBC results from May 2020 and April 2021 (the two subsequent CBCs that were discussed after the 2019 CBC) the term possible adverse drug reaction was not used. The comment noted by the clinical pharmacist stated 'anemia can potentially be associated with Donepezil use (<1%), [sic] implying that the association of anemia to Donepezil use is highly unlikely.
>
> It is important to note that the individual was hospitalized from 1/20/21 to 2/6/21 and 2/9/21 to 3/19/21 for bacteremia, sepsis, COVID-19 pneumonia, and cellulitis (Refer to submitted document TX-RI-2106-II.015) and had a long complicated recovery upon returned to the facility. The individual remained in the infirmary until 4/2021. Therefore, subsequent lab abnormalities (CBC from 4/2021) were likely due to acute illness.
>
> Monitoring team referenced a CBC from May 2021 (Hgb 9.3 g/dL), which resulted after the most recent submitted quarterly was completed (4/28/21), and these labs were addressed by provider per chart review with plan for workup. However, CBC from June 2021 and July 2021 yielded a WBC, RBC, H&H all WNL, while still receiving the same dose/regimen of donepezil.
>
> Therefore, there is no ADR to be reported regarding this finding as it is unlikely the anemia is attributed to Donepezil use, as June and July 2021 CBC does not suggest concern for anemia, while still taking the same regimen of Donepezil and is instead more likely be related to illness."

With regards to the QDRR, dated 4/28/21, the first line of the Lab Monitoring section includes the CBC dated 4/9/21. The Clinical Pharmacist noted that the individual's red blood cells, hemoglobin, and hematocrit were low. Therefore, the Clinical Pharmacist was acknowledging that the individual had anemia. The second line under the lab monitoring section stated: "Noted Anemia can potentially be associated with donepezil use (<1%)." Again, it is the Clinical Pharmacist that surfaces the possibility of an ADR by stating the association between the medication and the anemia. With regards to the 11/4/19 CBC, the Clinical Pharmacist stated: "Anemia is listed possible adverse drug reaction with donepezil use (<1%)."

Staff should report potential/suspected ADRs, and the, they should be put through the required process. The Monitoring Team member included the CBC data from 5/3/21, to show that the individual's anemia worsened over time.

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: It was good to see that the Center completed three clinically significant DUEs. For the two DUEs for which follow-up was due, Center staff completed it. If the Center sustains its progress in this area, after the next review, Indicators and b might move to the category requiring less oversight.		
#	Indicator	Score

a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2

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

- A DUE on Carbamazepine was presented to the P&T Committee on 11/12/20. The rationale for conducting the DUE was to ensure correct safety profile monitoring of carbamazepine.

  Seventeen individuals were prescribed carbamazepine and all were included in the study. The Health and Human Services Commission (HSCS) Medication Audit Criteria included complete blood count (CBC), electrolytes, liver enzymes, pregnancy test, and carbamazepine levels. Specific genetic testing was recommended for those at high risk. Lab monitoring was appropriate for 94.1% of the individuals. One individual did not have a MOSES completed in the appropriate timeframe and the recommendation was made to complete the assessment.

  On 11/12/20, the Pharmacist presented the DUE at the Pharmacy and Therapeutics Committee meeting. A recommendation was made to complete the MOSES evaluation. According to the P&T minutes, dated 2/10/21: " Recommendation completion is pending and responsible parties have been notified." Based on interview with the Clinical Pharmacist, the recommendation subsequently was completed.
- A DUE on Phenytoin was presented to the P&T Committee on 2/10/21. The rationale for conducting the DUE was to ensure appropriate safety profile monitoring of phenytoin.

  Eight individuals were treated with Dilantin and all were included in the study. Monitoring parameters included comprehensive metabolic panel (CMP), MOSES assessments, phenytoin levels, thyroid function tests (TFTs), and Vitamin D. The study showed that the monitoring of Vitamin D, phenytoin levels, and CMP was completed appropriately for 100% of the individuals. All of the individuals also had timely completion of the MOSES assessment. The thyroid stimulating hormone (TSH) was completed appropriately for 87.5% of individuals.

  On 2/10/21, the Pharmacist presented the DUE at the Pharmacy and Therapeutics Committee meeting. Person-specific recommendations were made during this meeting. The P&T minutes for the 5/11/21 meeting documented that all recommendations were completed.
- A DUE on lithium was presented to the P&T Committee on 5/11/21. The rationale for conducting the DUE was to ensure appropriate safety profile monitoring of lithium. The monitoring parameters per HSCS Medication Audit Criteria included: electrocardiogram (EKG), CBC, TFTs, CMP, urinalysis (UA) pregnancy test, weight, and lithium levels.

  Ten individuals were treated with lithium and all were included in the study. The study concluded that the CBC, CMP, EKG, and TSH were appropriately monitored for all individuals. The lithium levels were performed appropriately for 90% of the individuals.

  On 5/11/21, the Pharmacist presented the DUE at the Pharmacy and Therapeutics Committee meeting. Person-specific

	recommendations were made. A recommendation also was made to provide education on signs and symptoms of lithium toxicity to staff caring for individuals. Follow-up for the recommendations was pending and not yet due yet, so that is the reason that Indicator b was scored as N/A for this DUE.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 31 of these indicators were moved to, or were already in, the category of requiring less oversight, seven other indicators were moved to this category, and the four outcomes and 13 indicators in Psychology/Behavioral Health met sustained substantial compliance and were exited from monitoring.

Thus, at the start of this review, 26 indicators were in the category of requiring less oversight. For this review, an additional four were moved to this category in the areas of ISPs, psychiatry, and OTPT.

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

Assessments

In psychiatry, these three indicators scored higher than ever before: psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months; the psychiatrist or member of the psychiatric team attended the individual's ISP meeting; and the final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.

When determining individuals' level of risk, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year). 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.

For most of the nine individuals, the PCPs completed new-admission or annual medical assessments timely. PCPs should complete interval medical reviews quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

One of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

For the individuals in the review group, Center dental staff completed timely dental examinations. These individuals also received dental examinations and summaries that met all or most of the criteria for a quality assessment.

It was positive that for the one newly-admitted individual, the Registered Nurse Case Manager (RNCM) completed a timely nursing record review and physical assessment, as well as a timely quarterly assessment. However, for the remaining five individuals, problems were noted with regard to nurses' timely completion of annual and quarterly nursing record reviews and/or physical assessments.

For a quarter of the risk areas reviewed, nurses included status updates in annual record reviews, and for two of the 12 risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for RNCMs to analyze this information, and offer relevant recommendations. RNCMs also need to continue to improve the other components of annual and quarterly physical assessments. When individuals experience exacerbations of their chronic conditions, nurses need to complete assessments in accordance with current standards of practice.

In comparison with the last review, the scores during this review showed some improvement with regard to timely referral of individuals to the PNMT, and the timely completion of PNMT reviews. These are areas that require continued effort, though. For the one individual for whom the PNMT completed a full assessment, they completed it timely. However, for two other individuals, the PNMT should have completed comprehensive assessments, but they did not. Center staff also should continue their efforts to improve the quality of the PNMT reviews and comprehensive assessments.

It was positive that Occupational and Physical Therapists (OTs/PTs) generally completed timely OT/PT assessments for individuals in the review group. Based on the Center's sustained progress, the related indicator will move to less oversight. The quality of OT/PT assessments needs significant improvement.

For individuals reviewed, Center staff completed timely initial assessments for those who were newly admitted, but otherwise needed to focus on timeliness and currency of assessments and ensuring individuals received the correct type of assessment based on their needs. Significant work is also 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.

Less than half of the assessments included recommendations for skill acquisition.

Individualized Support Plans

In the ISPs, one individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, 23 goals met criteria. This was about a 30% increase from the last review. More work is needed regarding health goals (i.e., the IHCP). For measurability, about half of the goals met criteria. Of the 23 goals that met criterion for being personal and individualized, about half had corresponding action plans that were supportive of goal-achievement.

The QIDPs were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads. DSP staff were generally familiar with the skills and goals of the individuals they supported. For half of the individuals, the QIDPs ensured they received required monitoring, review, and revision of treatments, services and supports. For the other half, there were action steps and follow-up needs that had not been addressed.

Few of the ISP goals had regular implementation and reliable data, due in part to COVID-19. Without implementation and without data on performance, progress could not be determined. Across all six individuals, there was a total of 117 action steps evaluated, 13 of which had been implemented. Of the 104 remaining action steps that were not implemented, 60 could not be implemented due to COVID-19 community and gathering restrictions. Thus, of the 57 that could have been implemented, 13 were implemented (23%).

In psychiatry, Richmond SSLC show substantial improvement in the identification of psychiatric indicators to the point where 100% scores were achieved for three of the four monitoring indicators and 88% for the fourth indicator.

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.

Four of the nine physical and nutritional management plans (PNMPs) fully met individuals' needs. As indicated in the last report, with continuing efforts, Habilitation Therapy staff could make additional progress by the time of the next review.

Richmond SSLC was attending to SAPs, more so than ever before. This is reflected in the progress seen in the scoring of many of the monitoring indicators. That being said, two-thirds of the individuals had a single SAP.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: One individual's goals met criteria for all five personal goal areas. Moreover, across the six individuals, personal goals met criteria in from three to five areas for a total of 23 goals that met criteria. Overall, this was about a 30% increase	Individuals:

from the last review. More work is needed regarding health goals (i.e., the IHCP).

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health-IHCP goals. Both types of goals need to meet criteria, however, the State has reported that it is working towards improving both types of goals with two concurrent support and training programs.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. None of the individuals had a full set of goals that were written in measurable terminology, but overall, about half of the goals met criteria for this indicator. Indicator 3 shows that few of the goals had reliable data due in part to COVID-19. These three indicators will remain in active monitoring.

#	Indicator		Overall Score	787	344	122	195	227	78			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	Personal goals	17% 1/6 77% 23/30	3/5	4/5	4/5	5/5	4/5	3/5			
		Health goals	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
2	The personal goals are measurable.		0% 0/6 45% 13/29 57% 13/23	3/5 3/3	1/4 1/4	2/5 2/4	2/5 2/5	3/5 3/4	2/5 2/3			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.		0% 0/6	0/3	0/0	0/1	0/0	0/1	0/0			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Richmond State Supported Living Center: Individual #787, Individual #344, Individual #122, Individual #195, Individual #227, and Individual #78. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs, QIDPs, and a Residential Coordinator Assistant, and directly observed most of the individuals in their natural settings on the Richmond SSLC campus. One individual, Individual #227, could not be directly observed, because her home was under quarantine at the start of the review week, and she was subsequently hospitalized.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 18 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. During the current site visit, 23 goals met this criterion (i.e., an improvement). The personal goals that met criterion were:

- the leisure goal for Individual #787, Individual #344, Individual #122, Individual #195, and Individual #227.
- the relationship goal for Individual #787, Individual #122, Individual #195, Individual #227, and Individual #78.
- the work/day/school goal for Individual #344, Individual #122, and Individual #195.
- the independence goal for Individual #344, Individual #195, Individual #227, and Individual #78.
- the living options goals for Individual #787, Individual #344, Individual #122, Individual #195, Individual #227, and Individual #78.

For those individuals, the goals were attainable, aspirational, and based on their preferences and support needs. For example:

- Individual #787's leisure goal was to win a medal participating in a Special Olympics event with the Richmond SSLC Special Olympics team.
- Individual #344's work goal was to independently ambulate to work using his motorized wheelchair.
- Individual #122's relationships goal was to become a volunteer at the young-adult ministry at River Pointe Church, building positive relationships with members.
- Individual #195's work goal was to work full-time with Supported Employment as an office assistant.
- Individual #227's leisure goal was to attend a church of her preference five times a year.
- Individual #78's independence goal was to dress herself independently within three years.

Some goals did not meet criterion for the indicator, because they did not reflect the individual's specific preferences. Other goals did not meet criterion for the indicator because they were skills the individual already possessed. Finding included:

- Individual #787's work/day goal to enhance her vocational skills while working in a suitable environment did not reflect her specific strengths, abilities, or interests.
- Individual #787's independence goal was to continue to work on maintaining her personal appearance by independently styling and combing her hair. According to her ISP and FSA, she was already independent in all areas of personal care, including combing and brushing her hair. She could also braid hair and tie a scarf around her head. As written, the goal would not have led to the development of a skill or enhanced Individual #787's overall independence.
- Individual #344 did not have a relationships goal.
- Individual #122's goal to compete in a swimming competition was set for the leisure and independence life areas. As an independence goal, it was not clear what skills she would develop that could lead to greater independence.
- Individual #227's work goal to operate a preferred sensory item during leisure time on the home was not aspirational for the day/work life area.
- Individual #78's leisure goal was to hold an electronic device to listen to music. It was not clear how holding the device was aspirational.
- Individual #78 did not have a work goal. According to her ISP, she was to be assessed in order to determine her skill level.

For three individuals, implementation of actions to achieve some aspects of their personal visions did not occur because their guardians did not agree with their goals. Findings included:

- Individual #787 had a special friend with whom she wanted to attend the I-Fit dance. The IDT was supportive of the goal. Individual #787's guardian did not approve of the goal. The guardian, however, agreed that Individual #787 could begin working towards the goal as long as she did not actually attend the prom for at least two years.
- According to the QIDP, Individual #787 wanted to obtain a job in the community as a hairstylist. The IDT did not establish the goal in her ISP, because her guardian did not approve of Individual #787 working in the community.
- One of Individual #787's living options action steps was community money-management training. The step was not developed as a SAP because Individual #787's guardian did not approve of Individual #787 working in the community.
- Individual #227's health needs were identified as barriers to community living. Individual #227's QIDP reported that the barriers could likely be met by a provider in the community. Individual #227's guardian, however, would not approve of a community referral. There was no evidence that the IDT had discussed or explored potential providers that could meet her needs.
- Individual #227's goal to build a relationship with her volunteer was limited to on-campus visits and activities because Individual #227's guardian did not approve of her leaving the facility with the volunteer.
- Individual #195's guardian did not approve of a referral to the community due to her mistrust of community providers.
- Individual #195 wanted to work as an office assistant in the community. The IDT did not explore community options for work because Individual #195's guardian did not approve of her working in the community.

2. The Monitoring Team evaluated whether ISPs for the six individuals had goals that met criterion for measurability. Thirteen goals met criterion for measurability, in that they provided observable and quantifiable actions for which progress could be tracked. Three of the 13 measurable goals provided a timeline to determine when the goals would be achieved. The measurable goals were:

- Individual #787's leisure, relationships, and living options goals.
- Individual #344's living options goal.
- Individual #122's work/day and living options goals.
- Individual #195's work/day and living options goals.
- Individual #227's leisure, relationships, and living options goals.
- Individual #78's relationships and living options goals.

All of the 13 measurable goals met the previous indicator 1 criteria for being individualized, personal, and based on the individual's strengths.

Goals that did not meet criterion for measurability did not provide enough information about what the individual was expected to do or how many times they were expected to complete trials, tasks, or activities in order to meet the monthly criterion. For example:

- Individual #787 will enhance her vocational skills while working in a suitable working environment.
- Individual #344 will operate electronic devices by using an adaptive remote control in his bedroom and in the dayroom.
- Individual #195 will read a chapter book to a group of individuals. As written, it was not clear how much of the book she was expected to read, or for how long. Individual #195 was not able to maintain her focus on reading for more than two minutes.
- Individual #227 will operate a preferred sensory item during leisure time on the home.

- Individual #78 will hold an electronic device to listen to music.

3. Of the 13 goals that met criterion for indicators 1 and 2, eight could not be implemented due to COVID-19 community and gathering restrictions (resulting in a 0 in the denominator in the individual scoring boxes above for some individuals). None of the five remaining goals that had been implemented had reliable or valid data to determine if the individual was making progress. This was because action steps had not been fully implemented. For example:

- Individual #787 had three goals that met criterion for indicators 1 and 2. None of the three met criterion for indicator 3 because the goals and action plans listed in her ISP did not correspond to the goals and action plans documented in the QIDP Monthly Reviews. In other words, Individual #787's new goals had not been implemented.
- The majority of action steps corresponding to Individual #122's goal to work at Gringo's restaurant as a short-order cook were on-hold due to COVID-19. The action plan, however, included two steps that could have been implemented despite community restrictions. The steps were for Individual #122 to be assessed for off-campus work and to learn to complete a job application. Neither step had been implemented. According to staff report, Individual #122 would be taught to complete a job application after she was assessed for her ability to complete a resume and use a computer.
- Individual #227's goal to build a relationship with her volunteer could not be fully implemented because the volunteer had fallen ill shortly after the ISP meeting and was no longer able to visit Individual #227. The action plan included a step to send cards to the volunteer and a step to call the volunteer by telephone. Those action steps could have been implemented despite the volunteer's inability to visit the campus. The action steps were not implemented. The IDT did not meet to revise or replace the goal with an achievable alternative, and Individual #227 did not make progress towards goal-achievement.

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

Summary: Without implementation and without data on performance, progress could not be determined. Some, but not all, of the implementation was hindered by COVID-19. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 787	344	122	195	227	78			
4	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			

Comments:
4-7. For the personal goals that met criterion with indicator 3, indicators 4-7 were scored.

Across the six individuals, there were 13 personal goals that met criterion for indicators 1 and 2. None of the 13 goals had corresponding data that were reliable or valid, and there was no way to determine if the individuals met or were making progress towards goal-achievement.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
Summary: Across this set of indicators, there were some good examples of where criteria were met as well as examples of where criteria were not met. They are detailed in the comments below. These indicators will remain in active monitoring.				Individuals:								
#	Indicator		Overall Score	787	344	122	195	227	78			
8	ISP action plans support the individual's personal goals.		0% 0/6 48% 11/23	2/5	1/4	3/5	1/5	2/5	2/5			
9	ISP action plans integrated individual preferences and opportunities for choice.	Individual preferences	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
		Opportunities for choice	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.		0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.		83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
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.		33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.		33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.		20% 1/5	0/1	0/1	0/1	1/1	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.		50% 3/6	1/1	0/1	1/1	1/1	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	1/6	0/5	0/6	0/6	1/6	1/6			

Comments:

8. Although none of the individuals had comprehensive scores that met criterion for the indicator, of the 23 goals that met criterion for being personal and individualized, 11 had corresponding action plans that were supportive of goal-achievement. Findings included:

- Individual #787's relationships and living options goals.
- Individual #344's leisure goal.
- Individual #122's leisure, relationships, and living options goals.
- Individual #195's independence goal.
- Individual #227's relationships and independence goals.
- Individual #78's relationships and independence goals.

Twelve of the personal and individualized goals did not have supportive action plans leading to goal-achievement. For example:

- Individual #787's leisure goal to win a medal participating in Special Olympics events with the Richmond SSLC team had a corresponding action plan that included expectations for her to attend Special Olympics practices and events, and to purchase clothing and equipment as needed. There were no steps to teach or support the development of specific skills she would need to compete or win a medal.
- Individual #344's work/day, independence, and living options action plans did not map out clear paths to goal-achievement. The SAP to teach him to use an adaptive remote control had not been developed, and it was not clear how the skill would be taught. The goal to teach him to use a voice-output communication device had a corresponding action plan with one step, a SO for communication. The SO had not been developed and there was no way to determine how he would be supported to use the device.
- Individual #122's work/day goal was to work part-time at Gringos, a restaurant in the community, as a short-order cook. The action plan did not include training or support to teach culinary skills or to help her to obtain the identified position.
- Individual #195's work/day goal was to work full-time with Supported Employment as an office assistant. The corresponding action plan consisted of steps to work part-time with Supported Employment as an office assistant and work part-time in the vocational program on various contracts. It was not clear how Individual #195 would be supported to increase her hours to full-time.
- Individual #227's living options goal to live in a group home in the community had a corresponding action plan that included steps for her to participate in recreational activities in the community and on the home. There was also a step to update the guardian about community living options.
- Individual #78's goal to live in a group home in the community, had a corresponding action plan that included steps for her to attend a provider fair, attend CLOIP tours, and participate in scheduled community activities. The action plan was not individualized.

9. Two of the six ISPs contained a set of action plans that integrated both preferences and opportunities for choice. Findings included:

- Individual #122's action plan included steps to use the internet to search for an aqua center of her choice, shop for a swimsuit, and be given opportunities to choose a ministry or service she wanted to volunteer for. Her action plans also contained steps to shop for business attire, choose two or three group or foster care providers, and meet with her guardian to choose a provider to support her once she transitioned to the community.
- Individual #227's action plans included opportunities to participate in religious activities on her home, as well as CAPS concerts and music therapy sessions.

For the four remaining individuals, Individual #787, Individual #344, Individual #195, and Individual #78 it was not evident that their action plans integrated opportunities for choice.

10. None of the six individuals had ISPs that met criterion for the indicator. In general, Capacity Assessments identified deficit areas and an individual's inability to make informed decisions. ISP action plans did not identify training or supports to mitigate those deficits.

11. Five of the six ISPs had action plans that supported the individuals' overall independence. For each of those individuals, action steps taught functional skills, such as personal hygiene, domestic skills, communication, etc. For example:

- Individual #344's ISP contained action steps to teach him to use an adaptive remote control to operate electronic devices and to independently navigate the campus to get to work. As written, the action plan supported the goal. That being said, the action step listed in the ISP to teach Individual #344 to ambulate independently had been discontinued and replaced with a SO. Individual #344 had not mastered the skill to navigate independently. According to the SO, the SAP was discontinued after he mastered it with verbal prompts.
- Individual #122's ISP contained action steps to teach her to swim and complete a job application. There were also steps for her to obtain a personal identification card, join a church ministry, and meet with her guardian to choose a community provider.
- Individual #195's ISP contained action steps to teach her to prepare an envelope to mail cards, and a SO to prompt her to floss her teeth. The action plan also included a SAP to teach her to operate her Kindle.
- Individual #227's action plans included steps to teach her to operate sensory items and for staff to assist her to make phone calls and mail cards.
- Individual #78's action plans included a step to teach her to dress independently.

For the other individual, Individual #787, it was not evident that her action plans supported her overall independence. Her action plans included steps to teach her to brush a doll's hair, but according to her FSA and ISP, she was already able to independently brush and style hair. There was also a community money-management objective, however, Individual #787's guardian was adamantly opposed to Individual #787 developing skills to be utilized in the community. The money-management training was never developed.

12. None of the ISPs met criterion for the indicator. While some risks were addressed through the individuals' PBSPs, IRRFs and IHCPs, supports were not integrated into their ISP action plans to mitigate risks presented or to offer guidance to staff who were implementing action plans. For example:

- Individual #787 was at high risk for falls. Her falls were generally attributed to environmental factors, such as a wet floor or the shoes she was wearing. Falls were also attributed to her unsteady gait and aggressive behaviors. It was not evident that the IDT had discussed preventative measures to address her falls, and action plans did not integrate supports to address her

risk. She was also at high risk for skin infection due to skin-picking and toenail-removal behaviors. Her action plans did not incorporate behavioral strategies to address the risk.

- Individual #122 had been involved in at least four sexual incidents during the ISP year. She had a 1:1 staff assigned to her due to behavioral concerns. The IDT decided to put her on the waiting list for the San Angelo State Supported Living Center instead of referring her to the community because of her mental health challenges and need for therapeutic supports. Her action plans did not incorporate strategies to mitigate her behavioral risks or provide support and skill-building around her behavioral challenges. Individual #122's relationships goal was to become a volunteer at a young-adult ministry at a church in the community. It was not clear that the IDT had considered supports or strategies to mitigate Individual #122's risk of engaging in inappropriate sexual behaviors in that setting.
- Individual #227 had a number of health concerns that placed her at risk. She experienced frequent seizures that hindered her ability to access the community. She was also at high risk for weight because she was above the EDWR. Her action plans did not include supports to address the risks areas.
- Individual #78 was at high risk for weight because she was below the EDWR. She was also at risk for falls. The IDT was unable to assess her skills and abilities in a number of areas due to her inability to sit still. The IDT questioned whether or not she had a movement disorder. Individual #78 had a number of pending assessments and follow-up needs that were not addressed by the IDT.

13. Two of the six ISPs met criterion for the indicator. Findings included:
    - Individual #122 was over the EDWR. Her action plans included a SO to prompt her to walk for exercise and she was following a prescribed diet. Individual #122 enjoyed walking and understood that she was walking in order to improve her health and lower her weight.
    - Individual #195 spoke with low volume. Her goal to read a chapter book had a corresponding action step to obtain a microphone and speaker to amplify her voice. She also struggled to read smaller font sizes, and the IDT provided her with a Kindle that enabled her to increase the font size of words she was reading.

For the other four individuals, support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well-integrated, and they were not incorporated into action plans. For example:

- Individual #787 had a speech impairment and she would often engage in aggressive or self-injurious behaviors if her speech was not understood by others. Individual #787 could read and write. Although it was positive to hear that she was provided access to a pen and paper per her preference, she was not provided with other supports to increase or enhance her communication skills. According to her ISP, the SLP and BHS were to collaborate to come up with behavioral supports to increase Individual #787's functional communication. There was no evidence that this collaboration had occurred.
- Individual #344 was not able to communicate verbally with others, although he was social, interactive, and appeared to have good receptive language skills. He utilized picture icons to make requests and communicate his needs. Individual #344, who had been a resident of the Center since 1975, had access to only four picture icons on his wheelchair lap tray. According to his ISP, Individual #344 should have had access to additional icons to facilitate communication with others. There was no evidence that the additional icons were made available to him. It was positive to hear, during his ISP meeting held the week of the review, that the IDT had decided to provide Individual #344 with additional picture icons to make requests, as well as a Go-

Talk communication device.

14. To meet this indicator, action plans should lead to the development of skills and activities to promote community participation and should also support the individual to integrate into and become a member of their community. Two of the six individuals had goals that were supportive of community membership and likely to lead to community integration. Findings included:

- Individual #787's action plans included steps to participate in Special Olympics practices and events in the community. There was also an action step for her to participate in the I-Fit service and other events at the River Pointe Church in the community each month.
- Individual #122's action plans included steps for her to complete a swim class at an aqua center in the community, join the local YMCA, take swimming lessons at a swim school in the community, attend swimming competitions in the community, and compete in a Special Olympics event. She also had a step to join the young-adult ministry at the River Pointe Church.

For the four other individuals, their action plans did not integrate encouragement of community integration. In general, action plans included steps for individuals to participate in community outings. Action plans did not include support to help individuals to become active community members.

15. The indicator was not applicable to Individual #78, who was a new admission to Richmond SSLC. Her IDT was in the process of assessing her skills and abilities in order to determine her support needs and develop work or day-programming goals. Of the five remaining individuals, one individual's ISP met criterion for the indicator. Prior to COVID-19, Individual #195 was working as an office assistant through Supported Employment. The IDT had discussed her need to develop appropriate and professional interaction skills in order to be successful as an office assistant in the community.

For the other four individuals, it was not clear that the IDTs had explored opportunities for work or day programming in the community.

16. In general, it was positive to see that four of five individuals were engaged in an activity or returning home from an activity during nine of 12 observation periods conducted during the review week. Three of the six individuals met criterion for the indicator because their action plans supported opportunities for functional engagement with sufficient frequency, duration, and intensity to meet personal goals and needs. For example:

- Individual #787's action plans included a step to attend Special Olympics practices and events. According to the QIDP, she had been highly involved in Special Olympics activities prior to COVID-19. There were also action steps for her to attend I-Fit events at the River Pointe Church on a monthly basis, attend planned events at the gym with her special friend and watch four YouTube hair-styling videos.
- Individual #122's action plans included steps to swim on campus twice each week, take swim lessons at a swim school, join the YMCA and attend church twice each month.
- Individual #195's action plans included meeting up with a male peer bi-monthly, visiting the coffee shop weekly, working a part-time schedule as an office assistant and reading to a group of individuals weekly.

For the other three individuals, action plans did not support functional engagement with sufficient frequency to meet personal goals

and needs. For example:

- Individual #227's leisure goal was to attend the church of her preference five times a year. According to the QIDP, the ultimate goal was to expose her to different types of services, so that she would be more informed and able to choose a denomination she preferred. The action steps corresponding to the leisure goal included a step for Individual #227 to attend off-campus church service twice a year. The action step did not support church attendance with enough frequency to meet the goal.
- Individual #78's guardian had been recently appointed. The relationships goal was for Individual #78 and her guardian to get to know each other and build a relationship by attending outings together. The action plan included one step for Individual #78 to attend an outing or event with her guardian twice a year. The remaining steps were actions on the part of the home supervisor and staff to secure and provide items and supports Individual #78 would need during her outings. The action plan did not offer enough opportunities for Individual #78 and her guardian to engage in activities that might lead to the development of a meaningful relationship.

17. None of the six individuals had action plans that adequately addressed barriers to goal-achievement. For example:

- Although Individual #195's ISP did not specifically identify barriers for the leisure, relationships, work, or independence life areas, there were factors identified within the context of her ISP and assessments that hindered her ability to achieve goals, such as the limited range-of-motion in her arm and unprofessional interactions when answering the office phone on campus. Her action plans did not include strategies to address the barriers.
- Individual #787's barriers to goal-achievement included her challenging behaviors, communication deficits, and refusal to participate in activities. Her action plans did not include strategies to address the barriers.
- For Individual #227, one of the barriers to the achievement of her goal to build a relationship with her volunteer was that her volunteer was no longer available. The relationships goal was not revised or replaced, and Individual #227 did not make progress towards goal-achievement.

18. None of the six individuals had a comprehensive score that met criterion for the indicator, because action steps did not provide enough detailed information for implementation, data collection, and review to occur. For example:

- Individual #787's leisure goal had a corresponding action plan that included steps to participate in events and purchase proper clothing and equipment. There was no measurable expectation that could be tracked or monitored.
- Individual #344's leisure, work/day and independence goals had corresponding action plans that contained SAPs and a SO. The SAPs and SO had not been developed and there was no way to determine what was to be measured or tracked.
- Individual #195's work/day goal had corresponding action steps for her to work part-time as an office assistant with Supported Employment and to work part-time in the vocational program on various contracts. There was no measurable expectation that could be tracked or monitored.
- Individual #78's relationships goal had a corresponding action plan that included steps for the home supervisor to ensure Individual #78 wore appropriate clothing and was informed about her scheduled trip. There were also steps for staff to be informed about healthy food options for Individual #78 to eat during her outing, and for staff to ensure Individual #78 had her wheelchair available to her.

Although none of the individuals had a comprehensive score that met criterion for the indicator, across all six individuals, there were three life areas for which the indicator was met because the corresponding action plans contained discrete and measurable steps for the

individuals to complete. Findings included:

- Individual #787's relationships goal.
- Individual #227's independence goal.
- Individual #78's independence goal.

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

Summary: Indicators 19 and 24 will be moved to the category of requiring less oversight due to sustained high performance. There were some positive examples of criteria being met for some of the individuals for the other indicators, as well as some examples of where criteria were not met. These are detailed in the comments below. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 787	344	122	195	227	78			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	1/1	1/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The ISP included the opinions and recommendation of the IDT's staff members.	67% 4/6	0/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the	0% 0/1		0/1							

	individual was currently referred, to transition.										
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/3		0/1	0/1		0/1				
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A									

Comments:

19. Five of six ISPs included a description of the individuals' preferences for where to live and how their preferences were determined. For the remaining individual, Individual #78, it was not evident that her living preference was assessed or that the IDT attempted to explain living options to her. Individual #78 was a new admission. According to her ISP, her living preference was based on how she was adjusting to her home on campus. Individual #78 was able to speak single words and short phrases. It was not evident that the IDT had explored options for assessing her living preference or assisting her to express her goal.

21. Four of six ISPs included the opinions and recommendations of the IDT's staff members. For the other two individuals, Individual #787 and Individual #78, living options opinions and recommendations were not provided by all members of their IDTs. Findings included:

- Individual #787's IDT members individually recommended that she be referred for community placement. Individual #787 was not referred, and there was no consensus statement found in the ISP. According to the QIDP, Individual #787 was not referred to the community because her guardian did not approve.
- For Individual #78, behavioral and psychiatric concerns were the primary reasons she was not referred for community placement. The Behavioral Specialist did not make recommendations with regard to her living options goal. There were also no medical recommendations made.

23. Two of the six individuals, Individual #195 and Individual #78, met criterion for the indicator, because their LARs were already knowledgeable about community living and were not interested in information or education about living options.

For the other four individuals, it was not evident that their IDTs had thoroughly discussed potential placements in the community. Individual #122's IDT recommended that she be referred to the community, however, she was placed on the waiting list for the San Angelo SSLC because the IDT believed she would benefit from the therapeutic services offered there. It was not evident that the IDT had explored local community-based mental health, anger-management, or behavioral services.

24. All six individuals had ISPs that identified comprehensive lists of obstacles to community referral.

25. The indicator was applicable to one of the six individuals, Individual #344, whose ISP meeting was held during the week of the review. During the previous year's ISP meeting, all members of the IDT recommended community referral. The referral was suspended due to COVID-19 and the IDT was to reconvene once community restrictions were lifted. During the ISP meeting that was held during the review week, the PCP and nurse agreed that Individual #344 could not be referred to the community due to health concerns. One member of the IDT asked if Individual #344's medical needs could be met in the community. The nurse felt that community providers were not as diligent as SSLC staff and could not monitor him as closely.

26. The indicator was not met for any of the six individuals. None of their ISPs contained individualized, measurable action plans to address their obstacles to community referral. Although barriers to community transition were identified for four of the individuals, each member of their respective IDTs agreed that they could and should be referred to the community. None of the four individuals, however, was referred. Findings included:

- Individual #787 and Individual #195 were not referred, because their guardians preferred that they remain at the Center.
- Individual #122 was put on the waiting list for the San Angelo State Supported Living Center.
- Individual #344's IDT agreed to reconvene after COVID community restrictions had been lifted. At his ISP meeting that was held during the review week, the living recommendation was changed, and the IDT decided not to refer him to the community.

27. The indicator was applicable to one of the six individuals, Individual #344, whose ISP meeting was held during the week of the review. During the meeting, the PCP and nurse identified health concerns they considered to be barriers to community referral. The IDT did not discuss plans to address or overcome the barriers. The IDT also did not discuss potential community providers that could meet Individual #344's needs.

28. The indicator was not applicable to Individual #787, Individual #195, or Individual #78 whose guardians were already knowledgeable about community providers and were not receptive to information or education about living options. The indicator was not met for the three other individuals whose living options action plans did not include individualized and measurable plans to educate the individual or LAR about community living options.

29. The indicator was not applicable to any of the six individuals because significant obstacles to community referral had been identified.

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

Summary: Indicator 32, although at 33%, scored higher than ever before. On the other hand, indicator 34 scored lower than at the last review. These indicators will remain in active monitoring. Indicator 33 will remain in the category of requiring less oversight, but some comments are provided below.

#	Indicator	Overall Score	Individuals: 787	344	122	195	227	78			
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.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	50% 3/6	1/1	0/1	0/1	1/1	1/1	0/1			

Comments:

32. Action steps that were on hold due to COVID-19 restrictions were not considered in the rating of this indicator. For this indicator, two of the six individuals, Individual #195 and Individual #227, had ISPs that were implemented within 30 days of their ISP meetings. For the four other individuals, their ISPs were not fully implemented within 30 days of their ISP meetings. Findings included:

- For Individual #787 and Individual #344, the action steps that had been implemented did not correspond to the goals outlined in their ISPs.
- For Individual #122, the majority of her action steps were on hold due to COVID-19. Her goal to work in the community as a short-order cook had corresponding action steps for her to learn to complete a job application. In order to implement the step, Individual #122 had to be assessed for her ability to read, write, use a computer, and complete a resume. It was not evident that any of the assessments had been completed.
- Some of Individual #78's action steps were on-hold due to COVID-19. Other steps were on-hold due to pending assessments. Of the steps that had been implemented, data collection did not begin until three months after her ISP meeting.

33. Although QIDPs who were interviewed explained their processes for involving the individuals in their ISP-planning, ISPs did not generally reflect the individuals' involvement in the process. For example:

- According to Individual #344's ISP, the QIDP explained that his brother and the IDT would discuss his plan for the upcoming year.
- According to Individual #78's ISP, she was informed that the meeting would be about her, familiar staff would be there, she would be allowed to leave, and she would be provided a snack and an item to manipulate.

34. Three of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. For the other three individuals, crucial members of the IDT did not attend the meeting. Findings included:

- For Individual #344, there was no evidence that his QIDP attended the ISP meeting. There was also no DSP or other residential staff in attendance.
- Individual #122 was prescribed a 1200-calorie diet. She was being monitored by her PCP and dietician who did not attend the ISP meeting.
- Individual #227 was prescribed a 1000-calorie diet. She was being monitored by her PCP and dietician. Her PCP did not attend the ISP meeting.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Nursing assessments were not completed as per this indicator. The comment below points out that the summarizing document (Tier 2, item 17) was not correct. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	787	344	122	195	227	78			

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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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:

36. The indicator was met for four of the six individuals. For two individuals, Individual #195 and Individual #227, their Annual Nursing Assessments had not been completed although it was documented that they had been submitted for incorporation into the ISP.

- Document 17 in the Monitor's Tier 2 document folder shows the submission of assessments that are to be included in the ISP. For both individuals, document 17 indicated that their Annual Comprehensive Nursing Assessments had been submitted on time and that submission compliance for all assessments was 100%. For both individuals, the Monitoring Team initially scored these as met because of the information found in document 17. During the review week, however, it became apparent that this was not the case (i.e., nursing assessments were not submitted on time), and the above scoring was changed to unmet for both. The Center should ensure correct information is included in document 17.

For Individual #227, the day/retirement, audiology and capacity assessments were also not submitted in time to be incorporated into the ISP.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: It was good to see improvement in indicator 38. COVID-19 competed with the ability for the Center to implement many action plans, though there was little attempt to make adaptations over the ISP year. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	787	344	122	195	227	78			
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.	50% 3/6	0/1	0/1	1/1	1/1	1/1	0/1			

Comments:

37. None of the ISPs met criterion for the indicator. In general, IDTs did not meet to review ISP action plans or to develop strategies to revise action plans that were on hold due to COVID-19. IDTs also did not meet to review data or to discuss an individual's lack of progress towards goal achievement.

38. In general, the QIDPs were knowledgeable of the goals, strengths and support needs of the individuals on their caseloads. This indicator was met for three of the six individuals whose QIDPs ensured they received required monitoring, review, and revision of

treatments, services and supports. For the other three individuals, there were action steps and follow-up needs that had not been addressed. Findings included:

- Individual #787's QIDP Monthly Reviews had not been updated to correspond to her current ISP, and her functional communication needs had not been fully explored. Individual #787 declined the Boogie Board writing tablet that was offered to her. She preferred to use a pen and paper to write her requests and responses. It was not evident that the IDT had explored additional communication devices or supports to meet Individual #787's needs. According to the Communication Assessment, the SLP and BHS were to collaborate to address the behavioral challenges that were hindering Individual #787's functional communication. It was not evident that the collaboration had occurred.
- Individual #344's QIDP Monthly Reviews did not document the goals or action plans outlined in his ISP, and his functional communication needs had not been fully explored. Individual #344 was social and interactive. He had good receptive language skills, and he could follow instructions. His expressive communication abilities were hindered, because he was unable to communicate verbally, and because he had limited access to alternative modes of communication. Individual #344 was provided four icons to communicate his wants and needs.
- Individual #78's ISP documented a recommendation for a full neurological work-up to assess her constant and excessive movement. It was not evident that the work-up had been completed. During the review week, the QIDP-Coordinator informed the Monitoring Team that Individual #78 had recently been referred to a neurologist and would be scheduled for an evaluation.

Outcome 8 – ISPs are implemented correctly and as often as required.

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 787	344	122	195	227	78			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	80% 4/5	1/1	0/1	1/1	1/1		1/1			
40	Action steps in the ISP were consistently implemented.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

39. The staff of five individuals were interviewed and asked to comment on goals the individuals were working to achieve. Four staff were generally familiar with the skills and goals of the individuals they supported. For the fifth individual, Individual #344, the goals and action steps listed in the ISP were not the goals or action plans staff were implementing on the home.

The indicator was not applicable to Individual #227, whose home was under quarantine at the start of the review week, and during the review week, she had been hospitalized. The staff who supported Individual #227 were not interviewed.

40. Across all six individuals, there was a total of 117 action steps evaluated, 13 of which had been implemented. Of the 104 remaining action steps that were not implemented, 60 could not be implemented due to COVID-19 community and gathering restrictions. Thus, of the 57 that could have been implemented, 13 were implemented (23%). For two of the individuals, Individual #787 and Individual #344, goals and action plans as identified in their ISPs did not correspond to the goals and action plans that had been implemented.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Implemented Due to COVID-19	Action Steps Not Implemented
Individual #787	25	0	0	25
Individual #344	10	0	0	10
Individual #122	31	2	27	2
Individual #195	22	5	16	1
Individual #227	16	5	9	2
Individual #78	13	1	8	4

For four of the six individuals, the majority of their action steps were on hold due to COVID-19 community and gathering restrictions. The indicator was met for one individual, Individual #195. Of her six action steps that were not impacted by COVID-19, five had been implemented. According to her SAP data, teaching trials were offered consistently and with enough frequency to determine her progress towards goal achievement.

For the three other individuals, action steps that were not impacted by COVID-19 were not implemented consistently. Findings included:

- For Individual #122, many of her action steps were on hold due to COVID-19. Of the four steps that were not impacted by COVID-19, two had been implemented. These were a SAMs SAP and a SO. The other two steps involved obtaining an assessment and learning to complete a job application. Neither step had been implemented.
- For Individual #227, of the seven action steps that were not impacted by COVID, five had been implemented. Although there were data to show her participation in action step activities, there were no measurable criteria to determine the how often she was expected to participate in the activities or if the frequency of her participation were consistent. There were two action steps that had not been implemented. These were steps for her to send greeting cards to her volunteer and for her to be assisted to call her volunteer. Soon after the ISP meeting, it was discovered that the volunteer had become ill and would no longer be able to visit Individual #227. The IDT did not meet to revise or replace the goal. Although the action step for Individual #227 to send cards to the volunteer was discontinued, the other steps that supported building a relationship with the volunteer remained.
- For Individual #78, of the five action steps that were not impacted by COVID-19, one had been implemented. This was a SAP to teach her to dress independently. The four steps that had not been implemented were a SAP to teach her to hold an electronic device, and three assessments of her baseline skill level. According to the QIDP Monthly Reviews, completion of the assessments had been documented during a ISPA held on 3/15/21. The Monitoring Team was unable to find evidence that the assessments had been completed.

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	Individuals:

changes of status, they review the relevant risk ratings and update the IRRFs within no more than five days. These indicators will remain in active oversight.											
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	The individual's risk rating is accurate.	0% 0/12	0/2	0/2	0/2	N/R	0/2	N/R	0/2	0/2	N/R
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	25% 3/12	0/2	2/2	0/2		0/2		1/2	0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas (i.e., Individual #787 – circulatory, and falls; Individual #344 – constipation/bowel obstruction, and weight; Individual #300 – respiratory compromise, and skin integrity; Individual #78 – skin integrity, and seizures; Individual #264 – constipation/bowel obstruction, and cardiac disease; and Individual #544 – infections, and skin integrity).

a. For the individuals in the review group, IDTs did not effectively use supporting clinical data when determining risk levels.

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

However, it was concerning that often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #344 – constipation/bowel obstruction, and weight; and Individual #264 – constipation/bowel obstruction.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Richmond SSLC show substantial improvement on these monitoring indicators to the point where 100% scores were achieved for three of the four indicators and 88% for the fourth indicator. 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	273	787	346	549	344	122	510	497	195
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	100% 8/8	2/2	2/2	2/2	2/2	2/2	2/2	2/2		2/2
5	The individual has goals related to psychiatric status.	100% 8/8	2/2	2/2	2/2	2/2	2/2	2/2	2/2		2/2

6	Psychiatry goals are documented correctly.	88% 7/8	2/2	2/2	2/2	2/2	2/2	0/2	2/2		2/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 8/8	2/2	2/2	2/2	2/2	2/2	2/2	2/2		2/2

Comments:
The scoring in the above boxes has a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

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

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. In psychiatry, the focus is upon what have come to be called psychiatric indicators.

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

The Monitoring Team looks for:

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

4a. There was at least one psychiatric indicator to decrease for all of the individuals. There were psychiatric indicators to increase for all of the individuals.

4b. There was an explanation describing the relevance of the psychiatric indicators for reduction to the individual's diagnosis for all of the individuals. The psychiatric indicators to increase were relevant for all of the individuals.

4c. The psychiatric indicators for reduction were defined in observable terms for all of the individuals. The psychiatric indicators for increase were described in observable terminology for all 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 psychiatric goal for the psychiatric indicator to decrease was written for all of the individuals. Psychiatric goals were written for the psychiatric indicators to increase for all of the individuals.

5e. The specific instructions for how and when the data were to be collected were present for all of the individuals for the psychiatric indicators and goals to decrease and to increase.

6. Documentation:
The Monitoring Team looks for:

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

6f. The psychiatric goals for decrease appeared in the IHCP for all of the individuals, except Individual #122. The psychiatric goals for increase also appeared in the IHCP for all of the individuals, except Individual #122.

6g. There was documentation that the psychiatric goal for decrease (regarding physical aggression) was changed over the course of the year for Individual #787. As her behavioral presentation improved, the psychiatric goal related to physical aggression was changed to reflect her improving status. Similarly, the psychiatric goal for increase was modified over the year for Individual #787 as she showed improvement. There was no indication that changes were required for the other 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.

At Richmond SSLC, all of the psychiatric indicators were also PBSP target behaviors and replacement behaviors, that is, data that were collected by DSPs. Richmond SSLC showed sustained substantial compliance with the collection and evaluation of PBSP data and exited from section K of the Settlement Agreement.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.												
Summary:			Individuals:									
#	Indicator	Overall Score										
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.											
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.	
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.	
	Comments:	

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

Summary: All three indicators scored higher than ever before. Due to sustained high performance, indicator 19 will be moved to the category of requiring less oversight. For indicators 20 and 21, some attention to the details required in documentation remained a need. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 273	787	346	549	344	122	510	497	195
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, these indicators were 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).										
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	63% 5/8	0/1	1/1	1/1	0/1	1/1	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.	50% 4/8	0/1	1/1	1/1	0/1	0/1	1/1	1/1		0/1

Comments:

19. The 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.

20. Criteria were met for five individuals. For two of these five (Individual #122, Individual #510), the psychiatrist's name was on the attendance sheet and there was evidence in the documentation of attendance. For the other three of these five (Individual #787, Individual #346, Individual #344), the psychiatrist's name was <u>not</u> on the attendance sheet, but the Monitoring Team found references to their attendance within the documentation. The QIDP and psychiatrist should ensure that the psychiatrist's name appears on the attendance sheet if the psychiatrist attended the ISP meeting.

For the other three individuals (Individual #273, Individual #549, Individual #195), the ISP preparation document included information that the psychiatrist did not need to attend. This was good to see (i.e., that the IDT considered this). However, as detailed in the monitoring tool for this indicator, the psychiatrist also needs to weigh in (i.e., agree) by attending the ISP preparation meeting or by submitting some documentation that his or her presence is not needed.

21. The ISP met the content requirements for four of the individuals: Individual #787, Individual #346, Individual #122, and Individual #510. The ISP for Individual #344 that occurred during the review week was observed by the Monitoring Team. The psychiatrist did speak briefly, but the topics detailed in the monitoring tool were not discussed and documented.

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:			Individuals:										
#	Indicator	Overall Score											
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.												
32	HRC review was obtained prior to implementation and annually.												
Comments:													

Psychology/behavioral health

At a previous review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section K of the Settlement Agreement and, as a result, was exited from section K of the Settlement Agreement.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: For most of the nine individuals, the PCPs completed new-admission or annual medical assessments timely. If the Center sustains its progress, after the next review, indicators a and b might move to the category of less oversight. PCPs should complete interval medical reviews quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary, depending on the individual's clinical needs.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	86% 6/7	1/1	1/1	0/1	N/A	N/A	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
Comments: a. It was positive that for the two newly-admitted individuals, PCPs completed timely initial medical assessments. b. Individual #300's current AMA was completed on 1/29/21, and the previous one was completed on 1/14/20. c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). For most of the individuals in the review group, PCPs did not complete timely IMRs.										

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: Center staff should continue to improve the quality of the medical	Individuals:

assessments, particularly with regard to family history, childhood illnesses, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate. Indicators a and c will remain in active oversight.											
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	1/1	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.	24% 4/17	0/2	0/2	0/2	0/2	2/2	0/2	2/2	0/1	0/2

Comments: a. It was positive that Individual #78's AMA included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, and lists of medications with dosages at the time of the AMA. Most, but not all included pre-natal histories, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #787 – cardiac disease, and diabetes; Individual #344 – abnormal liver enzymes, and positive fecal immunochemical test (FIT); Individual #300 – peripheral artery disease, and hypothyroidism; Individual #178 – weight, and seizures; Individual #78 – seizures, and non-alcoholic fatty liver with abnormal liver enzymes; Individual #112 – osteoporosis, and Vitamin D deficiency; Individual #264 – normal pressure hydrocephalus (NPH), and constipation; Individual #544 – anemia, and chronic hypoalbuminemia; and Individual #227 – weight, and osteoporosis].

The IMRs that followed the State Office template, and provided necessary updates related to the risks reviewed included those for: Individual #78 – seizures, and non-alcoholic fatty liver with abnormal liver enzymes; and Individual #264 – NPH, and constipation.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2

	condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0/17									
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #787 – cardiac disease, and diabetes; Individual #344 – abnormal liver enzymes, and positive FIT; Individual #300 – peripheral artery disease, and hypothyroidism; Individual #178 – weight, and seizures; Individual #78 – seizures, and non-alcoholic fatty liver with abnormal liver enzymes; Individual #112 – osteoporosis, and Vitamin D deficiency; Individual #264 – normal pressure hydrocephalus, and constipation; Individual #544 – anemia, and chronic hypoalbuminemia; and Individual #227 – weight, and osteoporosis).

None of the related 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. In fact, many included no medical interventions.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Individuals reviewed received dental examinations and summaries that met all or most of the criteria for a quality assessment. The Center should continue to focus on the remaining criteria (e.g., timely completion of periodontal charting). The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the	100% 7/7	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1	1/1

	ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	67% 6/9	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	67% 6/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1

Comments: a. Overall, for the individuals reviewed, Center Dental staff completed a timely dental examination.

b. For the nine individuals reviewed, the many components of the annual dental exams were often thoroughly addressed. It was positive that for six of nine individuals reviewed, the dental exams included all the required components. The remaining three dental exams reviewed also included all the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Sedation use;
- Number of teeth present/missing;
- Treatment provided (treatment completed);
- Periodontal risk;
- An odontogram; and,
- A treatment plan that addresses the individual's needs.

Moving forward, the Center should focus on ensuring dental exams include periodontal charting. For Individual #178 and Individual #78, Dental Department staff did not submit evidence they had completed periodontal charting since the individuals were admitted. For Individual #112, based on the documentation submitted, Dental Department staff last completed periodontal charting in 2019.

In response to the draft report, the State provided the following clarifications:

- "Individual's #78 and #178 will not receive periodontal charting until they receive TIVA. Individual #78 is on hold for medical reasons. Individual #178 is not urgent, clinically, so will be scheduled later."
- "Individual #112 does not have a clinically indicated need for periodontal charting. The individuals [sic] periodontal condition is so advanced that periodontal charting would not contribute any useful information. The individual would require sedation, and periodontal charting would not be considered accurate."

As indicated in the interpretive guidelines in the dental audit tool: "For individuals with periodontitis, if the individual did not have periodontal probing completed, this indicator will be marked as '0.' Dental Progress Notes or the description of cooperation section of

the dental exam is where auditors would find documentation of any challenges and decisions to recall the individual to complete periodontal charting." Moving forward, the dentist should document any reasons/justifications for not completing periodontal probing, as well as any plan for completing it in the future (e.g., if TIVA is necessary).

c. It was positive that for six of the nine individuals reviewed, the dental summaries included all the required components. The three remaining annual dental summaries also included all of the following components:

- The number of teeth present/missing;
- Dental care recommendations;
- Recommendations for the risk level for the IRRF;
- A description of the treatment provided (i.e., treatment completed);
- Treatment plan, including the recall frequency; and
- Provision of written oral hygiene instructions.

The following describes concerns noted:

- For Individual #178, the annual dental summary did not address the effectiveness of pre-treatment sedation or make recommendations with regard to the need for desensitization or another plan.

  In its comments on the draft report, the State provided the following clarification: "Individual #178 was a new admission on 10/19/2020. The annual summary, dated 11/12/2020, was the initial visit. Dental had no recommendations at that time about desensitization or sedation needs." Moving forward, the dentist should include in the summary a statement similar to what it included in its comments on the draft report. As agreed to during the inter-rater process with State Office on the dental audit tool, dentists should not leave blank any sections of the dental summary.
- Individual #112 and Individual #264 both were administered Prolia, but their annual dental summaries did not address the risk of developing medication related osteonecrosis of the jaw.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: It was positive that for the one newly-admitted individual, the RNCM completed a timely nursing record review and physical assessment, as well as a timely quarterly assessment. However, for the remaining five individuals, problems were noted with regard to nurses' timely completion of annual and quarterly nursing record reviews and/or physical assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission	100%	N/A	N/A	N/A	N/R	1/1	N/R	N/A	N/A	N/R

		comprehensive nursing review and physical assessment is completed within 30 days of admission.	1/1									
	ii.	For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/5	0/1	0/1	0/1		N/A		0/1	0/1	
	iii.	Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/5	0/1	0/1	0/1		1/1		0/1	0/1	

Comments: a.i. and a.ii. It was positive that for the one newly-admitted individual, the RNCM completed a timely nursing record review and physical assessment. However, for the other five individuals, problems were noted with the timely completion annual comprehensive nursing reviews and/or physical assessments. Problems included:

- Individual #787's IDT held her ISP meeting on 12/3/20. It was not until 12/7/20, and 12/18/20, that the RNCM completed the physical assessment and the record review, respectively.
- Individual #344's IDT held his ISP meeting on 6/24/20. The most recent annual record review was completed on 7/15/20. Center staff did not submit a corresponding physical assessment.
- Individual #300's IDT held his ISP meeting on 2/10/21. The most recent annual record review was completed on 5/11/21.
- For Individual #264, no physical assessment was completed to correspond with her annual record review, dated 7/4/20.
- For Individual #544, no physical assessment was completed to correspond with his annual record review, dated 10/15/20.

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

- Individual #787's quarterly assessment was due in March, but the RNCM did not complete it until 4/1/21. In addition, the third quarterly for the previous year was not completed until 11/10/20, one month before the RNCM completed the annual review.
- For Individual #344's October 2020 quarterly assessment, no physical assessment was completed. In addition, the most recent quarterly assessment submitted was dated 11/30/20.
- Quarterly record reviews submitted for Individual #300 were dated 5/11/21, which was the same date as the annual, and 10/7/20.
- Individual #264's quarterly record reviews were due in October 2020, January 2021, and April 2021. The Center submitted quarterly record reviews dated 12/31/20, and 5/13/21.
- Individual #544's quarterly record reviews were due in January 2021, and April 2021. The Center submitted quarterly record reviews dated 3/22/21, and 5/9/21.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.	
Summary: For a quarter of the risk areas reviewed, nurses included status updates in annual record reviews, and for two of the 12 the risks reviewed, the quarterly record reviews included relevant clinical data. Work is needed, though, for RNCMs to analyze this information, and offer relevant recommendations. RNCMs also need to continue to improve the other components of annual and quarterly physical	Individuals:

assessments. When individuals experience exacerbations of their chronic conditions, nurses need to complete assessments in accordance with current standards of practice. All of these indicators will continue in active oversight.											
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual receives a quality annual nursing record review.	0% 0/6	0/1	0/1	0/1	N/R	0/1	N/R	0/1	0/1	N/R
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1		0/1		0/1	0/1	
c.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
d.	Individual receives a quality quarterly nursing record review.	17% 1/6	0/1	1/1	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.	17% 1/6	1/1	0/1	0/1		0/1		0/1	0/1	
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	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	25% 2/8	1/2	N/A	0/1		0/2		0/1	1/2	

	nursing protocols or current standards of practice.										

Comments: a. It was positive that all of the annual or new-admission nursing record reviews the Monitoring Team reviewed included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA);
- Procedure history;
- List of medications with dosages at the time of the ANA;
- Consultation summary; and
- Tertiary care.

Most, but not all included, as applicable:

- Family history;
- Social/smoking/drug/alcohol history;
- Lab and diagnostic testing requiring review and/or intervention; and
- Allergies or severe side effects to medication.

The component on which Center staff should focus includes:

- Immunizations.

Of note, many of the annual nursing record reviews included most of the required components. One of them (i.e., Individual #344) was only missing immunizations. With minimal effort, nurses could make continued progress on the quality of the annual nursing record reviews.

b. As discussed above, for three individuals (i.e., Individual # 344, Individual #264, and Individual #544), annual physical assessments were not available at the time of the ISP meeting. Problems with the physical assessments included missing vital signs assessments, missing reproductive system assessment, a lack of abdominal circumferences, missing Braden scores, and/or missing fall risk scores.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #787 – circulatory, and falls; Individual #344 – constipation/bowel obstruction, and weight; Individual #300 – respiratory compromise, and skin integrity; Individual #78 – skin integrity, and seizures; Individual #264 – constipation/bowel obstruction, and cardiac disease; and Individual #544 – infections, and skin integrity).

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, nurses included status updates, including relevant clinical data, for about a quarter of the risk areas reviewed in the annual assessments (i.e., Individual #300 – respiratory compromise, and skin integrity; and Individual #264 – constipation/bowel obstruction), and for two of the risk areas reviewed in the quarterly assessments (i.e., Individual #78 – seizures, and Individual #544 – infections). 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.

In addition, it is essential in annual and quarterly assessments that nurses provide specific dates. At times, individuals' clinical stories

were unclear, because dates of various events or summary data were missing.

d. It was positive that Individual #344's quarterly nursing record review met the criteria for this indicator. In addition, all of the quarterly nursing record reviews the Monitoring Team reviewed included the following, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- Procedure history;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Tertiary care; and
- Allergies or severe side effects to medication.

Most, but not all of the quarterly nursing record reviews the Monitoring Team reviewed included, as applicable:

- Family history;
- Social/smoking/drug/alcohol history;
- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

The component on which Center staff should focus includes:

- Complete immunization information.

e. For one of six individuals (i.e., Individual #787), the RNCM completed a quarterly physical assessment that addressed the necessary components. No quarterly assessment was submitted for Individual #344. Problems with the remaining assessments included a lack of or incomplete follow-up for abnormal findings, a lack of abdominal circumferences, and/or a lack of assessment of the individual's ear, nose, and mouth.

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

- In an IPN, dated 1/3/21, at 9:45 a.m., a nurse indicated that staff reported that Individual #787 fell and hit her head on the floor while "on her way to fight other resident." Corresponding IView entries showed that the nurse obtained a full set of vital signs, and completed pain and pupillary assessments. The assessments were in alignment with the nursing guidelines for a fall or suspected fall.
- In an IPN, dated 1/20/21, at 8:00 p.m., a nurse noted that Individual #544 was lying in bed with the head-of-bed elevated. He was unresponsive to verbal stimuli, but responded to tactile stimuli. The individual's respirations were unlabored. Lung sounds were coarse in all lobes. His oxygen (02) saturation was 88% on room air. The nurse started him on supplemental oxygen at 3 liters (L), which brought his 02 saturation to 92%. In an IPN, dated 1/20/21, at 8:10 p.m., a nurse stated that the individual was experiencing shortness of breath at rest, and had a low blood pressure and 02 saturations. The nurse called 911. According to a nursing IPN, dated 1/20/21, at 8:45 p.m., emergency medical services (EMS) arrived at 8:30 p.m., and left at 8:45 p.m. The individual was subsequently admitted to the intensive care unit (ICU) for COVID-19 pneumonia. Nursing staff followed standards of care for respiratory distress, including the timely initiation of 911 due to his emergent needs.

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

- On 2/22/21, at 4:22 p.m., Individual #787's blood pressure of 132/93 showed a high diastolic reading. Her heart rate also was high at 101. Nursing staff did not retake the individual's pulse rate until the next day, when it was still elevated at 102. No nursing IPN was found to explain the lack of follow-up.
- For Individual #300, in a IPN, dated 11/3/20, at 8:29 p.m., a nurse entered a Skin Impairment Assessment - Initial Assessment, and in it, the nurse stated that staff reported that when providing care, she noted that the individual's old sacral wound area was getting worse. The nurse noted the size of the injury, including the length and width, and documented that they cleaned the wound with normal saline, dried it with gauze, and applied triple antibiotic ointment. The nurse did not follow the nursing guidelines for skin impairment, because the assessment did not include baseline vital signs with oxygen saturation, as well as the dynamic location and a description the wound, including the depth of the wound. The nurse did not provide a description of the wound, such as color or drainage, including the type or amount.
- In an IPN, dated 12/17/20, at 3:16 a.m., a nurse stated that Individual #78 had a crack in the intergluteal cleft, measuring approximately 2 centimeter (cm) long. The nurse noted this while administering a scheduled suppository. The nurse referenced IView entries for measurements. However, in IView, the form for documenting the length, width, and depth was blank. The nurse cleaned the area with soap and water, applied triple antibiotic ointment, and placed the individual on sick-call list for PCP evaluation the next morning. The nurse did not follow the nursing guidelines for skin impairment, because the assessment did not include the dynamic location or description of the wound, and did not include measurements for width or depth. The nursing guidelines also state that if pressure is suspected to notify an RN. In an IPN dated 12/17/20, at 9:03a.m., the RN stated: "IDT notified [Individual #78] will be seen in sick call today for intergluteal cleft of the individual measuring 2 cm long while administering suppository. 12/16/20 at 2000 v/s T97.8, R 18, P 74, B/P 120/68, 02 sat 95% on room air." The RN did not assess whether or not the wound was suspect for a pressure injury. The RN also did not provide measurements.
- According to a nursing IPN, dated 3/16/21, at 1:30 p.m., Individual #78 had a 30-second seizure and 23-second seizure. The nurse identified the plan as: "Nursing Interventions Completed: Individual in wheelchair with seatbelt intact; 30 sec @ 0920 and 23 sec @ 1253 seizures reported by staff, no SOB [shortness of breath] or difficulty breathing; individual uncooperative to check B/P x multiple times, appears very lethargic and agitated, pull and pushing away during assessment. Impaction found and suppository given with positive effect. Diastat rectal 10mg given per her seizure protocol. ACP [acute care plan] for Risk for impaired gas exchange initiated x 48 hours." However, the nursing guidelines for seizures state that if an individual is medicated for a breakthrough seizure, then the nurse should conduct a full set of vital signs, including oxygen saturation, and document every 30 minutes for two hours; then, every two hours times two; then every four hours for a minimum of 24 hours. The next nursing IPN, dated 3/16/21, at 6:11p.m., was entitled: Skin Impairment Assessment Follow-up/Resolution Assessment. It did not include any reference to the post-seizure or seizure medication assessments, and the nurse noted no vital signs in the IPN. In related IView entries, dated 3/16/21, at 1:30 p.m., the nurse documented that the individual refused vital signs, but documented a respiratory rate of 20. The next IView entries that showed an assessment for vital signs were dated 3/16/20, at 7:40 p.m., followed by entries on 3/17/20, at 2:40 p.m. In sum, nursing staff did not follow nursing guidelines for a breakthrough seizure requiring medication. In addition, they did they follow the constipation guideline for assessment of hydration, and date of individual's last bowel movement. The nurse documented administration of the suppository with a positive effect, but did not define which suppository. Moreover, the nurse did not document the sequence in which the suppository was given, and did not state that they performed a rectal exam. This is important, because if the individual's rectal vault was not free from impaction, the medication for the seizure might not be effective.
- For Individual #264, the PCP provided a blood pressure parameter of 150/90. On the following dates and times, the

individual's blood pressure was out of this range, but nursing staff did not complete timely reassessments: 2/24/21, at 1:43 p.m.; 2/25/21, at 11:25 a.m.; and 2/25/21, at 7:15 p.m.

- For Individual #544, on 11/28/20, at 4:56 p.m., a nurse reported: "generalized integumentary [skin] is warm, dry and intact, perineal area is intact. Sacral area is intact with mild redness." No corresponding IView entries were found to show that the nurse took measurements of the red area, documented the dynamic location, or assessed whether or not the area was blanchable. Based on a standing order for scratches and abrasions, nurses applied A&D ointment. The next IPN that addressed his sacral area was dated 12/13/20, at 12:19 p.m. (i.e., over two weeks later). The nursing IPN noted the sacral area was intact with mild redness, and the area was protected with an Aquacel bandage. Still, in the IView entries, nursing staff did not provide measurements, or the dynamic location.

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 many 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: 787	344	300	178	78	112	264	544	227
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.	8% 1/12	0/2	0/2	0/2	N/R	1/2	N/R	0/2	0/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
d.	The IHCP action steps support the goal/objective.	0% 0/12	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).	17% 2/12	0/2	1/2	0/2		1/2		0/2	0/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	25% 3/12	0/2	1/2	1/2		1/2		0/2	0/2	

Comments: a. through f. Most of the IHCPs reviewed included nursing interventions. The exception was the weight IHCP for Individual #344, which included no nursing interventions. All were missing key nursing supports. For example, RN Case Managers and IDTs generally had not individualized interventions in relevant nursing guidelines and included in the action steps of IHCPs specific assessment criteria for regular nursing assessments at the frequency necessary to address conditions that placed individuals at risk [e.g., if an individual was at risk for skin breakdown/issues, then an action step(s) in the IHCP that defines the frequency for nursing

staff to assess the color, temperature, moisture, and odor of the skin, as well as the drainage, location, borders, depth, and size of any skin integrity issues]. In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to assess the effectiveness of adaptive equipment, staff adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.). Significant work is needed to include nursing interventions that meet individuals' needs into IHCPs.

a. The IHCP that included interventions for ongoing nursing assessments that were in alignment with applicable nursing guidelines/standards of care was for: Individual #78 – seizures.

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

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #344 – constipation/bowel obstruction, and Individual #78 – seizures.

f. The IHCP that identified the frequency of monitoring/review of progress were for: Individual #344 – constipation/bowel obstruction, Individual #300 – skin integrity, and Individual #78 – seizures.

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.											
Comments: Since the last review, the scores during this review showed some improvement with regard to timely referral of individuals to the PNMT, and the timely completion of PNMT reviews. These are areas that require continued effort, though. For the one individual for whom the PNMT completed a full assessment, they completed it timely. However, for two other individuals, they should have completed comprehensive assessments, but they did not. Center staff also should continue their efforts to improve the quality of the PNMT reviews and comprehensive assessments. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual is referred to the PNMT within five days of the	50%	N/A	N/A	1/2	1/1	0/2	N/A	N/A	1/1	N/A

	identification of a qualifying event/threshold identified by the team or PNMT.	3/6									
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 3/6			1/2	1/1	0/2			1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3			N/A	0/1	0/1			1/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 2/6			1/2	0/1	0/2			1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3			0/1	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	0/2			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% 0/4			0/2	0/1	0/1			N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3			N/A	0/1	0/1			0/1	

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

- For Individual #300:
  - On 3/28/21, he was diagnosed with a Stage 3 sacral pressure injury. Based on documentation submitted, the PNMT did not conduct a review and/or assessment. There was no acknowledgement in the PNMT documentation of this pressure injury.
  - From 5/18/20 to 6/18/20, Individual #300 was hospitalized with diagnoses of bilateral pneumonia, hypoxia, and sepsis. He was COVID-19 negative. On 5/18/20, he had a tracheostomy placed. Based on staff report, he pulled out his tracheostomy, which was the suspected cause of the aspiration pneumonia, which, therefore, was documented as facility-acquired. On 6/24/20, he was referred to the PNMT. On 6/30/20, the PNMT completed its review. No evidence was found of medical staff participation in the review, and the Dietician did not sign the review.

    In the review, the PNMT provided no discussion of whether he had previous aspiration pneumonia or other related

medical history. They only listed diagnoses. They listed his risk ratings, but did not describe the related current supports. The PNMT provided no discussion of his current health beyond the description of why he was admitted to the hospital and the prescription of antibiotic treatment. They stated that in 2019, he had a previous PNMT assessment. However, they provided no discussion of why he was referred at that time, and/or the results of the assessment. The PNMT provided no discussion of current supports or their effectiveness, but rather only stated that they were appropriate to mitigate risk and should continue. They offered no analysis or recommendations for interventions, supports, or follow-up/monitoring. Based on the incomplete review, they stated that they did not recommend a full PNMT assessment.

- On 11/18/20, Individual #178 was referred to the PNMT due to a right femoral shaft fracture, related to a fall on 11/10/20. On 11/11/20, he had an x-ray that was negative for a fracture. Then, on 11/13/20, he was seen in sick call for pain and swelling of his right leg, and he was not able to bear weight. He was sent to the ED, and admitted for a right femur fracture. On 11/18/20, while the individual was hospitalized, the PNMT conducted an initial review. The PNMT indicated in the review that he was found on the floor of his bedroom and he told staff he had fallen. The PNMT included a statement that upon his return, the PNMT RN would conduct a post-hospitalization review and discuss it further with the PNMT. After open reduction internal fixation (ORIF) surgery on 11/14/20, he was transferred to a rehabilitation facility for inpatient rehabilitation.

  On 11/30/20, he was discharged back to the Center due to limited progress. On 12/2/20, he was referred again to the PNMT. On 12/3/20, the PNMT conducted another review. The description of the incident was that on 11/10/20, at 7:31 p.m., staff found him on the floor in his bedroom. The individual said that he fell. The PNMT described him as newly-admitted, on 10/19/20; he moved to the Center from his family home. He reportedly had good upper and lower extremity strength, range-of-motion (ROM), and muscle tone except for his right ankle, which appeared to have foot drop due to a diagnosis of cerebral palsy. He had been at the Center for less than a month, when he had this unobserved fall. The PNMT provided no rationale for not completing a more comprehensive assessment. At the time of the review, he was still limited in his mobility, so further assessment was not entirely possible at that time, but could have been done later. They planned to meet with the IDT to discuss positioning supports for skin integrity concerns due to his decline in mobility, as well as supports to promote healing, out-of-bed activities, and wheelchair use and mobility. They identified that he required additional PNMP supports, and they qualified the recommendations as "requiring immediate action due to safety issues." They recommended a hospital bed with rails, Arjo lift for transfers, a 22"-wide wheelchair with a cushion for out-of-bed mobility, and daily skilled PT. Beyond these recommendations for equipment and follow-up therapy, the PNMT did not offer recommendations related to the prevention of similar incidents.
- For Individual #78:
  - Between 1/10/21 (109 pounds) and 2/8/21 (95.60 pounds), the individual lost 13.4 pounds (i.e., 12%). Her IDT made no referral to the PNMT, and no evidence was submitted to show that the PNMT reviewed this issue.
  - On 12/17/20, nursing staff documented that she had a crack in her intergluteal cleft, which was reported to be a reopening of a previous wound that scabbed over, and reopened due to wheelchair use. Staff initially did not believe that it was a pressure wound. On 12/18/20, the PCP ordered bedrest for 10 days, and placed a limit on her time in the wheelchair to two hours at a time. Nursing staff were to notify provider if "decubitus" worsens. The PCP made a referral to the PT to look at the individual's wheelchair. On 12/22/20, they suspended direct PT due to her quarantine status. On 12/22/20, nursing staff stated that the wound was intact and dry, and covered with a scab. On 12/30/20,

the area remained open, with a note that "problem not resolved." On 1/18/21, she was sent to ED due to an O2 saturation of 69%. On 1/27/21, a note stated that the IDT was notified of the hospital report that identified a "midline sacral stage 2 [pressure injury] gauze applied…" On 2/5/21, staff provided measurements of the sacral pressure injury. On 2/10/21, a PCP addendum identified a Stage 3 sacral pressure injury, hospital-acquired. The IDT did not refer the individual to the PNMT, and the PNMT did not make a self-referral. On 3/4/21, notes indicated that the sacral wound was not heal welling and was enlarging. There was still no referral to the PNMT. Given her multiple issues, the PNMT should have conducted a comprehensive assessment.

- On 2/8/21, Individual #544 was referred to the PNMT due to the placement of a new gastrostomy tube (G-tube). However, on 2/10/21, he returned to the hospital, and did not return to the Center until 3/19/21. On 3/24/21, the PNMT made a self-referral. On 4/23/21, the PNMT completed a comprehensive assessment. No evidence was found of medical staff participation in the review. The quality of the assessment is discussed below.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #178, and Individual #78). The following summarizes some of the findings related to Individual #544's PNMT assessment:

- It was positive that the assessment addressed the following to the depth necessary:
  - Presenting problem;
  - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
  - Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
  - The individual's behaviors related to the provision of PNM supports and services;
  - Evidence of observation of the individual's supports at his/her program areas; and
  - Identification of the potential causes of the individual's physical and nutritional management problems.
- The following provide examples of concerns noted:
  - The PNMT stated that his wheelchair was effective for pressure relief. However, they provided no evidence of pressure mapping or other data to support his conclusion, other than that staff demonstrated the ability to tilt the wheelchair to 30 degrees for pressure relief. They stated that they did not observe him in his recliner. He was not to wear heel protectors in his wheelchair or the recliner.
  - The assessment included no evidence of review of his PNMP supports over time relative to the G-tube placement. The information included in this regard appeared to be based only on the OT's assessment. Alternate positioning options reportedly were not observed. A PT, who was not a member of the PNMT, conducted the head-of-bed-elevation (HOBE) assessment. The PNMT assessment cited the findings from this 3/22/21 HOBE evaluation.
  - The PNMT made no recommendations. Actions already taken were identified, including a change of status (CoS) recommendation related to weight, and the individual's formula was changed to higher-calorie formula due to weight loss and low protein labs.
  - The PNMT also stated in the meeting minutes that, because they proposed no goals, and there was no need to monitor the individual, they had no need to meet with the IDT.
  - The PNMT provided limited discussion related to a Stage 3 coccyx pressure wound discovered on 3/27/21, although the assessment was not completed until 4/23/21.

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 many key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable. Four of the nine PNMPs fully met individuals' needs. As indicated in the last report, with continuing efforts, Habilitation Therapy staff could make additional progress by the time of the next review. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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.	22% 4/18	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2
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	1/1	0/1	0/1	0/1	1/1	1/1	0/1	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.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2	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 #787 - falls, and choking; Individual #344 – fractures, and choking; Individual #300 – skin integrity, and aspiration; Individual #178 – choking, and fractures; Individual #78 – weight, and skin integrity; Individual #112 – choking, and falls; Individual #264 - choking, and falls; Individual #544 – skin integrity, and aspiration; and Individual #227 – aspiration, and falls.

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

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were for Individual #344 – fractures, and choking; and Individual #227 – aspiration, and falls.

c. All individuals reviewed had PNMPs and/or Dining Plans. Four of the PNMPs fully met the individuals' needs. The remaining PNMPs were missing one or two elements. Problems related to the following:

- The oral hygiene instructions for three individuals (i.e., Individual #344, Individual #178, and Individual #264) appeared incomplete and instead referenced a separate oral care plan. Given that the PNMPs should provide direct support professional staff with a ready reference, they should include all relevant instructions.
- Individual #264 required total assistance, but the toileting/personal care instructions said: "communication instructions, delete if N/A."
- For Individual #227, the handling precautions/moving instructions merely stated "fragile bone, GERD [gastroesophageal reflux disease], history of fracture left ankle," but provided no actual strategies related to these risks.
- Individual #300's PNMP provided incomplete communication strategies.

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for: Individual #78 – weight, and Individual #227 – falls.

f. The IHCPs that identified triggers and actions to take should they occur were those for: Individual #544 – skin integrity, and aspiration.

g. None of the IHCPs reviewed included the frequency of monitoring/review of progress.

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	787	344	300	178	78	112	264	544	227
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	N/A	N/A	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to	N/A			N/A					N/A	

	progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.										

Comments: a. On 1/3/19, during a hospitalization for pneumonia and respiratory failure, Individual #300 had a G-tube placed due to failure to thrive. He received bolus feedings daily while upright in his wheelchair. On 1/21/19, he also had a tracheostomy placed, and it was still in place. The IDT noted that no plan was contemplated for decannulation due to failed trials in December 2019. The IDT stated that this was the least restrictive plan, but they documented no real discussion about why, or why the decannulation trial was not successful in 2019.

According to the PNMT review, on 1/20/21, Individual #544 was hospitalized for evaluation of low blood pressure and low oxygen (O2) saturation. He was admitted with diagnoses of dyspnea, sepsis, elevated troponin, pneumonia, and hypernatremia. The PNMT stated that he had "further developed difficulty swallowing" and a G-tube was placed. The IDT referred him to the PNMT, but did not develop a change-of-status (CoS) IRRF. As a result, the IDT had not documented discussion about the medical necessity of the G-tube, or any potential for the individual to move along the continuum to oral intake.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Given that during the last two review periods and during this review, OTs/PTs generally completed timely assessments (Round 15 – 89%, Round 16 – 90%, and Round 17 – 88%), Indicator a.iii will move to the category of requiring less oversight. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	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.	88% 7/8	1/1	1/1	1/1	0/1	N/A	1/1	1/1	1/1	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 with this indicator, it has moved to the category of 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; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. One of eight applicable individuals reviewed did not received assessments in time for the annual ISP or when based on change of healthcare status. The following describes concerns noted:

- For Individual #178, an ISPA, dated 12/1/20 indicated that, beginning on 12/7/20, the Center OT would evaluate him for a shower chair and complete the evaluation by 12/14/20. Further, the ISPA stated he should receive bed baths until that time. Over a month later, on 1/21/21, the Center OT documented in an IPN an attempt to complete the shower chair assessment, but was unable to do so because the shower chair did not have a seat belt attached. The IPN also noted the Center OT submitted a work order for the seatbelt to be added and stated a plan to re-initiate the assessment once the work order was complete. It was concerning that subsequent documentation submitted did not show Center staff ever completed this assessment, but that the individual was using a shower chair. For example, another ISPA, dated on 3/19/21, reported that as of 3/3/21, his shower chair did not match his existing PNMP and that he received a new one on 3/4/21. The PNMP, dated 3/27/21, also indicated he was using a shower chair at that time.

d. While the OT/PT assessments showed some improvement with regard to readability and conciseness, none of the comprehensive assessments reviewed met all criteria for a quality assessment.

Most assessments, but not all met criteria, as applicable, with regard to:

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

Moving forward, continued work is particularly needed on the identification of individuals' needs for supports and the determination of their efficacy. For example, there were cases where therapists deemed the supports for skin integrity to be effective, but the individual experienced significant skin wounds. Center staff should continue to focus attention on the following sub-indicators:

- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and,
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

Summary: Improvement is needed with regard to 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: 787	344	300	178	78	112	264	544	227
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
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.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy	33%	N/A	N/A	N/A	0/2	1/1	N/A	N/A	0/2	1/1

	interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	2/6									
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/4	N/A	N/A	N/A	0/4	N/A	N/A	N/A	N/A	N/A

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

c. and d. As applicable, individual's ISPs/ISPAs did not consistently include the strategies, interventions and programs as recommended in the assessment. The following describes concerns noted:

- For Individual #178's ISP, dated 11/19/20, the IDT did not develop action plans for two recommendations in the OT/PT assessment (i.e., to implement a goal/objective for taking sips of liquid, and for initiation of direct OT). In addition, after the OT devised the specific goals/objectives for the direct therapy (i.e., on 12/4/20), the IDT did not meet to discuss and approve them.
- Also, for Individual #178, on 3/1/21, the PT developed a direct treatment plan, with a goal/objective to ambulate ~200 feet. On 3/1/20, the IDT held an ISPA meeting during which the members discussed his progress in therapy; however, the documentation did not show the IDT members discussed or approved the specific goal/objective.
- For Individual #544, the ISP stated that he received direct OT services and included an action plan to continue to do so, but did not specify the goals/objectives (i.e., per a Habilitation Therapy Note dated 7/31/20, propel wheelchair and push up on armrests to shift weight or reposition self in wheelchair) or provide any information about his prior progress in therapy.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: For individuals reviewed, Center staff completed timely initial assessments for those who were newly admitted, but otherwise needed to focus on timeliness and currency of assessments and ensuring individuals received the correct type of assessment based on their needs. Significant work is also 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	Individuals:

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	787	344	300	178	78	112	264	544	227
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	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.	43% 3/7	1/1	1/1	0/1	N/A	N/A	0/1	1/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. through c. The Center continued to need focus on timeliness of assessments and ensuring individuals received the correct type of assessment, based on their needs. The following describes concerns noted:

- For the following five individuals, the Center did not submit a current assessment:
  - For Individual #300, the Center submitted a comprehensive assessment dated 2/12/19. This evaluation stated that he would receive an update in 2020, but there was no evidence that one was completed. The one subsequent assessment, dated 1/25/21, reviewed only the Communication Dictionary. The SLP should have completed a full assessment in January 2021, but did not. As a result, the individual had neither a timely assessment nor the type of assessment he needed.
  - The Center did not submit an assessment for Individual #112.
  - For Individual #544, Center staff last completed a comprehensive assessment on 10/8/19. That assessment recommended completion of a subsequent assessment in 2022, even though the 2019 version identified a significant decline since his previous assessment in October 2017. For example, the 2019 assessment indicated that, in 2017, he was nonverbal but expressed his thoughts, feelings and needs through nonverbal communication, as well as some words and short phrases. However, in 2019 he was no longer demonstrating any of those skills. The 2019 assessment also stated that he had nonexistent communicative behaviors and, because his dementia had progressed, recommended discontinuation of his Communication Dictionary. The assessment did not offer any rationale for not considering any additional supports or methods for others to interact with him. On 10/15/20, Center staff completed an assessment limited to a review of his Communication Dictionary, which appeared to have been retained despite the recommendation to discontinue it, but this did not meet his overall assessment needs. The SLP should have completed a full assessment in October 2020, but did not. In the previous assessment, they laid the foundation that due to regression, he should have subsequent evaluations, and ideally additional supports. In other words, the information in the assessment did not justify the 2022 date for reassessment. As a result, the individual had neither a timely assessment nor the type of assessment he needed.
  - For Individual #227, Center staff completed a comprehensive assessment in 2017. They updated it in 2018, but the updated version appeared to be largely a reiteration of the 2017 assessment. Neither of these adequately addressed her needs. For example, the assessments described the individual as nonverbal, but having demonstrated some initial interest in voice-output devices as well as the physical ability to potentially use one. The assessments stated that there would be collaborative development and implementation of a skill acquisition program (SAP) for switch activation, but neither the assessment nor the update explored possible alternatives or included relevant recommendations. Center staff completed only one other assessment since 2018 (i.e., on 12/11/20), but it consisted only of a review of the individual's Communication Dictionary. Given the significant quality issues with the assessments in 2017 and 2018, a review of just the Communication Dictionary did not meet the individual's needs. As a result, the individual had neither a timely assessment nor the type of assessment she needed.

d. As described above, Center staff did not submit a current assessment Individual #300, Individual #112, Individual #544 or Individual #227. For the remaining individuals reviewed, none of the comprehensive assessments met all applicable criteria for a quality

assessment.

Center staff needed to continue to focus on all of the sub-indicators, as described below:

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

There was some indication of progress for the most recent assessments submitted (i.e., for Individual #787, Individual #178 and Individual #78). For example, all three of their assessments adequately addressed pertinent diagnoses, medical history and current health status. In addition, two of those assessments met criteria with regard to a functional description of expressive and receptive skills, as well as for evidence of collaboration between Speech Therapy and Behavioral Health Services. However, each of these assessments still required significant improvement with regard to many, if not most, of the applicable criteria.

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.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1

	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.	13% 1/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	N/A									
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. For the ISPs reviewed, the respective IDTs did not consistently provide a full and clear description of how individuals communicated, including how staff should communicate with them. SLPs and QIDPs should work together to make improvements.

b. As applicable, IDTs often failed to document a thorough review of an individual's Communication Dictionary. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap.

c. Based on review of documentation submitted for applicable individuals reviewed, communication assessments did not consistently identify strategies to expand their communication skills. For example, the assessments for Individual #787, Individual 344, Individual #78, Individual #264 and Individual #227 did not adequately address the potential to benefit from AAC and/or make recommendations for related strategies.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: Richmond SSLC was attending to SAPs, more so than ever before. This is reflected in the progress seen in the scoring of many of the indicators of this and the other outcomes of this section of the Settlement Agreement. That being said, two-thirds of the individuals had a single SAP. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										

3	The individual's SAPs were based on assessment results.										
4	SAPs are practical, functional, and meaningful.	80% 12/15	2/2	1/1	1/1	2/3	1/1	0/1	0/1	3/3	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	83% 10/12	2/2	0/1	1/1	0/1	1/1		1/1	3/3	2/2

Comments:
The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs to review for Individual #273 and Individual #195, and one SAP available to review for Individual #787, Individual #346, Individual #344, Individual #122, and Individual #510, for a total of 15 SAPs for this review.

3. Individual #549's FSA indicated that he was independent in operating his music player, and Individual #510's FSA indicated she was independent in preparing meals, therefore, these SAPs were not based on assessment results. Individual #344 did not have a FSA (he had an annual update, but not a full FSA).

4. Eighty percent of the SAPs were judged to be practical and functional. This represents an improvement from the last review when 62% of SAPs were judged to be practical and functional. The three SAPs that were judged not to be practical or functional represented a compliance issue rather than a new skill (i.e., Individual #122's state medication facts SAP), or were identified as skills currently in the individual's repertoire and, therefore, did not represent skill acquisition plans (i.e., Individual #510's prepare a meal SAP, and Individual #549's operating his music player SAP).

5. Eighty-three percent of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. This represents a dramatic improvement from the last review when six percent of SAPs had IOA. Individual #122's state her medication facts, and Individual #549's order food online and operate his music player were new SAPs, and SAP integrity checks were not due at the time of the document review. Therefore, these three SAPs are not included in the calculation for this indicator. Individual #787's brush the doll hair did not have IOA. Individual #549's identify self-checkout items SAP did have IOA, however, it was below 80% and, therefore, was scored as zero. When a SAP integrity.

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 some changes and improvements to the vocational assessment content, indicator 12 could also be met for all/more individuals. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	to the IDT at least 10 days prior to the ISP.	9/9									
12	These assessments included recommendations for skill acquisition.	44% 4/9	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1
Comments: 11. PSIs were not available to the IDT at least 10 days prior to the ISP for Individual #346 and Individual #510. 12. Individual #195, Individual #497, Individual #122, Individual #344, and Individual #346's vocational assessments did not include a recommendation for SAPs, or a rationale why vocational SAPs were not necessary.											

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

This domain contains 39 outcomes and 164 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. One outcome and 12 indicators in restraint met sustained substantial compliance and were exited from monitoring and four outcomes and 17 indicators in Psychology/Behavioral Health met sustained substantial compliance and were exited from monitoring. In addition, 36 other indicators were in the category of requiring less oversight. For this review, one additional indicator was moved to this category, in nursing.

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

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 other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, improve cardiac health; learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition. In addition, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Acute Illnesses/Occurrences

In psychiatry, Richmond SSLC updated goals when goals were met, and took action when an individual's condition was worsening.

For only one out of five acute illnesses/occurrences reviewed, nursing staff followed nursing guidelines when initially assessing the individuals. It was good to see that for four of the five, nursing staff timely notified the practitioner/physician of the individuals' signs and symptoms in accordance with the nursing guidelines for notification. For two of the five, nurses did not develop acute care plans, but should have. The three acute care plans reviewed included some necessary interventions, but were missing key interventions. Nurses' implementation of the acute care plans was incomplete.

Work was still needed to improve assessment and follow-up for individuals experiencing acute illnesses/occurrences that medical providers treated at the Center. It was positive that prior to individuals' transport to the ED or hospital, providers conducted evaluations. However, in a couple instances, significant problems were noted with the quality of these assessments. Upon individuals' returns to the Center, PCPs completed the necessary follow-up for the examples reviewed.

Implementation of Plans

Psychiatric medication side effect assessments were occurring as required. For some of the individuals, some assessments were not reviewed timely by the prescriber.

For psychiatric polypharmacy, criteria were met for three of the four individuals to whom this indicator applied. For the other individual, a medication that was identified as dual usage was not considered in the determination of whether the individual met criteria for polypharmacy. This was corrected during the review week.

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

Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For four of the 18 chronic or at-risk conditions reviewed, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s), interventions, and strategies, as appropriate.

Moreover, each of the 18 IHCPs reviewed should have included medical interventions. Only five included any medical interventions, and none of these five included a complete list. For three of the five, the PCP implemented the one action step assigned. Due to ongoing problems with the quality of the medical plans included in IHCPs, the related indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

Due to problems with the timely review of non-facility consultation reports, the related indicator is at risk of returning to active oversight. The Center also needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

It was positive that the eight individuals in the review group who needed osteoporosis screening received it. However, none of the nine individuals reviewed received all of the preventative care they needed. In some cases, COVID-19 issues appeared to be the cause for the delays in the provision of the care, but in other cases, delays were unrelated to the COVID-19 pandemic. In addition, IDTs generally did not follow the process of meeting to review the risk-benefit of delaying preventative care.

At times, medical practitioners 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. However, this is an area that still needs improvement.

Two newly-admitted individuals had not yet had assessments to determine whether or not they had periodontal disease. One individual had Type III, and three had Type IV periodontal disease. One individual was edentulous. Five of the eight individuals had not received all necessary dental treatment.

For at least the three previous reviews, during observations, medication nurses followed individuals' PNMPs. The related indicator will move to the category requiring less oversight. Areas that require focused efforts are improvement in medication nurses' adherence to infection control procedures, as well as the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.

Based on observations, there were still numerous instances (62% of 45 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., when staff did not intervene when individuals took large unsafe bites, or ate at too fast a rate; or staff presented food while the individual's head was in hyperextension) placed individuals at significant risk of harm.

In addition, proper fit of adaptive equipment often was still an issue. Based on the Monitoring Team's observations, 65% of the 26 individuals observed did not appear to have adaptive equipment that fit them properly. During the review week, the Monitoring Team member talked with the Habilitation Therapy Director, and the State Office Discipline Lead about the ongoing concerns for positioning and seating across campus. The State Office Discipline Lead indicated that State Office was developing a plan to assist Center staff with assessment and perhaps some additional focus on wheelchair design. Given the number of individuals that this impacts, the provision of quality seating that meets individuals' needs should be an important focus. There is the added concern of the significant occurrence and reoccurrence of pressure injuries. There is always the possibility that individuals' wheelchairs might be contributing to that problem. This is an urgent need.

Restraints

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

Psychiatry

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

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Richmond SSLC updated goals when goals were met, and took action when an individual's condition was worsening. With sustained high performance, these indicators might be moved to the category of requiring less oversight. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
8	The individual is making progress and/or maintaining stability.	88% 7/8	2/2	2/2	2/2	2/2	2/2	0/2	2/2		2/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	100% 1/1		1/1							
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 1/1						1/1			
11	Activity and/or revisions to treatment were implemented.	100% 1/1						1/1			

Comments:

8. All of individuals who were prescribed psychiatric medications were making progress, except for Individual #122.

9. Individual #787 was making progress and in response to this improvement, the psychiatric team modified her goals.

10. Individual #122's psychiatric status had deteriorated and in response the psychiatric team was transitioning her to a different antipsychotic.

11. This intervention was implemented in a timely manner.

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:			Individuals:									
#	Indicator	Overall Score										
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
34	Quarterly reviews contained required content.											
35	The individual's psychiatric clinic, as observed, included the standard components.											
Comments:												

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: Side effect assessments were occurring as required. For some of the individuals, some assessments were not reviewed timely by the prescriber. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	63% 5/8	1/1	0/1	0/1	1/1	1/1	1/1	0/1		1/1
Comments: 36. The MOSES and AIMS evaluations were performed in a timely manner for all of the individuals. There were delays in the timely review of the AIMS for Individual #787, Individual #346, and Individual #510.												

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

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.												
Summary:			Individuals:									
#	Indicator	Overall Score										
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.											
42	There is a treatment program in the record of individual who receives psychiatric medication.											

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	
	Comments:	

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Criteria were met for three of the four individuals to whom this indicator applied. For the other individual, a medication that was identified as dual usage was not considered in the determination of whether the individual met criteria for polypharmacy. This was corrected during the review week. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
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.	75% 3/4		1/1	0/1	1/1		1/1			
Comments: 46. The polypharmacy committee met quarterly and reviewed each individual whose psychiatric medications meet the criteria for polypharmacy. Individual #346 had not been reviewed in polypharmacy because he was considered to be on two psychotropic medications: Zyprexa and Paxil. However, during the review week observation of the polypharmacy meeting, it was pointed out by the Monitoring Team that the psychiatric team had considered Valproic Acid to be a dual use medication for both neurological and psychiatric purposes. This would mean that Individual #346 was receiving three medications for psychiatric purposes. The facility psychiatrist agreed that Individual #346 should be followed by the polypharmacy committee and also noted that in addition to VPA, he was prescribed two additional anticonvulsants (Vimpat, Onfi). Thus, going forward he will be followed by the polypharmacy committee.											

Psychology/behavioral health

At a previous review, the Monitor found that that the Center achieved and maintained substantial compliance with the requirements of section K of the Settlement Agreement and, as a result, was exited from section K of the Settlement Agreement.

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/1	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/13	0/2	0/1	0/2	0/1	0/1	0/2	0/1	0/1	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 #787 – cardiac disease, and diabetes; Individual #344 – abnormal liver enzymes, and positive FIT; Individual #300 – peripheral artery disease, and hypothyroidism; Individual #178 – weight, and seizures; Individual #78 – seizures, and non-alcoholic fatty liver with abnormal liver enzymes; Individual #112 – osteoporosis, and Vitamin D deficiency; Individual #264 – normal pressure hydrocephalus, and constipation; Individual #544 – anemia, and chronic hypoalbuminemia; and Individual #227 – weight, and osteoporosis).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight, or improve cardiac health; engage in specific activities to stop smoking; make specific diet modifications to reduce GERD; drink a specific amount of fluid per day to prevent constipation; etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

Some chronic or at-risk conditions required action plans, but did not require a personal goal/objective in which the individual or direct support professionals needed to engage to improve the individual's health. These included: Individual #344 – positive FIT, Individual #178 – seizures, Individual #78 – seizures, Individual #264 – normal pressure hydrocephalus, and Individual #544 – anemia.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it

was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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: It was positive that the eight individuals in the review group who needed osteoporosis screening received it. However, none of the nine individuals reviewed received all of the preventative care they needed. In some cases, COVID-19 issues appeared to be the cause for the delays in the provision of the care, but in other cases, delays were unrelated to the COVID-19 pandemic. In addition, IDTs generally did not follow the process of meeting to review the risk-benefit of delaying preventative care.

At times, medical practitioners 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. However, this is an area that still needs improvement.

Individuals:

#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual receives timely preventative care:										
	i. Immunizations	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
	ii. Colorectal cancer screening	75% 3/4	N/A	1/1	1/1	N/A	N/A	0/1	N/A	1/1	N/A
	iii. Breast cancer screening	50% 1/2	N/A	N/A	N/A	N/A	N/A	1/1	0/1	N/A	N/A
	iv. Vision screen	100% 5/5 Cannot fully rate due to COVID-19	1/1	1/1	1/1	1/1	N/R - C	1/1	N/R - C	N/R - C	N/R - C
	v. Hearing screen	50% 3/6 Cannot	1/1	1/1	Not rated due to COVID-	1/1	N/R - C	0/1	0/1	0/1	N/R - C

		fully rate due to COVID-19			19 (N/R – C)						
	vi. Osteoporosis	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	80% 4/5	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A	0/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	67% 6/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: a. None of the nine individuals reviewed received all of the preventative care they needed. In some cases, COVID-19 issues appeared to be the cause for the delays in the provision of the care, but at times, delays were unrelated to the pandemic.

According to the chart State Office submitted to the Monitors entitled: "Richmond Activities on Hold due to COVID-19 5 2021," on 3/16/20, Richmond SSLC stopped consultations and preventative care, and off-campus appointments unless emergent, but then re-opened them on 5/27/20. The chart further indicated that: "Continued wound care clinic on campus and other consults via telehealth. Expanded post vaccination clinics- not all consultants were willing to continue their clinics (e.g. audiology). New contractor for audiology was identified, began 5/7/2021." As referenced in the chart, the State Office expectation was that IDTs needed to document risk-benefit discussions for any delays for off-campus appointments after 5/27/20.

Further, during the remote review in an interview, the Monitoring Team requested information from the Medical Director about the impact of COVID-19 on on-campus and off-campus appointments. Some of the information the Medical Director provided differed from the information that State Office provided in the chart. For example, although none of this information was included in the chart, the Medical Director indicated that the on-campus clinics, such as vision, had not resumed until April 2021. In addition, the Center Director indicated that the State Office-required ISPA process was "burdensome," and so Richmond SSLC discussed risk-benefit in morning medical meetings. The Monitoring Team asked about documentation of these discussions, and the Medical Director indicated that she believed the Settlement Agreement Coordinator provided what documentation they had to the Monitoring Team.

In a document request, the Monitoring Team specifically asked for: "For any preventative care not completed due to COVID-19 precautions, please provide the ISPA showing the IDT risk-benefit discussion." As described below, for the individuals in the review group, IDTs generally did not follow the State Office process of meeting to review the risk-benefit of delaying preventative care. The Center offered no evidence of a request for a waiver of the State Office-required process, and Center staff did not provide documentation of any alternative method of discussing and weighing the risks/benefits (i.e., as referenced in the interview with the Medical Director). It will be essential moving forward that staff follow the State Office procedure, and reschedule individuals for these services as soon as it is possible to do so safely.

The following provide examples of findings:

- It was positive that the eight individuals in the review group who needed screening for osteoporosis received it.
- For Individual #787, the immunization record did not include documentation of the administration of the vaccine for measles, mumps, and rubella (MMR).
- Individual #344 was 59 years old, and did not have documentation of having had the Shingrix vaccine.
- For Individual #300:
    - The immunization record did not include documentation of the administration of the MMR vaccine.
    - He was 57 years old, and did not have documentation of having had the Shingrix vaccine. The PCP ordered it the day before the interview with the Monitoring Team.
    - On 2/18/10, a Tdap was administered. Therefore, in February 2020, a repeat Tdap or Td was due, but had not been administered. According to the PCP, the tetanus booster was ordered and the consent was pending.
    - On 2/27/20, he had his last audiological exam, which was inconclusive. The recommendation was to return in one year. As noted above, as a result of the COVID-19 pandemic, the Center had to replace the audiologist that ran the clinic. As a result, this sub-indicator was not rated.
- For Individual #178:
    - The immunization record did not include documentation of the administration of the MMR vaccine.
    - On 12/21/20, he received the Td vaccine, but there was no documentation of the required Tdap.
- For Individual #78, who was re-admitted on 11/3/20:
    - Her MMR and PSV23 vaccinations were not documented in the official immunization record.
    - She had not had a vision screening. Based on information the Medical Director provided, the on-campus vision clinic did not resume until April 2021. As a result, this indicator was not scored.
    - As part of the Tier II document request, Center staff did not submit an audiology appointment. Although the PCP reported that, on 5/12/21, the individual had an audiological evaluation, the PCP indicated there was no assessment of her hearing. Per interview, the audiologist requested that she return after irrigation with sedation. However, given the issues that COVID-19 caused with the Center's audiology clinic, this sub-indicator was not rated.
- For Individual #112:
    - She had a colonoscopy in 2012. She needed a repeat due to "small lesions may have been missed" due to poor preparation. In February 2017, GI recommended a colonoscopy, but the PCP reported there were problems with the preparation, so GI recommended a Cologuard test. The PCP stated during interview that the Cologuard was delayed due to problems with insurance and billing. According to the AMA, on 2/21/18, the test was completed and was negative. The recommendation was to perform a colonoscopy in three years. It had not yet been completed, but in the AMA, the PCP indicated: "GI screening ordered for scheduling colonoscopy."
    - On 1/29/15, she completed her last audiological screening, and the recommendation was to return in five years. She was due to return in January 2020, which was prior to the suspension of preventative care appointments.
- For Individual #264:
    - On 3/2/16, she completed her last mammogram. During interview, the PCP reported: "She was past due for her mammograms for a number of years." There was no further explanation for this deficiency.
    - On 3/16/20, she underwent a vision screening with a recommendation to return in one year. Based on information the Medical Director provided, the on-campus vision clinic did not resume until April 2021. As a result, this indicator

was not scored.
    - On 8/20/18, an audiological exam showed she had moderate to severe hearing loss. The recommendation was to return in one year. Per the PCP, she returned in 2019 for ear irrigation, but did not have a repeat audiological assessment.
- For Individual #544:
    - In 1991, he had the PSV 23 vaccine. The AMA and immunization record recorded different months, but he was now 69 and was due for a booster at age 65. During interview, the PCP reported that the order was "placed when we were going over his chart on yesterday."
    - On 3/29/19, he completed his last vision exam, which showed cataracts, and recommended return in one year. On 3/3/20, the PCP placed an order. During interview, the PCP stated: "the order is still there." The AMA included no plan for the cataracts. The PCP did not complete an informal vision assessment as part of the AMA. Based on information the Medical Director provided, the on-campus vision clinic did not resume until April 2021. As a result, this indicator was not scored.
    - On 1/23/20, he completed his last audiological exam, which showed moderate hearing loss. The recommendation was to return in three years. The audiologist made recommendations for strategies to improve the individual's hearing. The PCP did not assess the individual's hearing as part of the physical exam for the AMA.
- For Individual #227:
    - On 10/2/09, she received the Tdap vaccine, but had not received the booster. According to the PCP, it was ordered on 6/1/21.
    - On 9/6/19, she had her last eye exam. She is blind, and the recommendation was to return in one year. Based on information the Medical Director provided, the on-campus vision clinic did not resume until April 2021. As a result, this indicator was not scored.
    - On 1/2/20, she completed his last audiological exam, which was inconclusive. The recommendation was to return in one year. Given the issues that COVID-19 caused with the Center's audiology clinic, this sub-indicator was not rated.
    - In 2015, she had cervical cancer screening, which was negative. In October 2020, she was due for rescreening. In July 2020, the PCP requested an appointment, but it was never scheduled. Center staff did not submit an ISPA to show the IDT discussed the risk-benefit of moving forward with or postponing this follow-up appointment.

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

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	787	344	300	178	78	112	264	544	227

		Score									
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: Work was still needed to improve assessment and follow-up for individuals experiencing acute illnesses/occurrences that providers treated at the Center. It was positive that prior to individuals' transport to the ED or hospital, providers conducted evaluations. However, in a couple instances, significant problems were noted with the quality of these assessments. Upon individuals' returns to the Center, PCPs completed the necessary follow-up for the examples reviewed. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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.	44% 4/9	1/2	0/1	1/2	1/2	1/1	N/A	N/A	N/A	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	43% 3/7	N/A	0/1	1/2	1/2	0/1				1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 7/7	N/A	N/A	N/A	2/2	2/2	N/A	1/1	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.	0% 0/2				0/2	N/A		N/A	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	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									

	out-of-home care.										
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.										
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 3/3				1/1	1/1		N/A	1/1	
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.	100% 5/5				2/2	2/2		N/A	1/1	

Comments: a. For six of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #787 (cough on 11/19/20, and sore throat on 3/11/21), Individual #344 (COVID-19 disease on 2/2/21), Individual #300 (Stage 3 pressure injury on 11/4/20, and UTI on 3/31/21), Individual #178 (Stage 1 pressure injury on 12/5/20, and finger contusion/edema on 2/27/21), Individual #78 (constipation, cough, shortness of breath, and abnormal chest x-ray on 12/29/20), and Individual #227 (seizures on 11/17/20).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #787 (sore throat on 3/11/21), Individual #300 (UTI on 3/31/21), Individual #178 (Stage 1 pressure injury on 12/5/20), and Individual #78 (constipation, cough, shortness of breath, and abnormal chest x-ray on 12/29/20).

b. For the following, the PCPs conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #300 (UTI on 3/31/21), Individual #178 (Stage 1 pressure injury on 12/5/20), and Individual #227 (seizures on 11/17/20).

The following provide examples of concerns noted:

- On 11/19/20, nursing documented that Individual #787 complained of not feeling well and having a dry cough. The PCP evaluated the individual and noted that the individual had a history of a non-productive cough and no other symptoms. The physical exam was unremarkable. The PCP's diagnosis was occasional cough. Cough is a symptom and not a diagnosis. The PCP did not document a differential diagnosis for the symptoms. The plan was to treat the cough with Robitussin DM for five days and follow-up for any problems. On 11/26/20, nursing staff documented that the problem was resolved.
- On 2/1/21, nursing staff documented that Individual #344 had been coughing. On 2/1/21, the PCP evaluated the individual for follow-up of a skin infection. The PCP did not document a history of a cough. On 2/2/21, nursing staff again documented the "individual has been coughing." The PCP evaluated the individual and noted that the evaluation was being performed due to a "cough that was first noted this morning." The PCP's assessment was cough. The plan was to provide symptomatic treatment with Robitussin and Claritin. The individual was also tested for the SARS-CoV-2 virus. On 2/3/21, nursing staff documented that the test was positive.

  On 2/4/21, the PCP documented a telehealth evaluation of the individual who was in isolation. The specific modality for

telehealth was not documented in the records. Per PCP documentation, the individual received his initial COVID-19 vaccination on 1/15/21. According to documentation, the individual had no symptoms. The plan was to conduct further evaluation if the individual developed any symptoms.

On 2/8/21, the PCP assessed the individual as part of the IMR process. The PCP stated the individual was receiving pro re nata (PRN, or "as needed") Robitussin and Claritin for symptom management. Similar to the IPN entry, dated 2/4/21, this IPN entry listed cough, stuffy nose/nasal congestion, and rhinorrhea as possible symptoms of COVID-19. Based on this information, the individual was not asymptomatic, but was experiencing mild symptoms. Telehealth visits were conducted on 2/10/21, 2/12/21, and 2/16/21, and the PCP reported the individual was doing well.

This was a 59-year-old individual with multiple chronic conditions, including hypertension, hyperlipidemia, dementia, and asthma. There was no documentation in the records reviewed that the PCP assessed the risk for progression to severe disease or hospitalization based on comorbid conditions. This assessment is an important factor in determining whether or not an individual is a candidate for COVID-19 specific outpatient therapy.

During interview, the Monitoring Team member asked the Medical Director if the Center had protocols related to outpatient management of COVID-19 disease. The Medical Director reported that initially there were local guidelines for the PCPs to follow relative to testing and triage, but those had not been updated. The Center submitted a copy of the COVID-19 Manual. This manual did not include any information regarding the medical management of COVID-19 disease, such as the assessment of risk for progression to severe disease, laboratory monitoring, and the available therapeutic options for management of mild to moderate disease in the outpatient setting.

- On 11/3/21, nursing staff documented that staff reported that Individual's #300's old sacral wound was getting worse. On 11/4/20, the PCP evaluated the individual. The PCP documented a 3cm-by-4cm wound at the superior end of the gluteal cleft. The PCP's assessment was unspecified open wound. The PCP did not stage the wound. The plan was to apply MediHoney and cover it with DuoDerm. Frequent position changes were recommended. The PCP did not place an order for a wound care specialist to assess the individual. The PCP included no other specific interventions in the plan of care.

  On 11/7/21, the PCP conducted follow-up on and described "a large open wound, ~ 6cm x 4cm exposing the subepidermal tissue with mild erythema surrounding the open area." The assessment was unspecified wound that "looks about the same as 3 days ago and has not worsened." The plan was to continue current management and follow-up in six days. On 11/12/20, the PCP documented that the skin integrity nurse suggested a change in dressing. The PCP further documented: "Individual continues to have an open wound at the sacral area. There has been no improvement over the past 5 days." The PCP changed the wound care orders to reflect the recommendations of the skin integrity nurse. On 11/19/21, the PCP changed the wound care treatment. On 11/30/21, the PCP noted no improvement in the wound, but made no changes in the plan of care. The plan of care was not comprehensive and did not address all aspects of wound management, such as attention to nutritional status, and pressure offloading. The PCP started Bactrim for treatment of cellulitis of the neck.

  On 12/10/20, the PCP noted that the wound was slowly improving. On 12/11/20, the PT documented that the wound was a Stage 2 pressure ulcer. On 12/16/20, the PCP documented the sacral wound was "clean and improving." The plan was to

continue wound care and follow-up in one week.

The PCP did not document follow-up the next week. On 3/8/21, the PCP made the next IPN entry, and it was regarding an abrasion of the individual's right forearm.

On 3/16/21, in an IPN entry, the PCP stated: "He has been receiving wound care to the wound," and described the wound as a 2cm-x-2cm open sacral wound with a 9cm-x-6cm area or erythema. The assessment was unspecified open wound of lower back and pelvis that persisted despite wound care. The plan of care included continuing off-loading and consulting the wound care specialist for further management.

The Monitoring Team reviewed the consults from the wound care specialist. It appeared that the initial consultation occurred on 3/18/21, at which time the consultant staged the wound as a Stage 3 pressure injury. The specialist conducted follow-up weekly.

On, 3/30/21, the PCP documented: "Individual was seen during Sick Call for evaluation of increased redness at the sacral area. He has had a wound. However, during the night there was a malfunction of his mattress, and he was found lying on a deflated mattress. The sacral area has a larger area of erythema, and the wound is reported to be larger." The plan was to continue wound care. The PCP ordered ascorbic acid and zinc as healing supplements. In the documents submitted, the next and final PCP entry related to the sacral wound was dated 4/15/21. According to this note, the wound remained open and "has been healing slowly."

On 4/23/21, the wound care nurse documented a checklist. The checklist included the assignments for each discipline. It did not provide sufficient information for several of the areas reviewed. For example, Dietary Services was assigned the task of the nutrition review. It addressed weight gain/loss, and the use of supplements. The checklist noted: "No change in diet; weight is improving." The checklist should have included a review of protein/calorie intake, hydration status, serum albumin and/or prealbumin, and total lymphocyte count. The wound care physician and nurse were assigned the task of assessing a nonhealing wound and ruling out osteomyelitis. It addressed this area by documenting that there was "No order for a consult. 7/26/2019 MRI – Ruled out osteomyelitis." Delayed wound healing may be the only sign of infection and it did not appear that osteomyelitis had been ruled out as a cause for non-healing.

- On 2/27/21, nursing staff documented that Individual #178 had mild edema to the left proximal phalanx of the index finger. The Medical Director was notified, and an x-ray was ordered. In a separate note, nursing staff documented that the finger had "mild edema, fading and slight purplish-brown discoloration." In the documents submitted, there was no documentation by a medical provider of an assessment or x-ray results.
- On 12/29/20, nursing staff documented that staff reported that Individual #78 was coughing and drowsy. The nurse notified the PCP. At 4:06 p.m., the PCP documented that the "Individual was seen during Sick Call for evaluation of labored breathing and tachycardia this morning." The time of the PCP's actual assessment was not clear. The PCP documented that the physical exam was normal. The PCP's assessment was cough, shortness of breath, and constipation. The PCP ordered a chest x-ray, and an x-ray of the kidneys, ureter, and bladder (KUB), and COVID-19 testing. At 4:17 p.m., the PCP documented x-ray results of "left basilar heterogenous opacities may represent infection or atelectasis," and "diffuse colonic stool may indicate

constipation." The rapid COVID-19 test was negative. The plan was to treat the individual's constipation with an extra suppository. The PCP prescribed Guaifenesin every six hours for the cough. The individual would also be monitored for symptoms of infection, but the PCP did not outline a specific plan.

The PCP did not document any follow-up related to the diagnosis of constipation or the abnormal chest x-ray findings. The next PCP documentation was on 1/4/21, and it was related to the individual being transferred to the hospital for evaluation and treatment of multiple seizures. After this ED visit for seizures and a UTI, on 1/12/21, the PCP documented that upon review of the most recent two weeks of data in CareTracker, staff determined that the individual had not had a bowel movement in six days. The plan was to add MiraLAX to the bowel regimen and continue to monitor.

- On 11/15/20, and again on 11/17/20, Individual #227 experienced two seizures. On 11/17/20, the PCP evaluated her. According to a PCP notation, the last neurology consult was on 8/11/20, and the individual was treated with six anti-epileptic drugs (AEDs).

  Per PCP documentation, the individual was diagnosed with seizure disorder, not intractable. However, the epileptologist had diagnosed the individual with an intractable seizure disorder following resection of a right parietal oligoastrocytoma. The medical plan of care was to check a urinalysis and continue current management. The PCP did not include a plan to check AED levels or refer to the individual to epileptology for an earlier follow-up appointment, since the seizure frequency had not improved with the increase in the Lamictal dose. On 11/18/20, the PCP saw the individual again due to another seizure. The PCP documented that there was no evidence of a UTI, and the plan was to monitor. A basic metabolic panel (BMP), done on 11/17/20, was normal. On 12/1/20, the PCP saw her for follow-up of edema and congestive heart failure for which Bumex was prescribed. There was no further seizure activity reported.

  The lab monitoring was not sufficient to meet the individual's needs. On 2/19/21, the Clinical Pharmacist noted that a complete blood count (CBC) and comprehensive metabolic panel (CMP) were required every six months, and the last was done on 4/30/20.

  On 3/1/21, the individual had a telehealth epileptology consult. Reportedly, the last consult occurred in July 2020. The consultant documented that Lamictal was increased in July with seemingly little effect, and it was unclear why there was an increase in cluster seizures. It was reported that the guardian refused to proceed with vagus nerve stimulator (VNS) implantation. The plan was to increase the Fycompa, and check a Lamictal level due to the July dose increase. The consultant made recommendations regarding changes in the rescue medications.

c. For four of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #178 (hospitalization for femur fracture on 11/11/20, and ED visit for contusion/hematoma to right upper extremity on 1/26/21), Individual #78 (ED visit for seizures and UTI on 1/4/21, and hospitalization for bilateral pneumonia, sepsis, and respiratory failure on 1/17/21), Individual #264 (hospitalization for subdural hematoma on 4/20/21), and Individual #544 (hospitalization for COVID-19 disease on 1/20/21, and hospitalization for COVID-19 pneumonia, sepsis, and pressure ulcer on 2/10/21).

c. and d., 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 #78 (ED visit for seizures and UTI on 1/4/21, and hospitalization for bilateral pneumonia, sepsis, and respiratory failure on 1/17/21), Individual #264 (hospitalization for subdural hematoma on 4/20/21), and Individual #544 (hospitalization for COVID-19 pneumonia, sepsis, and pressure ulcer on 2/10/21).
- On 11/11/20, nursing staff documented that direct support professional (DSP) staff reported that Individual #178 complained of right knee pain since falling the previous night. The individual reported this as staff were taking him to the shower. Per nursing staff, the individual had limited range of motion of the right knee.

  The Medical Director saw him, and noted that the individual had a one-day history of pain and swelling of the right knee. The note indicated that there was no history of trauma. The physical exam was documented as "right knee with mild effusion and warmth detected, AROM [active range of motion], jt line nttp [sic]." The provider did not document examination of the individual's hips or distal lower extremity. There was no documentation of the neurovascular status of the lower extremity. Nursing staff documented that the individual had to be wheeled to the bathroom, and had limited range-of-motion (ROM) of the knee. The Medical Director's plan was to obtain an x-ray and administer ibuprofen for pain.

  On 11/12/20, the PCP conducted follow-up for left knee swelling. The x-ray of the knee was negative for a fracture. However, the individual refused to ambulate. The PCP further noted that nursing staff reported that the right thigh appeared swollen. The PCP noted that the right knee was swollen with mild tenderness and no active ROM. The right thigh appeared larger than the left and the hips had good ROM. The PCP did not provide an objective measurement of thigh size. The PCP's assessment was right knee pain and swelling. The PCP ordered labs and increased the ibuprofen dose. The PCP did not order any additional x-rays.

  On 11/13/20, the PCP evaluated the individual due to continued complaints of knee pain and refusal to ambulate. The physical exam showed right knee swelling, and a right thigh that appeared larger than the left. There was no active ROM. Again, the provider did not document the neurovascular status of the extremity. The provider also did not document vital signs, even though a septic joint was included in the differential.

  The PCP's assessment was right knee pain and swelling in an individual who was unable to ambulate. The individual was transferred to the ED for further evaluation. He was admitted with a right displaced femoral shaft fracture, and on 11/14/20, he underwent an ORIF. The individual required transfusion with two units of packed red blood cells (pRBCs) due to significant blood loss associated with the fracture.

  On 11/20/20, he was transferred to a rehabilitation hospital for further therapy, and on 11/30/20, he returned to the Center. On 11/30/20, the PCP conducted a post-hospital assessment (i.e., note signed on 12/2/20). The PCP's assessment was status post (S/P) ORIF for right femoral fracture. The plan was to provide pain management, add MiraLAX, and continue Lovenox and iron supplementation. On 12/1/20, the PCP saw him again. The plan was to increase the opiate strength and add a stool softener.
- On 1/26/21, the PCP assessed Individual #178 due to reports of right wrist pain. The PCP's physical exam of the individual's

right wrist was normal, but did not include documentation of the neurovascular status the extremity. The PCP did not document an exam of the remainder of the distal right upper extremity.

On 1/29/21, at 7:52 a.m., nursing staff documented that there was bruising and swelling to the individual's right arm. The individual guarded the arm and reported pain. A nurse left a voicemail for the PCP. On 1/29/21, the PCP evaluated the individual due to a bruise that was discovered just below the right elbow. The physical exam was pertinent for "bruising from below the elbow extend to mid forearm, minimal swelling, no tenderness to palpation, skin intact, good ROM of elbow. Right wrist with no swelling or bruising, normal ROM." The PCP did not document the neurovascular status of the extremity. The plan was to provide Tylenol and obtain x rays. Nursing staff documented notifying the PCP at 2:45 p.m. of the x-ray results. The x-ray of the elbow showed an abnormality, and a CT scan was recommended. At around 5:15 p.m., the individual was transferred to the ED for further evaluation.

On 1/30/21, he returned from the ED, and the PCP saw him. The diagnosis was contusion with soft tissue hematoma and acute right upper extremity pain. The plan was to continue the use of the elastic wrap, administer Tylenol PRN for pain, and apply warm compresses. On 1/31/21, the PCP noted that current management would continue. On 2/3/21, the PCP made an IPN entry documenting that the individual was improving.

- According to nursing documentation, on 4/20/21, at 5:45 p.m., a DSP discovered Individual #264 "in shower area on her own." The individual was sitting upright on shower floor with bleeding noted to posterior scalp. The bleeding was controlled with pressure. The nurse notified the PCP, who ordered transfer to hospital.

  On 4/21/21, at 9:54 a.m., a nurse added an addendum that the PCP was notified of the injury and ordered that individual be sent out if bleeding persisted. Upon assessment, nursing determined that bleeding had stopped and there were no other changes. Therefore, staff did not call 911. Staff transferred the individual to the hospital in a Center van. At 6:30 p.m., on 4/20/21, the on-call PCP documented that the individual was transferred to the ED for evaluation of a bleeding laceration. There was no additional documentation from the PCP.

  According to mortality documentation, a CT scan showed a right-sided complex subdural hematoma with mass effect and shift of midline. She was transferred due to the need for a higher level of care. Upon arrival at the ED, she was intubated. A repeat CT showed brain herniation and the injury was determined to be irreversible with an extremely poor prognosis. Palliative care was provided, and on 4/29/21, the individual died.
- Nursing staff documented that on 1/15/21, Individual #544 was placed in quarantine due to a positive COVID-19 test. There was no evidence in the documents submitted that the PCP assessed the individual to determine if symptoms were present or what medical evaluation and/or treatment was needed. This was a 69-year-old individual with multiple chronic conditions. There also was no documentation in the records that the PCP assessed the risk for progression to severe disease based on comorbid conditions and age. This assessment is an important factor in determining if an individual is a candidate for COVID-19-specific outpatient therapy.

  On 1/18/21, nursing staff documented that the individual was in no distress, but had "crackle breath sounds." There was no documentation that nursing staff notified the PCP. Previous exams did not document abnormal lung sounds. On 1/19/21,

nursing again documented abnormal breath sounds. On 1/20/21, nursing documented that at 8:00 p.m., the individual "is unresponsive to verbal. Responded to tactile stimuli." The lung sounds were coarse in all lobes. The oxygen saturation on room air was 88%. Oxygen at 3 liters per minute was provided and the saturation increased to 92%. There was no documentation that the nurse notified the PCP of this significant change. Per nursing documentation, at 8:10 p.m., "Individual is having shortness of breath at rest and had low BP and 02 saturations." At 8:14 p.m., EMS was activated. On 1/20/21 at 8:45 p.m., the individual was transferred to the ED due to lethargy, non-responsiveness to verbal stimuli, hypotension, and decreased oxygen saturation.

The first documentation by a medical provider was on 1/20/21 at 11:28 p.m. This was almost two hours after the time of the individual's transfer. The PCP noted: "Individual was seen during Sick Call for evaluation of abnormal lung sounds. The nurse reports that she hears gurgling in the throat. He has been noted to have had decreased oral intake today and has been refusing to get out of bed. He has not had coughing or respiratory distress. He has had no other symptoms or problems reported." The PCP documented a blood pressure of 87/62 and lung sounds with rhonchi transmitted from the throat. The assessment was other seasonal allergic rhinitis due to mucous drainage in the throat. The plan for COVID-19 infection was to monitor.

On 1/21/21, the on-call PCP noted that the individual was transferred to the ED due to hypoxia with an oxygen saturation of 88% and lethargy. He was admitted with acute hypoxic and hypercapnic respiratory failure, COVID-19 pneumonia, and septic shock. He was admitted to the ICU and required vasopressors for blood pressure support.

On 2/6/21, the individual returned to the Center, and on 2/7/21, the PCP evaluated him. The PCP noted that the individual was treated with remdesivir, ivermectin, and tocilizumab for COVID-19 disease. He was also treated with antibiotics and Levophed for his septic shock. On 2/8/21, the PCP documented an assessment, but the note was signed on 3/6/21. On 2/9/21, the PCP did not assess the individual in the Infirmary.

On 2/9/21, the on-call PCP documented that nursing staff reported that the individual was hypotensive and "not looking good." The PCP gave an order to transfer by non-emergency transport unless the individual became hemodynamically unstable. On 2/10/21 at 12:36 a.m., the individual was transferred.

The Hospital Liaison Nurse note, dated 2/11/21, included an excerpt from the attending physician's progress note on 2/10/21, which stated: "The pt. was discharged actually in fairly good condition… The pt. was brought in again from RSSLC when he was noted to be hypotensive. Blood pressure dropped to 60 systolic. The pt. was also obtunded with worsening mentation. Currently the pt. is nearly back to his usual mentation."

Per documentation by the Center's Hospital Liaison Nurse, on 2/11/21, a CT scan done showed a large volume of free intraperitoneal air in the patient's abdomen. There was also extensive subcutaneous emphysema demonstrated in the anterior abdominal wall throughout extending into the superior aspect of the scrotum. On 2/10/21, a CT scan was also done, but that report was not submitted. According to nursing documentation at 5:50 a.m., on 2/10/21, the Center was notified that the individual was admitted to the ICU for hypotension and "large amount of inter-peritoneal and subcutaneous free-air extending to the scrotum."

On 3/19/21, the individual returned to the Center, and on 3/20/21, the PCP saw him. The PCP documented diagnoses of resolved COVID-19 pneumonia, sepsis, and a pressure ulcer.

The next PCP assessment was dated 3/22/21. On 3/23/21, the Medical Director documented that the individual was seen on 3/21/21. The next PCP assessment was on 3/26/21. None of the post-hospital assessments provided an adequate summary of the hospital events. For example, the individual had a pneumoperitoneum and extensive subcutaneous emphysema, and Center medical staff did not discuss these diagnoses.

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

Summary: Due to problems with the timely review of consultation reports, Indicator b is at risk of returning to active oversight. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. However, due to problems noted, Indicator b is at risk of returning to active oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
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.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.										
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 1/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: For eight of the nine individuals in the review group, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #787 for cardiology on 1/7/21; Individual #344 for gastroenterology (GI) on 4/13/21, and podiatry on 4/14/21; Individual #300 for wound care on 4/1/21, and optometry on 4/8/21; Individual #178 for orthopedics on 3/18/21, and orthopedics on 4/8/21; Individual #78 for surgery on 12/11/20, and wound care on 3/11/21; Individual #112 – optometry on 4/22/21, and urology on 3/9/21; Individual #544 for neurology on 11/24/20, and wound care on 4/1/21; and Individual #227 for epileptology on 3/1/21.

b. For five of the 14 consultation reports reviewed, PCPs did not complete the review timely, and/or did not follow-up to obtain the

consult report timely, including those for: Individual #300 for wound care on 4/1/21, Individual #78 for surgery on 12/11/20, and wound care on 3/11/21; Individual #112 – optometry on 4/22/21; and Individual #544 for wound care on 4/1/21. As a result, Indicator b is at risk of returning to active oversight.

e. In response to Individual #227's consultation with epileptology on 3/1/21, the PCP ordered a new nasal medication to abort seizures. The IDT should have discussed this change.

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

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

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
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.	22% 4/18	0/2	0/2	0/2	1/2	1/2	1/2	1/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #787 – cardiac disease, and diabetes; Individual #344 – abnormal liver enzymes, and positive FIT; Individual #300 – peripheral artery disease, and hypothyroidism; Individual #178 – weight, and seizures; Individual #78 – seizures, and non-alcoholic fatty liver with abnormal liver enzymes; Individual #112 – osteoporosis, and Vitamin D deficiency; Individual #264 – normal pressure hydrocephalus, and constipation; Individual #544 – anemia, and chronic hypoalbuminemia; and Individual #227 – weight, and osteoporosis).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #178 – seizures, Individual #78 – seizures, Individual #112 – Vitamin D deficiency, and Individual #264 – constipation.

The following provide examples of concerns noted:

- Individual #787 was diagnosed with cardiomyopathy. According to the PCP, the individual was not diagnosed with hypertension. The records reviewed documented numerous instances in which the individual's diastolic blood pressures and heart rates were elevated. The elevations were not consistent. The QDRR, done on 1/4/21, made a specific recommendation to monitor the individual's heart rate due to the use of medications. However, the PCP reported that she was not aware of the frequent elevations documented in the months of April and May. State Office medical policy requires that PCPs complete quarterly interval medical reviews. A review of vital signs is included as part of the State Office template. If nursing staff did not report the abnormal findings to the PCP, the PCP should have noted the elevations as part of the review to complete the IMR. On 2/19/21, a locum tenens physician completed an IMR. In the summary, that PCP stated: "Her diastolic blood pressure

tends to be on the high side." Therefore, this physician appeared to have some concern with regard to the individual's blood pressure. This individual should have had an IMR completed in May 2021, but it was not done.

On 1/7/21, a cardiology consult was completed. This was a tele-medicine consult, but the exact modality was not specified in the consult and should have been. The consultant only noted that the individual had a history of cardiomyopathy and the 2019 echocardiogram showed an ejection fraction of 50-55%. The recommendation was to repeat the echo in March. The echocardiogram completed on 3/15/21, showed trace mitral and tricuspid regurgitation, mild left ventricular hypertrophy, and an ejection fraction of 55-60%.

Of note, the goal was for the individual to have no avoidable complications from cardiomyopathy as evidenced by controlled blood pressure. The nursing intervention was to notify the PCP of chest pain, irregular rhythm, abnormal heart rate, and blood pressure.

In its comments on the draft report, the State provided the following as "clarification:"

> "For individual #787, according to assessment by PCP on Annual Medical Assessment (AMA) (TX-RI-2106-II.005EB, pg. 9-11):
>
> Abnormal Echocardiogram, Hx of cardiomyopathy: She was started on Lisinopril 2.5 mg daily with normal blood pressure and was discontinued on 8/25/15. Nuclear exercise stress test was done on 02/22/16, findings are non-diagnostic for inducible ischemia. Myocardial perfusion imaging is negative for inducible ischemia. There is a small fixed perfusion defect located in inferior wall. This finding is consistent with diaphragmatic attenuation. Overall left ventricular systolic function is normal, left ventricular ejection fraction 65%. No need to restart Lisinopril, no new recommendation and annual f/u with cardiology was recommended.
>
> Comments regarding elevated BP,HR- She is not diagnosed with HTN, there was no consistent elevation of HR or BP. None of her EKGs ever showed tachycardia.
>
> She has Obsessive compulsive disorder and adjustment disorder with depressed mood. Ms. Boyce spends a lot of time engaging in repetitive behaviors. She enjoys having her day scheduled, if any activity during the day is changed she becomes anxious and also engages in aggression. Her occasional elevated BP and HR possibly due to her behavior/anxiety/OCD. She is on propranolol for Anxiety/OCD. There is an order for checking BP/HR daily prior to give meds.
>
> Her cardiologist recommended to start Lisinopril if her EF is < 50%. Most recent echo shows LVEF-55-60, so no Lisinopril started.
>
> Her cardiomyopathy was addressed on each cardiology visits- Annual cardiology f/u on 01/27/21, per cardiologist-No major health issues have been reported since last visit, H/o of cardiomyopathy- currently asymptomatic, last echo in May

2019 showed low-normal EF at 50-55%. Repeat echo and f/u in 1 year was recommended.
Echo on 03/15/21 showed Normal Left ventricular systolic function with estimated LVEF-55-60%.Trace mitral regurgitation and trace tricuspid regurgitation. Mild LV hypertrophy."

As indicated in the draft report, this individual's PCP should carefully monitor the individual's blood pressure, including during the IMR process. In addition, the PCP should review this individual's case within the context of the revised hypertension clinical guidelines that State Office issued on 7/22/21.

- According to the AMA, Individual #787 was diagnosed as being overweight. The PCP stated during interview that according to the most recent AMA, the individual met two criteria for metabolic syndrome, including abdominal circumference of 40 and high-density lipoprotein (HDL) of 36. The QDRR, dated 4/1/21, documented that the individual met three of five criteria for metabolic syndrome, including a waist circumference (WC) of 35, weight of 173 pounds on 3/14/21, HDL of 42 on 1/8/21, and a fasting blood glucose of 108 on 1/8/21. The IMR completed by the locums physician, dated 2/19/21, specifically noted that no A1c was recorded. Additionally, the IRRF entry signed on 12/4/20, also documented that the individual met three of five criteria for metabolic syndrome. The PCP did not respond in the April 2021 QDRR, or dispute the clinical pharmacist's comment that the individual met the criteria for metabolic syndrome.

  The individual was on a 1200-calorie diet for weight loss. The desired body mass index (BMI) was <25. The PCP made the recommendation to the IDT that the individual participate in an exercise program. According to the IRRF, the individual's physical activity was restricted due to pandemic precautions.

  The IRRF and QDRR both documented that the individual met the criteria for the diagnosis of metabolic syndrome. However, this was not listed as a diagnosis in the AMA or the 2/19/21 IMR.

  It should be noted that lab monitoring was not done in a timely manner. The lipids and glucose were due at a minimum annually and should have been repeated in November 2020, but they were not done until January 2021.
- According to the PCP consultation note completed on 3/9/21, Individual #344 had a history of an elevated alkaline phosphatase dating back to 2019. On 7/8/20, an abdominal ultrasound showed a non-visualized gallbladder. The PCP noted that the 8/10/20 labs "indicate elevation of hepatic origin." The May 2020 AMA did not discuss the 2019 elevated alkaline phosphatase.

  On 4/13/21, a GI consult was completed. The consult addressed two outstanding GI issues. The first issue was the need to complete a colonoscopy, and the second was related to the evaluation of the abnormal liver enzymes. The GI recommendation was to proceed with laboratory evaluation to assess for autoimmune, infectious and metabolic causes of liver disease. At the time of the PCP interview, on 6/9/21, the labs requested by GI had been ordered (4/14/21), but not done. Based on the documentation reviewed, the PCP ordered the labs to be completed on 8/30/21. This effectively translated into a two-year delay in obtaining the appropriate workup. It is not clear why the PCP would further delay the medical evaluation to determine if the individual had an autoimmune, infectious or metabolic etiology of liver disease. If identified, it would be important for these issues to be addressed in a timely manner. There are numerous clinical pathways and protocols available to assist medical providers in the evaluation of liver disease. The PCP could have ordered many of these laboratory tests prior

to the GI consultation.

- According to the GI consult done on 4/13/21, Individual #344 had an esophagogastroduodenoscopy (EGD) done in September 2018 due to a hemoglobin of around 6. The EGD showed a duodenal ulcer. Per the GI consult: "FIT in April 2019 positive. Last colonoscopy in 2015 poor prep and 2016 abnormal. In August 2019, an EGD and colonoscopy was ordered, a colonoscopy was attempted and solid stool was seen in rectum so they were unable to complete. He arrived for colonoscopy in December and was found to be hypertensive. He was sent back and advised to make adjustments in blood pressure medication and then be rescheduled." The AMA completed in May 2020 noted that the 12/12/19 colonoscopy could not be completed due to hypertension, but failed to mention that the individual had a positive FIT in April 2019. At the time of the review, the colonoscopy had not been repeated.

  It should be noted that all of the consultation notes that documented blood pressures, indicated markedly elevated blood pressures. The PCP attributed this to "white coat hypertension." The records reviewed included a recent EKG (4/1/21). The computerized interpretation included moderate voltage criteria for left ventricular hypertrophy (LVH). The 2017 echocardiogram showed diastolic dysfunction.
- According to the AMA, completed on 1/21/21, on 8/21/18, the podiatrist found Individual #300 had cyanotic toes. The PCP's AMA discussion documented the following: "Evaluation with bilateral lower extremity arterial Doppler study on 9/6/2018 reported 'Consider right External Iliac artery disease clinically - low velocity CFA. Normal flow and velocity all other bilateral vessels through Popliteal arteries with less than 50 percent nonfocal stenosis in the right PDA."

  Per PCP documentation in the AMA, the individual has continued follow-up with podiatry and at the last appointment on 10/20/20, the podiatrist noted: "Neurovascular and musculoskeletal exam is unchanged since last visit... Patient has diminished but palpable DP/PT pulses. Capillary refill time is greater than 10 seconds."

  The PCP did not document an adequate examination of the lower extremities in the physical exam for the AMA. It was not known if the individual was symptomatic. This induvial had peripheral arterial disease (PAD), but the AMA did not include any discussion related to addressing factors that impact PAD. The individual was not referred to vascular surgery for evaluation to determine if additional therapy was warranted.
- According to the AMA, on 1/21/21, Individual #300's thyroid stimulating hormone (TSH) was .07. The PCP did not provide a plan to address the suppressed TSH. On 4/9/21, the repeat TSH was also low at .36. These values indicated overtreatment of hypothyroidism. The AMA did not document a plan to address this, but stated the individual would see endocrinology, if necessary.

  Patients with primary hypothyroidism who are taking levothyroxine replacement therapy can be monitored by assessing the serum TSH only. Serum free T4 measurements are very insensitive for assessing the appropriateness of the levothyroxine dose.
- According to the PCP documentation in the AMA, Individual #178 weighed 237 pounds upon admission and had a BMI of 36.3. He was diagnosed with the metabolic syndrome based on a glucose of 118, triglycerides (TG) of 195, HDL 30, and WC of 49 inches. Prior to admission to the Center, he was treated with metformin and his A1c was 5.3. The PCP elected to discontinue treatment with metformin. Repeat lab values showed persistence of the lipid abnormalities and fasting glucoses greater than

100.

The PCP did not include metabolic syndrome as an active diagnosis, and, therefore, there was no plan to address it. Obesity was included as an active diagnosis, and the plan was to continue a low cholesterol diet and encourage physical activity.

The PCP did not address the individual's overall caloric intake or the increased risk for endocrine abnormalities based on the use of a second generation antipsychotic medication.

- According to the AMA, based upon her admission labs, Individual #78 had an elevated alkaline phosphatase and elevated aspartate transaminase (AST) and alanine transaminase (ALT). The plan was to order an abdominal ultrasound and fractionated alkaline phosphatase for further evaluation.

  According to the IMR, dated 5/2/21, the elevated alkaline phosphatase "seems to be related to fatty infiltration of her liver." There was no additional information related to a comprehensive plan to manage this diagnosis. Moreover, there was no plan to further evaluate for other causes of liver disease.

  During interview, the PCP reported that the most recent liver enzymes in May remained elevated and the individual was being referred to GI. At the time of the review, the appointment had not been scheduled. The Center submitted an email, dated 6/16/21, from the SAC that indicated the GI appointment was scheduled for 7/9/21.

  There was documentation of elevation of the liver enzymes on labs completed on 9/27/20, and since admission on 11/3/20. It was not clear why the PCP did not make the referral until eight months after the first documentation of the abnormality. Additionally, the labs required to initiate a workup for liver disease are found in numerous algorithms that are readily available and do not require a GI referral for completion.
- According to PCP documentation in the AMA, Individual #112 was diagnosed with bilateral osteoporotic hip fractures that required surgical management with open reduction and internal fixation (ORIF).

  On 7/17/17, the individual had a DEXA scan completed and measurements of the lumbar spine were done to assess response to therapy. In 2015, her treatment was changed from bisphosphonates to Prolia.

  During interview, the PCP reported that the DEXA was due in July 2019, but this was missed because the AMA was not done until January 2020. At the time the AMA was completed in 2020, the PCP ordered the DEXA. During interview, the PCP reported that he was not aware if there were any attempts to complete the DEXA in 2020. However, an attempt was made in January 2021, and it was not successful. The study remained outstanding and the plan was to reorder and complete the study with the use of pretreatment sedation.

  The PCP's comment regarding the DEXA being missed underscored the need to have a robust system for tracking the required preventive care and diagnostic studies. The study was now overdue by two years.
- Starting in 2015, Individual #264 had a history of abnormal gait and falls. A neurologist and a movement disorder specialist evaluated her. In April 2018, a CT scan showed normal pressure hydrocephalus (NPH). In June 2018, following placement of a

ventriculoperitoneal (VP) shunt, her gait improved and falls decreased.

According to the AMA, the movement disorder specialist continued to follow the individual with the last appointment being completed on 7/2/19. The May 2020 evaluation was rescheduled due to pandemic precautions. The PCP documented that the individual was wearing knee pads, elbow pads, and a helmet to protect her from falls, but he did not specify the frequency or number of falls. The indication in the IRRF was for "protection from frequent falls." The IRRF also stated: "She is to wear her soft shell helmet at all times except in wheelchair during awake hours." The etiology of the continued falls also was not discussed. Per PCP documentation, neurosurgery also followed the individual regularly. The last neurosurgery follow-up appointment was on 1/9/19. The recommendation was to follow-up in one year. Per PCP documentation in the discussion section of the AMA: "She is past due for her neurosurgery follow-up."

The IMR, dated 3/11/21, noted that the individual had a neurology appointment on 8/11/20, which stated gait disorder resolved. It was also noted that she saw psychiatry on 2/31/21 (i.e., which appeared to be an incorrect date) for increased agitation. The IMR also noted that her lisinopril was increased from 10 mg to 40 mg, and hydrochlorothiazide (HCTZ) was added, and blood pressures remained out of target range.

There was no clear documentation in the medical records of the number of falls or a change in gait status. It appeared that there was evidence of falls since there was requirement for protective equipment as documented in the AMA. On 4/21/21, the individual sustained a fall that resulted in a subdural hematoma that was the cause of her death. She was not wearing a helmet at the time of the fall.

Gait dysfunction is the most prominent clinical feature of NPH and is the feature most responsive to shunting. In the most recent physical exam, the PCP documented a wide-based gait, but did not note how this compared to her baseline. There was no discussion of cognitive impairment such as psychomotor slowing, attention, and concentration. There was no documentation of evidence of incontinence. Notable negatives such as headaches, nausea, vomiting, visual loss, and papilledema were not documented.

The documentation submitted provided no evidence that the IDT met to conduct a risk-benefit assessment of proceeding with a neurosurgery consult. Per the Medical Director's comments in the Clinical Death Review "without the current status of her VP shunt, it could be speculated that without a proper working shunt, her gait would be affected."

- On 5/3/21, Individual #544 had a CBC done that showed a hemoglobin (Hb) of 9.3, hematocrit (HCT) of 30.7, and platelets of 580. On 4/9/21, the previous Hb/Hct was 12.0/37.4. This represented an acute blood loss of almost 3 grams (gms) of hemoglobin in less than one month. During the PCP interview on 6/10/21, the PCP reported that he was not aware of the results. "I have not seen that result." On 3/29/21, the Hb/Hct was 13.3/39.8.

  During the initial part of the interview, the PCP reported that he was aware of the State Office policies, procedures, and clinical guidelines. However, when asked about the requirements to address labs the PCP responded: "I am not aware."

  According to State Office Policy 009.3 Medical Care, effective 2/29/20, the PCP should "Review, initial, and date all non-

electronic PCP diagnostic reports within five business days of receipt. It is recommended the PCP document when the report is received so that credit can be given for the five-business day timeframe. Significantly abnormal reports need to be acted upon sooner. For significant or abnormal diagnostic reports, the PCP will document the significance of the results that may require interventions and document the care plan in the progress notes of IRIS."

The PCP failed to review labs results in accordance with State Office guidelines. This resulted in the failure to recognize a significant loss of blood volume.

- During interview, the PCP was asked what actions were taken to address Individual #544's diagnosis of hypoalbuminemia. The PCP's response was "I have not done anything." The individual's albumin levels were as follows:
    - 1/31/21 - 1.7
    - 2/2/21 - 2.0
    - 2/4/21 - 2.0
    - 2/6/21 - 2.2
    - 3/29/21 - 2.7
    - 4/9/21 - 2.5
    - 5/3/21 - 2.2

  Hypoalbuminemia has multiple possible etiologies. There was no medical documentation that the PCP had further evaluated the etiology or implemented corrective actions.

  The literature is replete with evidence that albumin is a good marker of nutritional status in clinically stable individuals and is a mortality prognostic indicator for elderly people whether they live in the community, are hospitalized, or reside in long-term care facilities. The PCP should have been aware of these results and what actions were taken to address them.
- For Individual #227, the diagnosis of obesity was not listed as an active medical problem in the AMA. However, the PCP stated during interview that since 2016, the individual was on a very low calorie diet of 1000 calories per day, but had not lost weight. In fact, he believed she might be gaining weight. The individual was dependent on staff for all care and had no ability to independently access food. The failure to lose weight while receiving a very low calorie diet was described by the PCP as a "mystery we are investigating." According to the Medical Director, the 1000-calorie per day diet did not include the snacks staff provided to the individual. If this statement were accurate, then the PCP, nutritionist, and IDT would not have any information on the actual dietary intake or calories. The PCP was asked if a calorie count had been performed as part of the investigation. The PCP responded that this had not been done.

  According to the IRRF, the individual's weight was 177 pounds at the beginning of the year, was 190 pounds at the time of the ISP, and on 3/9/21, at an ISPA meeting, it was 192. The individual's BMI was 31. Moreover, the IRRF documented that the individual was seen on sick call for generalized edema and continued weight gain weight even though she was provided a 1000 calorie per day diet. According to the IRRF, congestive heart failure (CHF) was a likely cause of the weight gain. According to the PCP, a November 2020 echocardiogram showed LVH and diastolic dysfunction, but a cardiology evaluation on 5/10/21 indicated that there was no evidence of CHF.
- According to the AMA, Individual #227 had a diagnosis of osteoporosis. The AMA further noted that the 1/17/14 DEXA

showed osteoporosis of the left hip. The PCP stated in the discussion of osteoporosis: "It is unclear why DEXA scans were completed at such a young age." It should be noted that the individual had a diagnosis of intractable epilepsy that was treated with six AEDs. The prolonged use of AEDs is an indication for measurement of bone mineral density.

The DEXA, completed on 2/14/19, showed low bone mass of the left hip, and the lumbar spine bone mass had decreased from the prior study. According to PCP documentation in the AMA, the individual could not be treated with bisphosphonates due to GERD. During interview, the PCP acknowledged that no fracture assessment was done. There was no evidence that the PCP considered alternative pharmacologic treatment for this individual with a history of osteoporosis. Treatment was limited to calcium and Vitamin D.

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

Summary: Each of the 18 IHCPs reviewed should have included medical interventions. Only five included any medical interventions, and none of these five included a complete list. For three of the five, the PCP implemented the one action step assigned. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	60% 3/5	0/1	0/1	1/1	1/1	N/A	N/A	1/1	N/A	N/A

Comments: a. Each of the 18 IHCPs reviewed should have included medical interventions. Only five included any medical interventions, and none of these five included a complete list. For three of the five, the PCP implemented the one action step assigned. Individual #787's PCP did not complete the IMR required by the IHCP, and Individual #344's PCP did not monitor diagnostics in a timely manner. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

Pharmacy

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

Summary: N/R

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227

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

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.												
Summary: Improvement is needed with regard to the review of lab results, and the inclusion of related recommendations in QDRRs.			Individuals:									
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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;	71% 12/17	2/2	0/2	2/2	2/2	1/1	0/2	2/2	1/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 11/11	2/2	2/2	N/A	2/2	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:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or										

	sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.										
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	Not rated (N/R)									

Comments: b. The following problems were noted:

- On 6/18/19, Individual #344's A1c was 5.7. On 8/10/20, it was also 5.7. These values were consistent with prediabetes. The Clinical Pharmacist documented multiple elevated blood glucoses, but made no recommendation to repeat the A1c level for an individual with hypertension and hyperlipidemia who was treated with a second-generation antipsychotic (SGA).
- In both of the QDRRs submitted for Individual #112, the Clinical Pharmacist noted in the additional notes that an EKG was needed to monitor for QTc prolongation. The last was done on 4/10/20, but the Pharmacist made no formal recommendation to repeat it. The Center submitted the 4/10/20 EKG as the most recent, indicating it was not repeated for monitoring of the QTc.

  In its comments on the draft report, the State disputed this finding, and stated: "For individual #112 please note the most recent QDRR submitted for the individual was completed on 4/1/21- (TX-RI2106-II.009 RG pages 4-28). The EKG complted [sic] on 4/10/20 revealed a QTC that was not prolonged (QTc 429ms (female)). It was noted that the individual was on the same medication (Solifenacin) at the same regimen/dose when the 4/10/20 EKG was completed. The clinical pharmacist would have recommended a new EKG if it were greater than 1 year from most recent EKG, however it had not yet been 1 year since the last EKG was obtained. Additionally, the package insert does not specify a recommended EKG monitoring frequency, suggesting that lack [sic] of recommendation at the time of QDRR is not out of compliance for monitoring recommendations for Solifenacin. Also, note the individual is not on additional medications that would potentially warrant EKG monitoring. There is no indication based on previous QTc that there is an issue of concern that may warrant an EKG before 1 year."

  In the QDRRs, dated 1/12/21 and 4/1/21, the Clinical Pharmacist noted: "EKG monitoring with Solifenacin is recommended as there is a risk for increased risk for QTc prolongation. Noted 4/20/20 EKG does not suggest QTc prolongation." Moreover, the Clinical Pharmacist documented under pharmacologic risks, the association between Solifenacin and "atrial fibrillation, prolonged Q-T interval on ECG, torsades de pointes." Given that the Clinical Pharmacist found it necessary under two sections of the QDRR to comment on the risk for serious cardiac complications associated with the use of the medication, the Clinical Pharmacist should have made a recommendation regarding the frequency of EKG monitoring. At the time of the Monitoring Team's document request on 5/7/21, the EKG had not been repeated.

  In the QDRR, dated 4/1/21, the Clinical Pharmacist noted that the individual's blood glucose was 122 and previously was 148. There was no recommendation for A1c, but the PCP ordered it on 4/6/21, and it was 5.7.
- In Individual #544's QDRR, dated 4/28/21, in the recommendations section, the Clinical Pharmacist noted that the hyponatremia did not appear to be associated with medication use. The recommendation was to continue to monitor and "adding salt to diet can be considered." The Clinical Pharmacist did not document any evaluation of the hyponatremia to

support the use of adding dietary salt.

The recommendations included a comment that the individual's anemia might be associated with donepezil, but there was no actual recommendation related to evaluation of the anemia. The individual's follow-up CBC demonstrated a decrease in hemoglobin from 12 to 9.3. The Clinical Pharmacist noted that anemia is a listed possible ADR with donexepril.

In its comments on the draft report, the State disputed the finding related to the possible ADR. The Monitoring Team's response to the State's comments are provided with regard to Outcome #3 in Domain #1.

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

Dental

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

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

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1		0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #300 was edentulous and did not require formal dental goals. The Monitoring Team reviewed eight individuals who had elevated dental risks due to periodontal disease (i.e., one individual had Type III, and three had Type IV) and/or poor to fair oral hygiene. None of these individuals had clinically relevant, achievable, and measurable goals/objectives related to their dental risks.

The Monitoring Team has worked with State Office staff on this issue so that they could provide more guidance to the Centers about the development of clinically relevant goals. 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?" The causes of individuals' dental problems are different, and so the solution or goal should be tailored to the problem. As an example, the IDTs for many of the eight individuals reviewed developed goals/objectives for direct support staff (DSP) to provide daily care in accordance with the oral hygiene care plan (OHCP). Neither the goals/objectives nor the OHCPs addressed the specific reasons for the individuals' existing periodontal disease and/or oral hygiene status, and IDTs did not identify the etiology or cause of the problem. So, asking why the individuals had issues with periodontal disease and/or oral hygiene, and developing a goal/objective to address the specific "why" might have been a place to start (e.g., need for skill acquisition, increase in tolerance for staff brushing their teeth, need to floss teeth, need to follow a routine, etc.). These are the types of questions IDTs should be asking themselves when deciding upon a goal.

c. through e. Due to the lack of clinically relevant, achievable, and measurable goals/objectives, integrated progress reports with data and analysis of the data were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress, or when progress was not occurring, that the IDTs took necessary action. For eight individuals, the Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services. Individual #300 was edentulous and was part of the outcome group, so the Monitoring Team conducted only a limited review for him.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									
c. As indicated in the dental audit tool, the Monitoring Team will only score this indicator 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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	63% 5/8	1/1	0/1	N/A	0/1	0/1	1/1	1/1	1/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	88% 7/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual has had x-rays in accordance with the American Dental	63%	1/1	1/1	N/A	0/1	0/1	1/1	1/1	0/1	1/1

	Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	5/8									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 2/2	1/1	1/1	N/A	N/A	N/A	N/A	N/A	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 with these indicators, they 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 e. Individual #300 was edentulous. Five of the remaining eight individuals had not received all necessary dental treatment. The following describes concerns noted:

- Individual #344 had Type IV periodontal disease. He attended Dental Clinic for frequent cleanings and was on a three-month recall, which was appropriate, but the Center did not submit any documentation to show he received a needed deep cleaning.
- Individual #178 and Individual #78 were newly admitted and received their initial dental examinations in November 2020. For both individuals, Dental Clinic staff were unable to complete procedures to determine the extent of pocket depth, to complete prophylaxis, or to take x-rays. For both individuals, it appeared Dental staff were exploring options for sedation before considering total intravenous anesthesia (TIVA)/general anesthesia. However, based on submitted documentation, a specific plan had not been outlined for either individual.
- Individual #544 last had full mouth x-rays in 2019, but did not have bite-wing x-rays in 2020 as needed.
- Individual #227 and/or her staff did not receive twice-yearly tooth brushing instruction. Based on the documentation submitted, Dental Clinic staff provided the instruction only once, on 3/22/21.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									

Comments: a. through c. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced a dental emergency.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: For the four individuals who received suction tooth brushing, none had measurable plans/strategies in their ISPs. Going forward, IDTs will need to ensure that the measurable action plans address both the needed frequency and duration of suction tooth brushing, as well as the frequency of needed monitoring. In addition, while there was some progress noted, monthly integrated progress notes did not provide data reflective of the implementation of suction tooth brushing.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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% 0/4	N/A	0/1	N/A	N/A	0/1	N/A	N/A	0/1	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4		0/1			0/1			0/1	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	50% 2/4		1/1			0/1			0/1	1/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4		0/1			0/1			0/1	0/1

Comments: a. and b. For the four applicable individuals, the IDTs did not provide a measurable strategy for suction tooth brushing. The following describes concerns noted:

- For Individual #344 and Individual #227, the IHCP and/or the Oral Hygiene Care Plan (OHCP) referenced therein specified the frequency with which Center staff should complete suction tooth brushing, but did not specify the expected duration of tooth brushing sessions.
- For Individual #78, the Center did not develop a dental IHCP.
- Following a hospitalization for Individual #544, the IDT held an ISPA meeting on 2/9/21, to discuss a change of status with regard to his IRRF. The ISPA indicated that IDT agreed that the RNCM would contact the PCP to request an order for suction tooth brushing. Based on the documentation submitted, the IDT did not develop a specific and measurable strategy at that time or submit evidence of any revisions to the IHCP thereafter. Further, as described below, it did not appear that Center staff initiated suction tooth brushing until 5/13/21.

Going forward, because the successful implementation of these indicators requires actions by multiple disciplines, the IDT will need to ensure that the measurable action plans address both the needed frequency and duration of suction tooth brushing, as well as the frequency of needed monitoring, and clearly designate the responsible parties for the implementation of each step.

b. Based upon the respective Suction Toothbrushing Detailed Entry charts submitted for the most recent three months, Individual #344 and Individual #227 typically received suction tooth brushing twice per day, although some lapses occurred. The charts also indicated

the frequency of each session in the provision of suction tooth brushing, which varied from ten to 30 seconds in some instances, and up to two minutes in others. However, because their IDTs did not specify the required duration of the sessions, the Monitoring Team could not evaluate whether the documented frequencies met the individuals' needs. Individual #78 also typically received suction tooth brushing twice per day and most often for two minutes, but she did not have an IHCP that specified duration or frequency. For Individual #544, even though the IDT agreed to seek an order for suction tooth brushing on 2/9/21, the documentation the Center submitted (i.e., Suction Toothbrushing Detailed Entry charts for the past three months) showed Center staff provided suction tooth brushing on only two days (i.e., 5/13/21, and 5/14/21). As applicable for this group of individuals, reasons were not provided for the days/times that staff did not provide individuals with the required tooth brushing support.

c. The IHCPs for Individual #344 and Individual #227 indicated that Dental Clinic staff should perform quality assurance of the suction tooth brushing protocol annually. Based on dental IPNs, it appeared that Dental Clinic staff completed training with Center DSPs on the individuals' OHCPs, on 6/9/21, and 3/22/21 respectively. The documentation indicated that the training included an assessment of the DSP's performance. On 2/10/21, Dental Clinic staff also completed OHCP training for Individual #78, but because Center staff did not develop an action plan that prescribed the requirements for monitoring for her, the Monitoring Team could not determine if this was sufficient. The IDT for Individual #544 did not develop an action plan for monitoring and did not submit evidence that Dental Clinic staff completed OHCP training related to the initiation of suction tooth brushing. The last OHCP training documented for him occurred on 8/20/20.

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." Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. QIDP reports frequently did not include specific data with regard to the provision of suction tooth brushing. The exception was for Individual #227, for whom the QIDP recorded some, but not all, of the required 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). In addition to monitoring and reporting the data, when issues arise with regard to the implementation, monitoring and/or outcomes of suction tooth brushing, the QIDP should re-convene the IDT to discuss and make needed revisions to the strategies.

Outcome 9 – Individuals who need them have dentures.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									

	recommendation(s).										
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
	Comments: b. Based on the documentation provided, during the six months prior to the review, none of the individuals in the physical health review group required dentures.										

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: For only one out of five acute illnesses/occurrences reviewed, nursing staff followed nursing guidelines when initially assessing the individuals. It was good to see that for four of the five, nursing staff timely notified the practitioner/physician of the individuals' signs and symptoms in accordance with the nursing guidelines for notification. For two of the five, nurses did not develop acute care plans, but should have. The three acute care plans reviewed included some necessary interventions, but were missing key interventions. Nurses' implementation of the plans was incomplete. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	20% 1/5	0/1	0/1	0/1	N/R	1/1	N/R	N/A	0/1	N/R
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	80% 4/5	1/1	1/1	1/1		1/1			0/1	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/4	0/1	0/1	0/1		N/A			0/1	
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% 0/1	N/A	N/A	N/A		0/1			N/A	
e.	The individual has an acute care plan that meets his/her needs.	0%	0/1	0/1	0/1		0/1			0/1	

		0/5									
f.	The individual's acute care plan is implemented.	0% 0/5	0/1	0/1	0/1		0/1			0/1	

Comments: The Monitoring Team reviewed five acute illnesses and/or acute occurrences for five individuals, including Individual #787 – candidiasis on the abdominal fold area on 1/4/21; Individual #344 - blister on the left foot on 4/20/21; Individual #300 – urinary tract infection (UTI) on 4/3/21; Individual #78 – hospitalization from 1/17/21 to 2/4/21 for bilateral bacterial pneumonia, and hypoxia with respiratory failure; and Individual #544 – bilateral acute conjunctivitis on 12/2/20.

a. The acute illness/occurrence for which initial nursing assessments (physical assessments) were performed in accordance with applicable nursing guidelines was for Individual #78 – hospitalization from 1/17/21 to 2/4/21 for bilateral bacterial pneumonia, and hypoxia with respiratory failure.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol entitled: "When contacting the PCP" were: Individual #787 – candidiasis on the abdominal fold area on 1/4/21; Individual #344 - blister on left foot on 4/20/21; Individual #300 – UTI on 4/3/21; and Individual #78 – hospitalization from 1/17/21 to 2/4/21 for bilateral bacterial pneumonia, and hypoxia with respiratory failure.

e. For the following acute issues, nurses should have developed acute care plans, but they did not: Individual #344 - blister on left foot on 4/20/21, and Individual #300 – UTI on 4/3/21.

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

- In an IPN, dated 1/3/21, at 8:45 a.m., a nurse documented that Individual #787 had redness on the right side of her stomach fold. The nurse did not follow the skin integrity nursing guidelines, which require measurements of the skin integrity issue. Measurements are necessary to allow determination of whether or not treatment/medications are effective. On 1/4/21, at 12:04 p.m., a provider saw the individual in sick-call.

  On 1/4/21, at 3:59 p.m., nursing staff initiated an acute care plan. It included many of the necessary interventions. Missing was any assessment for pain or discomfort. In addition, the intervention included for the assessment of the abdominal fold did not instruct nurses to take and document measurements of the rash. Based on review of a sample of documentation, nurses did not consistently implement the interventions, such as the completion of vital signs. In addition, nurses did not provide measurements, so it was unclear whether the rash was improving, staying the same, or getting worse. On 1/20/21, nursing staff closed the acute care plan, but again, without measurements, it was not clear that the skin integrity issue was resolved.
- According to an IPN, dated 4/20/21, at 2:19 p.m., Individual #344 was seen in sick call for a blister on the small toe of his left foot. Nursing staff did not follow nursing guidelines, including documenting the dynamic location of the skin integrity issue, and full measurements (i.e., length and width were included, but height of the blister was missing). Nurses did not develop an acute care plan. Based on review of follow-up documentation, nurses also did not follow the skin integrity nursing guidelines for ongoing assessments. Nursing staff described the blister as filled with old blood and intact, unruptured. They documented that he was on a blood thinner, and that he wore his heel protectors. They also assessed pain. However, they did not provide weekly measurements, including length, width, and height of the blister.

- On 3/31/21, at 2:00 a.m., a Registered Nurse (RN) noted that a Licensed Vocational Nurse (LVN) reported a blood stain in Individual #300's diaper. In the documents submitted, a corresponding assessment from the LVN was not found. The RN placed the individual on the sick-call list for the morning. On 4/3/21, the individual received the first dose of antibiotic for treatment of a UTI. Nursing staff did not implement an acute care plan. It was positive, though, that nurses followed the guidelines for ongoing assessments for a UTI and antibiotic treatment.
- According to an IPN, dated 1/18/21, at 12:23 a.m., a nurse documented that at 10:15 p.m., on 1/17/21, DSP staff called the nurse to report that Individual #78 was not acting like herself. The nurse assessed her, and reviewed the record that showed the individual accepted her evening medications, but refused to eat dinner. The nurse instructed DSPs to continue to monitor her, and notify the nurse of any changes. At 10:30 p.m., a DSP called the nurse and reported the individual was thrashing about in bed and making a grunting sound. The nurse took the individual's vital signs, which showed a blood pressure of 117/48, pulse of 60, oxygen saturation of 69%, and respirations of 22. The nurse left a message for the on-call PCP. At 10:45 p.m., prior to calling the on-call PCP, the nurse called 911 for emergency transfer. Based on the individual's signs and symptoms, the nurse was prudent in her decision to call 911. The home nurse called the Infirmary nurse, and placed the individual on the non-breather mask at 15 liters (L). The nurse continued to monitor the individual, and found the individual's oxygen saturation was 80%. The individual remained lethargic. At 11:15 p.m., emergency medical services (EMS) staff arrived and initiated transfer to the hospital, where she was admitted with bilateral bacterial pneumonia.

  On 2/4/21, the individual returned to the Center. In assessing the individual, nursing staff documented a sacral pressure injury measuring 2 centimeters (cm) long by 1 cm wide. The nurse did not document the dynamic location, depth, or the stage of the pressure injury.

  On 2/5/21, at 1:31 a.m., nursing staff initiated an acute care plan. Although it included some necessary interventions, some were not measurable (e.g., the pain assessment scale was not identified, and a frequency was not stated for monitoring for signs and symptoms of respiratory distress or changes in health status).

  Based on a review of a sample of follow-up assessments, it was positive that nurses completed vital sign and oxygen saturation assessments, as well as lung sound assessments. However, based on IView entries, nurses did not document measurements of the pressure injury, information about the wound edge, descriptions of the wound bed tissue, whether or not exudate was present or pressure point, or if a dressing was present On 4/14/21, nurses discontinued the acute care plan, but on 4/22/21, at 4:14 p.m., a wound assessment noted the wound was still active, with a length of 2.3 cm, width of 0.7 cm, and depth of 0.3 cm. The wound was being cleaned with Vashe solution and Medi-Honey applied.
- In an IPN, dated 12/2/20, at 1:01 p.m., an RN documented that at 9:00 a.m., the on-duty LVN reported that Individual #544's left eye was red with mild drainage. No evidence was found to show that the LVN completed an assessment. The RN's plan did not include notification of the PCP or placement of the individual on the sick-call list. Rather, it appeared the plan was to give verbal report to the oncoming nurse with follow-up as indicated.

  The PCP saw the individual in sick-call, diagnosed him with bilateral blepharitis, and prescribed ophthalmic Gentamicin for seven days, every four hours while awake, bilaterally; contact precautions, and CuSoft eyelid scrubs. The acute care plan included some of the necessary interventions. However, nurses did not include interventions in alignment with the nursing

guidelines for the administration of a new medication.

Based on a review of IView entries, and IPNs, nurses did not conduct assessments on each 12-hour shift. For example, on 12/6/20, nurses did not complete and/or document vital sign or pain assessments; and on 12/7/20, assessments were only documented on one shift.

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 develop goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their at-risk conditions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/12	0/2	0/2	0/2	N/R	0/2	N/R	0/2	0/2	N/R
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	8% 1/12	0/2	1/2	0/2		0/2		0/2	0/2	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	
d.	Individual has made progress on his/her goal/objective.	0% 0/12	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% 0/12	0/2	0/2	0/2		0/2		0/2	0/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #787 – circulatory, and falls; Individual #344 – constipation/bowel obstruction, and weight; Individual #300 – respiratory compromise, and skin integrity; Individual #78 – skin integrity, and seizures; Individual #264 – constipation/bowel obstruction, and cardiac disease; and Individual #544 – infections, and skin integrity).

IDTs developed clinically relevant, achievable, and measurable goals for none of these risk areas. In other words, IDTs did not identify activities in which individuals needed to engage or skills that they needed to learn to improve their health (e.g., exercise to lose weight and/or improve cardiac health, learn to wash their hands or apply cream to dry skin to reduce the risk for skin infections, elevate their legs at specific intervals throughout the day to reduce edema, make specific diet modifications to reduce GERD, drink a specific amount of fluid per day to prevent constipation, etc.), and then, develop goals/objectives/SAPs to measure individuals' progress with such activities or skill acquisition.

Although the following goal/objective was measurable, because it did not reflect a clinically relevant action the individual could take to reduce his risk, the related data could not be used to measure the individual's progress or lack thereof: Individual #344 – weight.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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 six 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 sufficiently address individuals' at-risk conditions, and many of those included were not measurable. Even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, IDTs often did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 787	344	300	178	78	112	264	544	227
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% 0/11	0/2	0/1	0/2	N/R	0/2	N/R	0/2	0/2	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	0/2	N/A	0/2		0/2		0/1	0/2	
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/11	0/2	0/1	0/2		0/2		0/2	0/2	

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. Although, at times, nurses implemented some of the interventions, for most, documentation did not support consistent implementation. As noted above, Individual #344's IHCP for weight included no nursing interventions, but should have.

At times, this lack of implementation potentially contributed to poor outcomes for individuals. For example:

- Individual #300's IHCP for skin integrity called for nursing staff to complete a weekly skin integrity check. Based on review of IView entries, in November and December 2020, nursing staff did not complete these weekly checks. However, the individual

had a number of skin issues, one of which was likely the initial stage of a pressure injury. More specifically, nurses documented the following skin issues:

- On 11/3/20, a nurse noted a facility-acquired abrasion with a length of 1.2 cm, a width of 2.5 cm, and depth of 0 on the individual's sacral area
- On 11/30/20, a nurse noted cellulitis at the individual's tracheostomy stoma.
- On 12/15/20, a nurse noted cellulitis at the sacral wound area.
- On 12/18/20, a nurse noted a facility-acquired abrasion with a length of 4.0 cm, width of 2.0 cm, and depth of 0.1 cm to the individual's sacral area.
- On 3/18/21, the individual was diagnosed with a Stage 3 sacral pressure injury with a length of .7 cm, width of .5 cm, and depth of .1 cm.
- By 5/5/21, notes indicated that the pressure ulcer continued to deteriorate with a red rash around the wound that was blanchable.

A significant problem was the lack of measurability of the supports. For example, some of the individuals' IHCPs called for nursing physical assessments, but the IHCPs did not define the frequency (e.g., every shift, every day, each Friday, on the first day of the month, etc.). In other instances, broad terminology resulted in interventions that were not measurable, such as "assess, intervene, document, and notify PCP as needed of pertinent findings." As a result, it was difficult, if not impossible, to identify in IView entries and IPNs whether or not and where nurses had documented the findings from the interventions/assessments included in the IHCPs reviewed.

b. As illustrated below, a continuing problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of conditions that placed individuals at risk. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- From January through March 2021, Individual #787 experienced elevations in her blood pressure and heart rates. No evidence was submitted to show that the IDT reviewed these issues, reviewed her IHCP or its implementation, and/or made changes as needed.
- In November/December 2020, Individual #787 had three falls in 25 days (i.e., 11/8/20, 11/13/20, and 12/3/20). No evidence was submitted to show that the IDT reviewed these falls, reviewed her IHCP or its implementation, and/or made changes as needed.
- On 2/12/20, 5/18/20, and 10/19/20, Individual #300 successfully removed his tracheostomy, which can result in respiratory distress. From 5/18/20 to 6/18/20, he was hospitalized for bilateral pneumonia, and hypoxia. On 6/26/20, and 6/29/20, he unsuccessfully attempted to remove his tracheostomy. Evidence was not found to show that the IDT developed and implemented interventions to address the individual's continued attempts to remove the tracheostomy, and to review and revise them, as needed.
- As discussed above, Individual #300 developed a Stage 3 sacral pressure injury. On 12/28/20, the IDT held an ISPA meeting to discuss the schedule for wound care. The IDT discussed that the individual had a "sacral abrasion." The recommendations included: sacral wound being treated with Prisma and covered with Aquacel , and daily schedule adjusted to 6 p.m. to 8 p.m. up in wheelchair. The IDT did not review an acute care plan, or the IHCP. The IDT did not discuss the wound staging or the size of the "sacral wound abrasion." On 3/18/21, the individual was diagnosed with a Stage 3 sacral pressure injury with a length of

.7, width of .5, and depth of .1. By 5/5/21, notes indicated that the pressure ulcer continued to deteriorate with a red rash around the wound that was blanchable.

- According to Tier I documents, on 11/25/20, Individual #78 was diagnosed with a Stage 3 sacral decubitus ulcer. On 12/17/20, a medical progress note indicated that the individual had a curvilinear intergluteal cleft wound that measured about 2 cm in length. The assessment/plan indicated that it was possible that this old wound "re-opened due to wheelchair use." On 1/26/21, she was diagnosed with a Stage 3 hospital-acquired pressure injury. Based on the ISPAs submitted, the IDT did not meet to discuss the wounds identified on 11/25/20, or 12/17/20. In the submitted ISPAs, the first reference to skin integrity was dated 2/1/21, at which time, the IDT discussed a hospital report that noted she had a "Midline sacral stage 2 gauze apply." On 2/22/21, the IDT held a change-of-status (CoS) ISPA meeting for her hospitalization from 1/17/21 to 2/6/21. For skin integrity, the IDT increased her risk rating from medium to high due to the current Stage 3 pressure injury. However, the IDT did not review an acute care plan or the IHCP. The IDT did not discuss her multifactorial risks related to skin integrity, such as a change in her Braden Score, mobility, positioning, her ongoing chronic problem with overactive bladder, use of pull-ups, or the plan for monitoring and reporting measurable progress related to her Stage 3 wound.
- On the following dates, Individual #78 experienced seizures:
    - 11/25/20, at 5:00 a.m., for10 seconds; and 8:00 a.m. for four minutes, and at 1:21 p.m. for one minute. Nursing staff administered Diastat. It was determined that the individual was impacted;
    - 12/6/20, two seizures, lasting three minutes, requiring the use of Diastat;
    - 12/7/20, for 45 seconds;
    - 1/4/21, transferred to the ED due to recurrent seizures (i.e., five episodes);
    - 2/19/21;
    - 3/11/21; and
    - 3/16/21, two seizures requiring the use of Diastat.

  Based on the ISPAs submitted, prior to 2/22/21, the IDT did not meet to address her seizures, the use of Diastat, and/or the associated findings of constipation, and impactions associated with her seizures.
- On 3/21/21, Individual #264's PCP increased the dose of one medication and added a blood pressure medication due to uncontrolled blood pressure. On 3/10/21, she also had an abnormal electrocardiogram (EKG). However, based on the ISPAs submitted, her IDT did not hold a CoS meeting. No evidence was submitted to show that the IDT reviewed her IHCP or its implementation, and/or made changes as needed. The IHCP was deficient in a number of ways, but, for example, included no preventative interventions.
- Individual #544's IHCP for infections, dated 10/29/20, did not meet his needs. It included five interventions assigned to nursing staff. None of them were measurable (e.g., evaluate hydration status; evaluate vital signs, pain, skin, and oxygen saturation without any frequency listed). He experienced the following infections: 12/2/20 to 12/9/20 – conjunctivitis; hospitalization from 1/20/21 to 2/6/21 for dyspnea, sepsis, elevated troponin, pneumonia, COVID-19 positive, hypernatremia, and bacteremia with MRSA; and 3/19/21 - post hospital cellulitis at G-tube site with MRSA. Although the IDT held a number of ISPA meetings and increased his infections/skin integrity risk ratings to high on 2/5/21, no evidence was submitted to show that the IDT reviewed his IHCP for infections or its implementation, and/or made changes to make needed improvements.
- Similarly, Individual #544 had ongoing skin integrity issues, including on 3/19/21 - cellulitis of the G-tube site with MRSA; 3/27/21 - Stage 3 coccyx pressure injury; 4/22/21 - Stage 3 right ankle pressure injury non-healing with MRSA; and 4/29/21 - dermatitis of the chin. Again, the IDT met on a number of occasions, and, at times, recommended additional interventions, such

as two-hour repositioning, and checks. However, the IDT did not use data (e.g., Braden scores and screening information, which can be a predictor of skin issues), and conduct analyses to the depth necessary to identify potential underlying causes of his ongoing skin issues, and/or make modifications to his IHCP, which did not meet his needs.

Outcome 7 – Individuals receive medications prescribed in a safe manner.											
Summary: Given that for at least three reviews, nurses generally followed individuals' PNMPs during medication observations, and the Center had a system for self-auditing (Round 15 – 100%, Round 15 – 88%, and Round 16 - 100%), Indicator f will move to the category requiring less oversight. Areas that require focused efforts are improvement in medication nurses' adherence to infection control procedures, as well as the inclusion in IHCPs of respiratory assessments for individuals with high risk for respiratory compromise that are consistent with the individuals' level of need, and the implementation of such nursing supports.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	448
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	33% 1/3	N/A	N/A	1/1	N/A	0/1	N/A	N/A	0/1	N/A

	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	40% 2/5	N/A	N/A	1/2	N/A	0/1	N/A	N/A	1/2	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	38% 3/8	1/1	1/1	0/1	0/1	0/1	1/1		0/1	0/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 5/5	N/A	N/A	1/1	1/1	1/1	N/A		1/1	1/1
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 5/5	N/A	N/A	1/1	1/1	1/1	N/A		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									

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

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #787, Individual #344, Individual #300, Individual #178, Individual #78, Individual #112, Individual #544, and Individual #448 (i.e., a substitution for Individual #227, who was in the hospital at the time of the review).

d. For the individuals reviewed, the Monitoring Team identified some concerns related to necessary respiratory assessments. The following provide examples of the Monitoring Team's findings:

- Individual #300 was at high risk for respiratory compromise. He received enteral medications. His IHCP required nurses to complete lung sound assessments with each medication administration. Based on review of a sample of records, nurses completed these assessments consistently, including before and after respiratory inhalation medications. However, during the medication administration observation, the medication nurse did not complete the assessment. A Center staff member reported the PCP changed the care order. When requested, documentation showed the PCP made this change the Friday before the Monitoring Team's review. The IHCP submitted continued to include the intervention for lung sound assessments before and after medication administration. Based on the submitted documents, the IDT had not modified the intervention, but when they do, they need to do it in a way that addresses this individual's continuing high risk.
- Individual #78's IDT rated her at high risk for aspiration/respiratory compromise. From 1/17/21 to 2/1/21, she was hospitalized for bacterial pneumonia, hypoxia, and respiratory failure requiring oxygen therapy, and intravenous (IV) antibiotics. Her IHCP included no interventions for lung sound assessments.
- Individual #544 was at high risk for respiratory compromise. He was hospitalized from1/20/21 to 2/6/21 with COVID-19 pneumonia, and on 2/5/20, he had a G-tube placed. His IHCP included an intervention for nurses to check lung sounds before and after the 7 a.m., and 7 p.m. medication passes and also as needed. Center staff did not submit IView entries for him for the months of February through April 2021, so the Monitoring Team could not confirm whether or not nurses regularly conducted these assessments. It was positive, though, that during the medication administration observation, after the individual coughed, the nurse listened to his lung sounds.

f. It was positive that during the observations, medication nurses followed the individuals' PNMPs, including checking the positions of the individuals prior to medication administration.

g. For the individuals observed, nursing staff often did not follow infection control practices. It was positive that in each instance, when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following provide examples

of concerns the auditor identified and addressed:

- For Individual #300, the medication nurse did not follow the hand hygiene protocol, and did not thoroughly sanitize the pill crusher.
- For Individual #178, the medication nurse did not use hand sanitizer between glove exchanges.
- For Individual #78, the medication nurse did not follow the hand hygiene protocol, touched her mask without follow-up with hand sanitizer, and did not sanitize the bins.
- For Individual #544, the medication nurse engaged in glove use practices that potentially caused cross contamination, and set and the pill crusher on an non-sanitized surface of the cart.
- For Individual #448, the medication nurse handled a paper copy of the PNMP, but did not use hand sanitizer before engaging in the next task. In addition, after using keys to unlock the medication cart, the nurse did not use hand sanitizer.

Physical and Nutritional Management

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

Summary: At times, when needed, IDTs did not refer individuals to the PNMT and/or the PNMT did not conduct a review. Some improvement was noted with IDTs' development of goals/objectives that reflected clinically relevant actions that the individuals could take to reduce their PNM risks. However, much more improvement was needed. As a result, overall, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, or when progress was not occurring, that the IDTs took necessary action. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
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;	25% 3/12	1/2	1/2	N/A	0/1	N/A	0/2	1/2	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/2	0/2		0/1		0/2	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		0/2	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		0/2	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		0/2	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;	50% 3/6	N/A	N/A	1/2	1/1	0/2	N/A	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	0/2			0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6			0/2	0/1	0/2			0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6			0/2	0/1	0/2			0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/6			0/2	0/1	0/2			0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6			0/2	0/1	0/2			0/1	

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #787 - falls, and choking; Individual #344 – fractures, and choking; Individual #178 - choking; Individual #112 – choking, and falls; Individual #264 - choking, and falls; Individual #544 – skin integrity; and Individual #227 – aspiration, and falls.

a.i. and a.ii. The IHCPs that included clinically relevant, and achievable goals/objectives were for: Individual #787 – choking (i.e., allow three- to five-second pause between each bite), Individual #344 –choking (i.e., chew and swallow food before taking another bite; and eat ground texture at moderate pace with two prompts), and Individual #264 - choking (i.e., swallow food 100% of time before taking the next bite of food with no more than one to two prompts).

This showed some improved thinking about the potential causes of the individuals' risks related to choking and the strategies to address them. IDTs should continue to individualize the goals/objectives and provide data to support the need for a SAP or strategies in a specific area(s). As indicated in previous reports, based on monitoring results, IDTs should ask themselves questions such as was the individual or staff not cutting the food to the proper diet texture, was the individual not adhering to specific "dining techniques" designed to slow his/her rate of eating, and/or did the individual (or staff) not position him/herself properly for safe eating? Depending on the findings, the IDT could then individualize the goal/objective to work on improvements in the specific prioritized area(s) in order to mitigate the risk to the extent possible. Analysis of such data should be included in the IRRF to support the goals/objectives that the IDT considered and agreed upon.

b.i. The Monitoring Team reviewed six areas of need for four individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included those for: Individual #300 – aspiration, and skin integrity; Individual #178 – fractures; Individual #78 – weight, and skin integrity; and Individual #544 – aspiration.

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

- On 3/28/21, Individual #300 was diagnosed with a Stage 3 sacral pressure injury. Based on documentation submitted, the PNMT did not conduct a review and/or assessment.
- Between 1/10/21 (109 pounds) and 2/8/21 (95.60 pounds), Individual #78 lost 13.4 pounds (i.e., 12%). Her IDT made no referral to the PNMT, and no evidence was submitted to show that the PNMT reviewed this issue.
- On 12/17/20, nursing staff documented that Individual #78 had a crack in her intergluteal cleft, which was reported to be a reopening of a previous wound. Staff initially did not believe that it was a pressure wound. By 1/25/21, Center documentation showed she had a Stage III sacral wound. The IDT did not refer the individual to the PNMT, and the PNMT did not make a self-referral.

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. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, QIDP integrated monthly reports often did not provide specific data related to the goal/objective, but rather made broad statements about the risk area (e.g., no choking incidents, x number of falls, etc.). As a result, it was difficult to determine whether or not individuals were making progress with regard to taking steps to improve their chronic or at-risk conditions, 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. The few PNM action steps that were included often 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	787	344	300	178	78	112	264	544	227
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	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	for completing the action steps.										
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/9	0/1	N/A	0/2	0/1	0/2	N/A	0/1	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.	N/A									

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of the action steps.

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

- Between 11/8/20 and 1/3/21, Individual #787 fell at least four times. Based on the ISPAs submitted, the IDT did not meet to discuss these falls, or to review and revise her IHCP, as needed. As illustrated elsewhere in this report, the IHCP included none of the necessary components.
- According to an ISPA, dated 12/18/20, the IDT noted that Individual #300 had a "sacral abrasion." They briefly discussed his current treatment, agreed to add protein to his diet, and determined that he would benefit from a better mattress, which staff would order and he would use a loaner until it arrived. They adjusted his schedule to add time up in his wheelchair from 6 p.m. to 8 p.m. The IDT engaged in/documented no other discussion related to the etiology of the skin integrity issue, or a clear plan for future prevention. By 3/28/21, the individual was diagnosed with a Stage 3 sacral pressure injury and bilateral pneumonia. In the submitted documentation, no evidence was found to show that the PNMT conducted any review or even acknowledged this pressure injury.
- On 11/10/20, at 7:31 p.m., staff found Individual #178 on the floor in his bedroom. The individual said that he fell. On 11/12/20, the IDT met to discuss this recent fall. More specifically, on 11/2/20, the IDT had reduced his level of supervision (LOS) from one-to-one to enhanced with 15-minute checks. On 11/5/20, they further reduced it to enhanced with one-hour checks. On 11/10/20, when staff found him on the floor, he had passed stool and urinated on his bed and the floor. He stated that his leg hurt when staff assisted him to stand. Later that night, he wet his bed twice, and staff prompted him to get up and use the restroom. Staff reported that he cried most of the night. On the morning of 11/11/20, staff prompted him to get up so they could assist him to clean up, because he had again "toileted on himself." He began to rip off his shirt. Less than an hour later, he complained about his knee hurting and he wet the bed again. Since the fall, he complained of knee pain and refused to walk. The PCP wrote an order that he could use a wheelchair as needed. According to the PT, the wheelchair was in use and staff were to push him in it. On 11/11/20, an x-ray of the right knee showed no acute fracture. The PT reported that the individual was hesitant to bear weight on his right leg. The PT added PNMP instructions for use of the wheelchair for mobility, as needed. On 11/12/20, the PCP wrote an order for 800 milligrams (mg) of Ibuprofen for knee pain for three days. Reportedly, the individual was sad, missed his parents, and had several toileting accidents. The IDT requested a counseling evaluation.

  On 11/13/20, he was sent to the ED. He was diagnosed with a right femoral shaft fracture. After ORIF surgery on 11/14/20, he

was transferred to a rehabilitation facility for inpatient rehabilitation. On 11/16/20, the IDT met again. On 11/30/20, he was discharged back to the Center due to limited progress, and was admitted to the Infirmary. On 12/1/20, the IDT met. They discussed a PNMP update, including his non weight-bearing status; use of the wheelchair for mobility; the need for bed baths until the PT assessed him for a shower chair; that he should be seated for grooming and oral care, and he should be in the bed for dressing; he could eat upright in bed or sitting on edge of bed; and he required a hospital bed with elevation. The IDT was considering transferring the individual to an alternate home when he was discharged from the Infirmary. He had a sitter with him in the Infirmary. Assessments were pending his return home. By 12/3/20, the RNCM was to update the IRRF. The IDT agreed to direct PT three to five times a week, focusing on strengthening until he could bear weight.

According to PNMT minutes, on 12/1/20, the caseload PT first saw him for an assessment. The minutes also indicated that the PNMT scheduled a meeting with the IDT on 12/11/20, to discuss PNM supports. Although a PNMT IPN referenced a meeting with the IDT to discuss his PNMP on 12/11/20, based on the ISPAs submitted, there was no evidence that this meeting occurred.

The PNMT stated that on 12/17/20, the IDT met again and decided to keep the individual in the Infirmary through 1/3/21, to meet his PNM and nursing needs. The PNMT stated: "will close the follow-up and defer to IDT." No evidence was found of further PNMT follow-up. Based on the ISPAs submitted, the IDT held no further meetings until 1/29/21, when he was transferred to a regular home. No evidence was found to show that the IDT modified the goals or interventions in the IHCP post-fracture to address his immediate needs and/or future prevention of additional falls/fractures. Moreover, there was no evidence of an acute care plan related to this fracture upon his return to the Center on 11/20/20, or any time subsequent, such as when he returned to a regular home, or in March, when he returned to his original home.

- Between 1/10/21 (109 pounds) and 2/8/21 (95.60 pounds), Individual #78 lost 13.4 pounds (i.e., 12%). Her IDT made no referral to the PNMT, and no evidence was submitted to show that the PNMT reviewed this issue. In addition, based on review of ISPAs, no evidence was found to show the IDT discussed this weight loss.
- On 12/17/20, nursing staff documented that Individual #78 had a crack in her intergluteal cleft, which was reported to be a reopening of a previous wound that scabbed over, and reopened due to wheelchair use. Staff initially did not believe that it was a pressure wound. On 12/18/20, the PCP ordered bedrest for 10 days, and placed a limit on her time in the wheelchair to two hours at a time. Nursing staff were to notify provider if "decubitus" worsens. The PCP made a referral to the PT to look at the individual's wheelchair. On 12/22/20, they suspended direct PT due to her quarantine status. On 12/22/20, nursing staff stated that the wound was intact and dry, and covered with a scab. On 12/30/20, the area remained open, with a note that "problem not resolved." On 1/18/21, she was sent to ED due to an O2 saturation of 69%. On 1/27/21, a note stated that the IDT was notified of the hospital report that identified a "midline sacral stage 2 [pressure injury] gauze applied…" On 2/5/21, staff provided measurements of the sacral pressure injury. On 2/10/21, a PCP addendum identified a Stage 3 sacral pressure injury, hospital-acquired. The IDT did not refer the individual to the PNMT, and the PNMT did not make a self-referral. On 3/4/21, notes indicated that the sacral wound was not heal welling and was enlarging. There was still no referral to the PNMT. Given her multiple issues, the PNMT should have conducted a comprehensive assessment.
- On 4/20/21, Individual #264 fell in the bathroom and sustained a laceration to the back of her head, as well as a head injury, resulting in placement in the ICU with intubation and mechanical ventilation. On 4/29/21, the individual passed away before the IDT could make a referral to the PNMT. As illustrated elsewhere in this report, her IHCP for falls included none of the

components necessary for a quality IHCP, and it did not meet her needs. On 5/10/21, the IDT held an ISPA meeting to discuss the fall that resulted in this serious injury, and the resulting Unusual Incident Report (UIR). This ISPA identified ongoing problems with the slippery nature of the shower areas in this individual's home. For example, the IDT documented an update, dated 5/12/21, which stated that the Residential Coordinator "followed up with staff to see if we are still having issues in the bathrooms during showering and the staff reported the following: Bathroom floor [sic] are still very slippery and they have to put towels on the floor to help with how wet the floors get. They also reported it gets very foggy in there when bathing… Staff did report that the anti-slip agent helped some, but not very much. This is concerning due to the individual on the waiting list for [name of home] does not use a shower chair and she showers with minimal support. This poses a fall risk for any of the ladies that walk to/from the showering area…"

- On 2/8/21, Individual #544 was referred to the PNMT due to the placement of a new gastrostomy tube (G-tube). However, on 2/10/21, he returned to the hospital, and did not return to the Center until 3/19/21. On 3/24/21, the PNMT made a self-referral. On 4/23/21, the PNMT completed a comprehensive assessment. The PNMT offered no recommendations related to the prevention of aspiration, only that his supports were reviewed and were found effective in mitigating his risk associated with the new G-tube placement. The individual also lost weight and had pressure injuries on his ankle and coccyx. The PNMT did not address his weight loss or pressure injuries. As illustrated elsewhere in this report, the individual's IHCPs for skin integrity and aspiration were missing most of the necessary components. The IDT did not make changes to correct these deficiencies with the IHCPs.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Based on observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. With regard to Dining Plan implementation, often, the errors that occurred (e.g., staff not intervening when individuals took large bites, ate while in hyperextension, and/or ate at an unsafe rate) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs correctly or effectively (e.g., competence, accountability, need for skill training for individuals, etc.), and address them. With regard to positioning, as described in further detail below, during the review week, the Monitoring Team member talked with the Habilitation Therapy Director, and the State Office Discipline Lead about the ongoing concerns related to positioning and seating across campus. The State Office Discipline Lead indicated	

that State Office was developing a plan to assist Center staff with assessment and perhaps some additional focus on wheelchair design. This is an urgent need. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	38% 17/45	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	N/R	

Comments: a. The Monitoring Team conducted 45 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during nine out of 20 observations (45%). Staff followed individuals' dining plans during seven out of 24 mealtime observations (29%). Staff completed transfers correctly during one out of one observation (100%).

The following provide more specifics about the problems noted:

- With regard to Dining Plan implementation, the great majority of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk, for example, when staff did not intervene when individuals took large unsafe bites, or ate at too fast a rate, or staff sat on the wrong side of the individual resulting in the individual turning his/her head, or staff presented food while the individual's head was in hyperextension. In about 30% of the observations, positioning concerns were noted with staff and/or the individuals. It was good to see that during all observations, texture/consistency was correct, and that with one exception, adaptive equipment was correct. The following describe additional problems noted:
  - In one case, staff was using a Dining Plan from 2019. It was unclear how this would happen if the necessary checks and balances were in place.
  - Therapists should consider reevaluating some individuals to determine if they can participate more in mealtimes by even closing their mouth on the spoon or cup.
  - A number of the tables appeared too high for some people and/or the chairs they were seated in were too low. The Monitoring Team has raised this concern in the past at Richmond SSLC, and it still requires attention.
- With regard to positioning, it was positive that for all of the observations, necessary adaptive equipment/supports were present. The problems varied, but the most common problem was that individuals were not positioned correctly. In about 25% of the observations, staff had not used equipment correctly.

During the review week, the Monitoring Team member talked with the Habilitation Therapy Director, and the State Office Discipline Lead about the ongoing concerns for positioning and seating across campus. The State Office Discipline Lead indicated that State Office is developing a plan to assist Center staff with assessment and perhaps some additional focus on wheelchair design. Given the number of individuals that this impacts, the provision of quality seating that meets individuals' needs should be an important focus. There is the added concern of the significant occurrence and reoccurrence of pressure

injuries. There is always the possibility that individuals' wheelchairs might be contributing to that problem. This is an urgent need.

- For the one transfer observed, staff followed proper procedures.

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	787	344	300	178	78	112	264	544	227
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. None.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: While some individuals reviewed had clinically relevant goals/objectives to address their needs for formal OT/PT services, most were not fully measurable. In addition, QIDP interim reviews generally 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	787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	23% 3/13	N/A	0/1	0/1	1/4	0/1	0/1	0/1	2/2	0/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	8% 1/13		0/1	0/1	0/4	0/1	0/1	0/1	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/13		0/1	0/1	0/4	0/1	0/1	0/1	0/2	0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/13		0/1	0/1	0/4	0/1	0/1	0/1	0/2	0/2

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/13		0/1	0/1	0/4	0/1	0/1	0/1	0/2	0/2

Comments: a. and b. Individual #787 was independent with motor skills and activities of daily living (ADLs) and did not have needs requiring formal OT/PT goals/objectives, but she did require OT/PT-related supports (e.g., a PNMP). The remaining eight individuals did have needs requiring formal OT/PT goals/objectives.

The goal/objective that was both clinically relevant and measurable was for Individual #544 (i.e., within eight weeks, propel wheelchair three to five feet). The following describes the goals/objectives that were clinically relevant but did not meet criteria for measurability:

- One of Individual #178's goals/objectives (i.e., ambulate ~200 feet independently safely). However, the goal/objective was not measurable because it did not state criteria for achievement (e.g., for five consecutive sessions by date) or provide a clear definition of what would constitute "safely."
- Individual #544's goal/objective to push up on his wheelchair armrests to shift weight or reposition himself. It was not measurable because it did not specify the required prompt level (i.e., independent, verbal prompt, physical prompt, etc.).

Overall, none of the remaining goals/objectives were fully measurable. In addition, IDTs did not integrate the goals/objectives into the individuals' ISPs/ISPAs. This was an important missing piece to ensure that an individual's IDT was aware of OT/PT goals/objectives, and the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan. Integration of goals/objectives into the ISP/ISPA remains a key requirement overall.

c. through e. Although therapists' IPNs sometimes provided information to show they implemented goals/objectives, 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. This also made it difficult for the IDTs to understand how the achievement of a therapy goal might impact the overall implementation of the individuals' ISPs, including their other action plans. The Monitoring Team conducted full reviews for all nine individuals, including Individual #787, who did not require formal OT/PT interventions, but did have OT/PT-related supports.

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	787	344	300	178	78	112	264	544	227
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP	0% 0/6	N/A	N/A	N/A	0/1	0/2	0/1	N/A	0/1	0/1

	meeting, then an ISPA meeting is held to discuss and approve the change.										

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 OT/PT needs were implemented. As described above with regard to Outcome 1 and Outcome 3, although therapists' IPNs sometimes provided evidence of implementation of formal therapy goals/objectives, most goals/objectives were not fully measurable and none were included in the individuals' ISPs/ISPAs. ISPs and ISPAs sometimes indicated that Center staff would implement OT/PT goals/objectives, but did not incorporate the specific goals/objectives. As a result, Indicator a was not applicable. OTs and PTs should work with IDTs to ensure that goals/objectives, including formal therapy plans, meet criteria for measurability and are integrated in individuals' ISPs through a specific action plan.

b. Similarly, QIDPs and OTs/PTs should work together to ensure that IDTs meet to consider termination of goals/objectives. For the five applicable individuals, their IDTs did not meet as needed to discuss and approve termination of their goals/objectives.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 15 – 65%, Round 16 – 71%, and Round 17 - 35%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	570	743	640	276	776	598	780	677	684
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	35% 9/26	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
		Individuals:									
#	Indicator		27	777	4	117	232	429	428	241	230
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	0/1	1/1	0/1	0/1	N/A	0/1	0/1	0/1
		Individuals:									
#	Indicator		538	592	399	635	402	300	477	544	125

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	0/1	0/1	N/A	1/1	0/1	0/1
#	Indicator	Individuals:									
			178								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1								

Comments: c. The Monitoring Team conducted remote observations of 28 pieces of adaptive equipment. Based on remote observations, for 17 individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

During the review week, the Monitoring Team member talked with the Habilitation Therapy Director, and the State Office Discipline Lead about the ongoing concerns for positioning and seating across campus. The State Office Discipline Lead indicated that State Office was developing a plan to assist Center staff with assessment and perhaps some additional focus on wheelchair design. Given the number of individuals that this impacts, the provision of quality seating that meets individuals' needs should be an important focus. There is the added concern of the significant occurrence and reoccurrence of pressure injuries. There is always the possibility that individuals' wheelchairs might be contributing to that problem. This is an urgent need.

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 skill acquisition, dental, and communication. At the last review, two indicators were in the category of requiring less oversight. At this review, no additional indicators were added to this category.

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

For SAPs, reliable data for most SAPs allowed for the Monitoring Team to assess progress. About three-fourths of the SAPs were progressing. SAPs were moved to the next step or objective when met, and actions were taken for the one SAP that was not progressing.

SAP content was fully met for more than half of the SAPs. Three-fourths of SAPs were implemented as written. SAP integrity was assessed regularly for most SAPs. Three fourth of SAPs were reviewed monthly.

More than half of the individuals were regularly engaged in activities when observed (remotely) by the Monitoring Team.

For the individuals reviewed, the IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

As applicable to the setting, most individuals observed had their AAC devices with them and were using them in a functional manner. However, due to a lack of sufficient assessment in this area, there were limited numbers of AAC devices and language-based supports available to individuals living at Richmond SSLC. SLPs and IDTs should work to ensure that individuals who could benefit from such supports have access to them.

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: Obtaining reliable data for most SAPs (indicator 5) allowed for the Monitoring Team to assess progress. About three-fourths of the SAPs were progressing. SAPs were moved to the next step or objective when met, and actions were taken for the one SAP that was not progressing. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	273	787	346	549	344	122	510	497	195

		Score									
6	The individual is progressing on his/her SAPs.	73% 8/11	0/1	0/1	1/1	0/1	1/1	1/1		3/3	2/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	100% 6/6	1/1					1/1	1/1	2/2	1/1
8	If the individual was not making progress, actions were taken.	100% 1/1	1/1								
9	(No longer scored)										

Comments:

6. Individual #510's prepare a meal SAP, Individual #273's adjust the volume SAP, and Individual #549's order food online and operate his music player SAPs had insufficient data to determine progress and were, therefore, not scored.

Individual #549's identify self-check items SAP also had insufficient data to determine progress, however, it was scored as 0 because his SAP data were not demonstrated to be reliable (see indicator 5). Additionally, Individual #787's brush her doll's hair SAP was progressing, but was scored as 0 because data were not demonstrated to be reliable (indicator 5). The Monitoring Team was impressed that Individual #273's apply toothpaste SAP was the only SAP not progressing.

7. Individual #195's use a Kindle SAP, Individual #510's prepare a meal SAP, Individual #497's open his CD player and match numbers SAPs, Individual #122's state medication facts, and Individual #344's turn on his DVD SAP all achieved an objective and were moved to the next objective. This represents an improvement from the last review when 73% of achieved objectives were updated in a timely manner.

8. Individual #273's apply toothpaste SAP was not progressing, however, his SAP progress note indicated that the SAP was reviewed by the IDT and modifications were suggested to address his lack of progress.

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

Summary: Performance on this indicator continued on an improving trend for three consecutive reviews. In other words, the content of SAPs was fully met for more than half of the SAPs. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 273	787	346	549	344	122	510	497	195
13	The individual's SAPs are complete.	60% 9/15	0/2 15/19	1/1 10/10	0/1 8/10	3/3 30/30	1/1 10/10	0/1 9/10	1/1 10/10	2/3 28/30	1/2 19/ 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 a 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.

The majority of SAPs contained all 10 components of an effective SAP (e.g., Individual #497's prepare a snack SAP). There was an impressive variety of SAP training procedures utilized at Richmond SSLC. The majority of SAPs used a total task training methodology where individuals were trained on each step of the SAP each session. Graduated assistance was provided on steps that individuals could not complete at the desired level of prompting, and subsequent objectives gradually reduced the intrusiveness of the prompts.

These SAPs either used a most-to-least prompting procedure (e.g., Individual #195's send greeting cards SAP), or a least-to-most prompting procedure (e.g., Individual #510's food preparation SAP). Some of these SAPs used forward chaining (e.g., Individual #497's match numbers SAP) and others used backward chaining (e.g., Individual #273's adjust the volume SAP).

Additionally, some multiple-step SAPs used a single step training procedure where staff completed the other steps, or the individual was prompted through the other steps (e.g., Individual #344's turn on a DVD SAP).

Finally, some SAPs just included one step (e.g., Individual #122's state medical facts SAP).

It is likely that the impressive improvements in SAP performance documented in indicator 6 were, at least in part, due to the sophisticated assessment and subsequent individualization of SAP training procedures. The range of procedures utilized, coupled with the relatively rapid changing of objectives (due to the individual progress on the SAP), however, resulted in several SAPs (discussed in more detail below) to have inconsistent or confusing training information.

All of the SAPs contained the majority of the necessary components. For example, 100% of the SAPs had a plan that included:

- a task analysis (when appropriate)
- behavioral objectives
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for correct responses
- a plan for maintenance and generalization
- documentation methodology

Regarding common missing components:

- The majority of SAPs that were judged to be incomplete had inconsistencies in the SAP training sheet. For example, Individual #195's use her Kindle SAP indicated that the current prompt level was verbal in one location in the SAP instructions, and as a gesture in another. In Individual #497's match numbers SAP, both steps 1 and 2 were identical; one indicated it was mastered, the other was identified as the current training step. Individual #273's adjust the volume SAP indicated that the training prompt was physical guidance, however, the instructions following an incorrect response indicated that the training prompt was verbal.

Other missing components:

- Individual #122's state medication facts SAP required a verbal target behavior, however, the SAP training sheet included physical guidance and manipulation that would be impossible with a verbal target behavior.

Outcome 5- SAPs are implemented with integrity.

Summary: Both indicators scored higher than ever before. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 273	787	346	549	344	122	510	497	195
14	SAPs are implemented as written.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	83% 10/12	2/2	0/1	1/1	0/1	1/1		1/1	3/3	2/2

Comments:

14. The Monitoring Team observed the implementation of nine SAPs.

Individual #497's prepare a snack SAP, Individual #273's apply toothpaste SAP, Individual #787's brush doll's hair SAP, Individual #346's prepare a meal SAP, Individual #549's identify self-checkout items, Individual #344's turn on his DVD, and Individual #510's prepare a meal SAP were all implemented and scored as written.

Individual #195's use a Kindle SAP was also implemented as written, however, it was not scored correctly. The DSP used a physical prompt for one step, but indicated that she would score the SAP as requiring only gestural prompts. In Individual #122's state her medications facts SAP, the nurse implementing the SAP did not consistently follow the prompting sequence in the SAP training sheet, or the instruction for how to present the SAP. Nevertheless, this indicator represents another improvement from the last review when 57% of SAPs were implemented as written.

15. A schedule of SAP integrity collection (within the first three months, and every six months after that) and a goal level (80%) was established for all SAPs. These frequencies and levels of SAP integrity were achieved for all individuals other than Individual #787's brush the doll's hair SAP, and Individual #549's identify self-checking items SAP (see indicator 5 for details).

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

Summary: Two-thirds of SAPs were reviewed monthly, about the same as at the last review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 273	787	346	549	344	122	510	497	195
16	There is evidence that SAPs are reviewed monthly.	67%	1/2	0/1	1/1	3/3	1/1	1/1	1/1	1/3	1/2

		10/15										
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										

Comments:
16. Sixty-seven percent of SAPs had a data-based review in the QIDP monthly report (e.g., Individual #346's prepare a meal SAP).

Individual #273's adjust the volume of his music SAP, Individual #787's brush the doll's hair SAP, and Individual #195's use her Kindle SAP were not reviewed in QIDP monthly report. Individual #497's match numbers and prepare a snack SAPs did not include complete SAP data which did not allow data-based decisions concerning the need to continue, discontinue, or modify them.

In a comment on the draft version of this report, the State referred the Monitor back to tier 2 documents regarding two of Individual #497's SAPs. Indeed, there were data in the QIDP's monthly report on those two SAPs, however, the data were not consistent with the SAP data in tier 2 document 26. For example, the November 2020 note for matching indicated that the objective was independent and it was gestural. The March 2021 note said the objective for prepare a snack was independent, but the data sheet said physical prompts. Also, the data in the March 2021 note did not match the data sheet.

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

Summary: More than half of the individuals were regularly engaged in activities when observed (remotely) by the Monitoring Team. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Not scored CV19									
20	The day and treatment sites of the individual have goal engagement level scores.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	Not scored CV19									

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times on campus during the review week. The Monitoring Team found Individual #195, Individual #497, Individual #549, Individual #346, and Individual #787 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Due to COVID-19 precautions all engagement measures had been suspended since March 2020.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings/activities were suspended due to COVID-19 precautions since March 2020.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
22	For the individual, goal frequencies of community recreational activities are established and achieved.	Not scored CV19									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	Not scored CV19									
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.	Not scored CV19									
Comments:											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: There were no individuals at Richmond SSLC who attended public school.			Individuals:								
#	Indicator	Overall Score	273	787	346	549	344	122	510	497	195
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: For the individuals reviewed, the IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	0%	0/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A

	and achievable to measure the efficacy of interventions;	0/3									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3	0/1			0/1		0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3	0/1			0/1		0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3	0/1			0/1		0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1			0/1		0/1			
Comments: a. through e. Based on the documentation Center staff submitted in response to the Monitors' Tier I document request, during the 12 months prior to the review, none of the individuals the Monitoring Team responsible for the review of physical health reviewed refused to cooperate with dental care. However, based on the dental IPNs submitted, it appeared that at least three individuals refused to cooperate with dental care. On 12/17/21, Individual #787 refused to allow Dental Clinic staff to check the status of her oral hygiene. On 4/1/21, Individual #178 verbally refused all treatment. On 3/1/21, Individual #112 was uncooperative and refused all efforts by Dental Clinic staff. None of the three individuals had clinically relevant or measurable goals/objectives to address the refusals.										

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 with communication needs did not have goals/objectives to address them. Going forward, SLPs should provide the IDTs with recommendations to assist in the development of meaningful formal communication services and supports. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	787	344	300	178	78	112	264	544	227
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1

d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1		0/1	0/1	0/1	0/1	0/1

Comments: a. through e. Based on review of documents submitted, Individual #178 communicated verbally and did not require a formal goal/objective or other communication strategies. The documentation for the remaining eight individuals identified communication needs and potential strengths that indicated they could have benefited from formal supports, but none had goals/objectives to meet these communication needs.

The Monitoring Team conducted full reviews for all nine individuals. As noted above, Individual #178 did not require any communication goals or strategies. Although he was part of the outcome review group, he was newly admitted and his initial comprehensive assessment was missing some components, so the Monitoring Team completed a full review for him. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.

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

Summary: Individuals did not have needed measurable strategies and action plans included in the ISPs/ISPAs related to communication. 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	787	344	300	178	78	112	264	544	227
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As described with regard to Outcome 1 above, none of the applicable individuals reviewed had measurable goals/objectives related to communication included in their ISPs/ISPAs. In addition, as described with regard to Outcome 3 above, individuals did not have needed ISP action plans to address their communication needs.

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: As applicable to the setting, most individuals observed had their AAC devices with them and were using them in a functional manner. However, due to a

Individuals:

lack of sufficient assessment in this area, there were limited numbers of AAC devices and language-based supports available to individuals living at Richmond SSLC. SLPs and IDTs should work to ensure that individuals who could benefit from such supports have access to them. These indicators will remain in active monitoring. [**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	738	306	452	112	321	364	568	678	722
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	90% 9/10	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	83% 5/6	1/1	N/A	1/1	1/1	1/1	N/A	N/A	0/1	1/1
			Individuals:								
#	Indicator		232	344							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		N/A	N/A							
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.	Not Rated									

Comments: a. and b. Based on observations, it was positive that, overall, devices were readily available to individuals. In addition, for most applicable individuals for which the Monitoring Team was able to observe the devices being used, they were able to do so in a functional manner. The only noted exception was for Individual #678, for whom there was a lack of clarity and consistency with regard to the purpose, methodology and frequency of use of her Talkable II device.

However, beyond the Communication Dictionary, there were limited numbers of AAC devices and other communication supports available to individuals living at Richmond SSLC. Based on the Monitoring Team's review of other individuals with identified communication deficits, there was a lack of sufficient assessment in this area. In many cases, the clinician merely described the existing supports, but did not demonstrate any exploration of potential methods to expand the individual's current system. For example, for Individual #344, the clinician identified that he would benefit from a different AAC device, but had to learn to use his picture board better before further exploring a higher tech device. These do not have to be mutually exclusive and could be used concurrently, particularly if the SLP provided direct intervention.

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, four indicators were in the category of requiring less oversight. As of this review, no additional indicators were added to this category.

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

Overall, Richmond SSLC continued to make good progress in their processes for facilitating transitions to the community.

There was good progress in the development of pre-move training supports that provided the competency criteria. Going forward, while much information in the pre-move training, the Center should be clear about what it is essential that provider staff need to know and know how to do on day one.

It was good to see that the APC developed a pre-move training template for the disciplines to use, which began with a learning objective and provided a clear narrative summary of what provider staff needed to know.

It was very positive to hear that, given the individual's needs, Center staff devoted most of a day to pre-move training and included role-play, demonstration, and return demonstration in the process. While this was a substantial investment of time and effort, it appeared to have paid dividends in the success of the transition. In particular, it was good to see that even though the individual had behavioral challenges, it appeared the provider staff were prepared to respond appropriately.

There was substantial improvement in the development of measurable supports, so that the provider and the Post-Move Monitor could clearly understand what was needed to demonstrate that a support was in place.

It was good to see improvement in the comprehensiveness of post-move supports.

Aided by the improved measurability of the supports, the Post-Move Monitor continued to improve her processes, especially with regard to providing detailed comments and referencing all the needed prongs of evidence. That being said, more thorough post move monitoring was still needed when determining if supports were being provided, and when following-up on supports that were not in place properly.

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: Good progress was demonstrated on the one transition that occurred since the last review. Going forward, while there was much information in the pre-move training, the Center should be clear about what it is essential that provider staff need to know and know how to do on day one. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 214								
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments: One individual (Individual #214) transitioned from the Center to a community home operated under the State's HCS program since the last review. The Monitoring Team reviewed this transition and discussed it in detail with the Richmond SSLC Admissions and Placement Coordinator (APC) and transition staff. Overall, Richmond SSLC continued to make good progress in their processes for facilitating transitions to the community.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. The IDT developed 12 pre-move supports for Individual #214, including five that addressed pre-move training supports in the areas of habilitation, behavior support, preferences and strengths, dental, nutrition, skill acquisition, and nursing.

Overall, there was good progress in the development of pre-move training supports that provided the competency criteria.

- Many of the pre-move training supports were written in measurable terms that defined specific expectations for what provider staff needed to know, and each support indicated that each provider staff must pass a corresponding test with 100% competency. Some also included a requirement for competency demonstration. However, it was not always clear that the expectations cited in the supports were intended to be the competency criteria or were a description of the training content, or both. In some instances, the training included more content than listed in the support, and it appeared to be essential information for provider staff to know (i.e., competency criteria). For example, the nursing training included important information describing what provider staff needed to know about their responsibilities for monitoring for specific signs, symptoms, and side effects, but the pre-move training supports did not reference those in the support, except for one broad and non-specific reference to medication side effects. (i.e., "side effects and symptoms to all medications that are vital for health"). Going forward, Center staff should carefully scrutinize what they designate as competency criteria. While they might include much information in the training, they should clearly state what will be essential for provider staff to know and know how to do on day one. They should then ensure that, at a minimum, both the training they design and the competency testing they administer address all competency criteria.

- Overall, there was continued improvement with regard to the design and content of the training material and it was thorough and well organized. The APC developed a pre-move training template for the disciplines to use that began with a statement of learning objectives and provided a clear narrative summary of what provider staff needed to know. In one very good example, Center habilitation staff used the template to develop a very effective tool with scripted prompts for the trainer to integrate demonstration and return demonstration throughout the training session. All the pre-move in-service supports also referenced methodologies for training.
- Testing needed to be constructed to measure all the specific criteria that would demonstrate staff were competent to provide supports as required, as well as be completed in the most suitable format (e.g., written quiz, return demonstration, etc.). For this CLDP, pre-move training supports still largely relied upon written tests for competency demonstration, but it was positive to see that they also required a mastery checklist of returned demonstration. To be measurable, though, those supports still needed to identify what specific skills or competencies would be tested through return demonstration. For example, for Individual #214's habilitation training, Center staff could have indicated if provider staff would have been expected to demonstrate the positioning of the bed wedge or how to cut food into bite-size pieces, while other important knowledge (e.g., dining instructions) could have been tested with a written quiz. Of note, however, even though each of the pre-move training supports indicated they would include a mastery checklist of returned demonstration, Center staff only provided such documentation for the behavioral training. The competency documentation provided as evidence for the remainder were written quizzes.
- In some instances, it was good to see that the competency quizzes were thorough and addressed all criteria listed. Overall, for example, the habilitation competency quiz addressed all of the topics listed in the support, although Center staff did not provide evidence, they completed the required return demonstration checklist portion. On the other hand, competency quizzes for some other topic areas reviewed did not include questions for all the topics and/or competencies listed as needed under each support. For example, with one exception, the skill acquisition plan training generally did not test provider staff knowledge of the specific training or data collection techniques.
- In addition, at times, Center staff did not provide pre-move evidence of competency for all relevant provider staff. For example, the Center provided an attendance sheet showing that relevant provider staff attended the pre-move training for the nursing topics. However, they only provided competency evidence for the provider nurse, even though the remaining provider staff that would be working with Individual #214 also had significant related responsibilities detailed in the post-move supports. While the pre-move site review (PMSR) documentation indicated that such evidence would be forthcoming in the future, Center staff were not able to provide it.
- Center staff should ensure that if they develop post-move supports for provider staff to implement, they also develop pre-move training to prepare them for those responsibilities. For example, there was an extensive post-move support for the individual's supervision needs, but Center staff did not develop a related pre-move training support.

With regard to post-move supports, the respective IDTs developed 73 post-move supports for Individual #214. Most post-move supports were stated in clear and straightforward terms and met criteria for measurability. This was very positive to see. The following describes the handful of exceptions:

- A post-move support called for provider staff to verify and document, on a daily basis, the correct placement of the individual's bed wedge, but did not describe the parameters to follow (i.e., 15 degrees.)
- A post-move support indicated that provider staff should help Individual #214 maintain her desired weight range by

monitoring her food intake (following her diet plan) daily. The evidence required was the weight log, but a log that tracked her weight would not show that provider staff monitored her food intake daily.

- A post-move support stated that the provider staff would notify the provider nurse of any unintentional weight change (gain or loss) greater or less than 10 pounds in one month, so that the provider nurse could schedule an appointment with the primary care practitioner (PCP) or a registered dietitian. Written in that manner, the support appeared to require nurse notification with any change at all, no matter how small.
- A support called for the provider management team and staff to review and document the psychiatrist treatment plan efficacy on a quarterly basis. It was not clear what documentation of efficacy should include.
- The CLDP included one support for the provision of training to any new provider staff, consistent with the pre-move training provided by Center staff. This would have consistent deficiencies as well.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for this individual and it was positive they had made a diligent effort to address her needs. This represented good continuing progress, although some improvement was still needed, as the following examples indicate:

- Past history, and recent and current behavioral and psychiatric problems: It was positive that the CLDP included pre-move training supports that clearly defined Individual #214's current behaviors and provided specific competency criteria for prompting and reinforcing behavior, precursors, prevention, and intervention techniques. In addition, it was good to see that CLDP supports identified some historical behaviors (e.g., urinating on herself or the floor, throwing food) and how to address them. However, while the post-move behavioral support indicated that provider staff should be aware that Individual #214 had a history of elopement, it did not include a clear strategy to address that risk, either in the post-move behavioral supports or in the supervision support.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The IDT developed many supports related to safety, medical, healthcare, therapeutic and risk needs. This was an area of significant improvement, but there was still a need to ensure the IDT developed clear and comprehensive supports for all important topics. Examples of supports that met criterion and those that did not included the following:
    - It was very good to see that Center staff developed a comprehensive post-move support for Individual #214's needs for supervision across various settings and for certain activities. However, Center staff also needed to ensure that provider staff received pre-move training and demonstrated competency with regard to these supervision requirements.
    - It was also good to see that the CLDP included specific post-move supports for nursing oversight of Individual #214's health conditions, although some (e.g., oversight of signs and symptoms associated with medications) could have been improved by citing the needed timeframes.
    - It was positive that the CLDP required that provider direct support staff have knowledge of many possible signs and symptoms of various health conditions, and that those often described a requirement to report them to nursing. While in some cases the expectation for when to report was specific (i.e., by end of shift), in others the support did not specify the timeframe for reporting (e.g., immediately, within 24 hours, etc.). In addition, Center staff again needed to ensure that provider staff received pre-move training and demonstrated competency with regard to those supports, but did

not.
    - Individual #214 had a dining plan to support safe eating (i.e.., staff prompts to not over-fill her spoon, take sips of water between bites of food and ensure she uses her utensils) and it was positive the pre-move training and competency testing included these strategies. The CLDP included a post-move support for supervision that addressed some, but not all, of the dining strategies.
    - The CLDP narrative highlighted a recent period of multiple falls and drowsiness, likely due to a significant weight loss and the lack of a corresponding adjustment in her psychotropic medications. The narrative stated that it was important to monitor her weight loss and notify the psychiatrist when weight loss occurred for consideration of dosage adjustment. Neither the requirement to notify the psychiatrist or staff knowledge of these specific risks related to weight loss were addressed in the pre-move training supports, the competency training, or the post-move supports.

- What was important to the individual: This sub-indicator did not meet criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. The CLDP stated that Individual #214 wished to live closer to her mother and see her more often, but did not describe any other personal ambitions or desires. When the IDT is considering what is important to the person with regard to community living, the members should draw upon the extensive work they have already done with the individual to identify preferences and strengths, personal goals, and an individualized vision for the future. This will allow them to further consider how they can develop supports that enable the individual to continue to experience the things that are important to them. For example, in Individual #214's case, the ISP identified a personal goal of hosting a card tournament in the community that would have been a very appropriate opportunity to continue once she transitioned.

- Need/desire for employment, and/or other meaningful day activities: This sub-indicator did not meet criterion. The IDT did not develop any related supports.
    - Individual #214 was a relatively young person at 33 years old. Based on her vocational assessment and other documentation, she had some employment skills and potential, even though her work effort was sporadic. Her PSI also indicated that she wanted to work in the community and make more money, while her ISP listed a personal goal for working part-time in the community. The CLDP Profile section stated that the IDT recommended that it would be to her advantage if the provider day program also offered pre-vocational training and a reward system to encourage her to be motivated to work for pay. The CLDP meeting narrative instead noted that the provider did not offer vocational or supported employment opportunities, and that, based on that, the IDT would not request a vocational assessment. During the discussion with transition staff about this concern, it was very good to hear the new State Office Continuity of Care Coordinator speak about some exciting initiatives the State is implementing to promote community-based work opportunities for individuals with developmental disabilities. It would be helpful for State Office to provide some additional training for Center staff to raise their awareness about the expectations they can have for community providers to provide employment opportunities and supports.
    - The CLDP did not describe meaningful day activities that would promote community participation and integration commensurate with living in the community. In other words, moving to the community should provide people with more opportunities to be a part of that community and partake in community activities on a regular basis.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. The IDTs defined supports that included elements of positive reinforcement and other motivating components and met criterion. As reported at the time of the previous review, it was very good to see that the IDT continued to provide specific pre-move and post-move supports for providing non-contingent positive reinforcement on a daily basis.

- Teaching, maintenance, participation, and acquisition of specific skills: Individual #214's CLDP met criterion. The IDT developed four supports to continue skill acquisition plans (SAPs) that were ongoing at the Center as well as two supports requiring the provider to assess her need for and implement additional life skills training.

All recommendations from assessments are included, or if not, there is a rationale provided: Richmond SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. Overall, it was effectively implemented and met criterion.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Post move monitoring improved since the last review. With some additional details during post move monitoring and follow-up after post move monitoring, further improvement in scores is likely. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	214								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	0% 0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/1	0/1								

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: Overall, and as reported at the time of the previous review, Center staff continued to be very knowledgeable about the status of the individual who transitioned. Similar to the findings from the previous review and as described further below with regard to the specific indicators, the Post Move Monitor (PMM) was diligent in her work and had continued to make improvements in her monitoring practices. Center staff should continue to place a particular focus on accurately identifying when follow-up is required and taking the appropriate follow-up action (e.g., notifying and consulting with the individual's IDT.)

4. At the time of previous reviews, the Monitoring Team reported observation of good progress in the efforts of the PMM to provide detailed comments describing the status of supports, but that the PMM Checklists still did not consistently provide valid and reliable data. Some of these findings continued to be applicable for this monitoring visit.

- It was good to see substantial improvement in the clarity and measurability of the language for many supports, which made it easier to ascertain what data needed to be collected.
- As reported previously, it was positive that most of the CLDP supports required several of the prongs of evidence: interviews, observations, and review of documentation. It was also good to see that, overall, the PMM consistently made an effort to address all these required prongs. However, this was compromised by the frequent failure of the provider to provide needed data and documentation, as described below in more detail in Indicator 5.
- The PMM did not always provide any comment or scoring for some supports. This was particularly true during the 180-day PMM review, for which there were numerous such lapses.

5. Based on information the Post Move Monitor collected, the individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. The following provides examples of supports the Post-Move Monitor found not to be in place:

- The provider did not consistently provide the documentation needed to full demonstrate the presence of some supports. For the seven through 90-day PMM visits, examples of unavailable or incomplete data included signs and symptoms of genitourinary issues, signs and symptoms of anticholinergic side effects, and the implementation of the behavioral supports. For the 180-day PMM visit, the provider did not submit documentation of the required quarterly psychiatric summary and related medication monitoring. That PMM visit occurred on 4/21/21; Center staff had not documented any additional follow-up since then to confirm completion.
- By the time of the 90-day PMM visit, the provider had not completed a life skills assessment as per the CLDP support or implemented additional life skills training as required. In addition, the provider never implemented the agreed upon post-move supports for teaching, maintenance, participation, and acquisition of specific skills.
- At the time of the seven-day, 45-day and 180-day PMM visits, the provider did not make arrangements for Individual #214 to have video calls with her family as required.

6. While there was improvement from previous reviews, based on the supports defined in the CLDP, the PMM sometimes still did not provide sufficient evidence to support a conclusion that supports were in place. In addition to the lack of valid and reliable data at

times, as described above, the following comments are relevant:

- The PMM sometimes scored a support as in place without having adequate documentation to confirm that. For example, for the seven, 45-, and 90-day PMM visits, the PMM regularly marked a support for extra fluids as in place, even though the comments noted the provider did not have documentation of this.
- The PMM found a support calling for the bed wedge to be appropriately positioned to be in place. However, the support did not indicate what the specific positioning (i.e., 15 degrees) needed to be and the PMM comments did not confirm the specific required positioning was met.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the Post-Move Monitor's assessment of whether supports were, or were not, in place. In many instances, when the PMM did identify a need for follow-up, she took assertive action to reach resolution, including engaging the IDT for assistance. This was very positive.

As examples, the PMM documented good follow-up related to Individual #214's visitation with her mother, the completion of her eye exam, and obtaining IDT assistance with ongoing behavioral challenges in the new home.

However, the PMM sometimes failed to accurately identify the absence of a support, which resulted in a lack of needed follow-up, or otherwise did not document follow-through to resolution.

- The CLDP included a support for daily monitoring Individual #214's blood pressure prior to the administration of her blood pressure medication. The support indicated that provider staff should hold the medication if the systolic blood pressure reading was less than 100 and then wait a few minutes before re-assessing. If the reading remained then below 100, provider staff were to notify the provider nurse. The PMM provided comments for the seven through 90-day PMM visits. Overall, these comments reflected a fundamental misunderstanding among the PMM and the provider staff interviewed, indicating that they believed the systolic reading should be less than 100 before the medication could be administered and that it should be held, and the provider nurse notified, if it exceeded 100. This was the opposite of the actual requirements. At the time of the 90-day PMM visit, the comment also indicated that provider staff reported Individual #214's blood pressure typically ranged from 100/21 to 100/45-47. This would have been a matter of concern. The PMM did not provide any follow-up comments or score for the 180-day PMM visit. The Monitoring Team recommended that Center staff contact the provider as soon as possible to confirm if these data were correct and, if so, to ensure needed action. Based on documentation Center staff provided in response, the data submitted were inaccurate. However, inaccurate data had been considered acceptable for a long period of time.
- At the time of the 45-day PMM visit, the PMM commented that provider staff stated that Individual #214 sometimes ate food that had not been cut into bite-size pieces, as required by the post-move supports and her Physical/Nutritional Management Plan (PNMP). It was positive that the PMM met with the provider team to discuss this concern and they indicated Individual #214 would see a community dietitian/nutritionist to evaluate the situation. It was also positive the PMM reported she communicated with the Center Occupational Therapist (OT) to discuss the safety implications of providing a diet that was not cut to bite-size and informed the provider the OT recommended they continue the diet texture as written. At the time of the 90-day PMM visit, the provider staff again stated that Individual #214 sometimes ate her food whole rather than bite-size, and that she had recently had a dietary consult. Center staff requested a copy of the consult, but by 2/10/21 had not received it.

There was no further documentation of follow-up to achieve resolution, including no comment at the time of the 180-day PMM visit.

- At the time of the 180-day PMM visit, the PMM documented a new medication (quetiapine) had been added. On 4/29/21, the PMM emailed the provider to request clarification of the purpose of the medication, but Center staff had not provided any further documentation to close the loop.
- At the time of the 180-day PMM visit, the PMM commented that the behavioral supports were no longer followed because the procedures had been changed as a result of the implementation of the community behavior support plan. When this occurs, the PMM should then continue to monitor whether the new behavior support plan remains in place, whether provider staff have been trained to implement it, and whether data and other documentation indicate it is effective. This may require revision of the supports, but as long as behavior supports are required, the PMM should continue to monitor that they are implemented and that behavioral needs are met.

9-10. PMM did not occur during this site visit. Therefore, these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.											
Summary: Individual #214 had no occurrences of negative events. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	214								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 1/1	1/1								
Comments: 11. Individual #214 had not experienced a PDCT event.											

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.											
Summary: Good progress was demonstrated on the one transition that occurred since the last review. Even so, most assessments did not describe clear provider training and competency needs, did not fully address/focus on the new community home and day/work settings, and did not make recommendations regarding all relevant risk areas. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	214								

12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/1	0/1								
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	100% 1/1	1/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 1/1	1/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/1	0/1								
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/1	0/1								

Comments:

12. Assessments did yet not consistently meet criterion for this indicator, but continued progress was noted and was good to see. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Overall, assessments provided for review met criterion for timeliness. This was positive.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Overall, assessments met criterion.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community; and Assessments specifically address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area. Assessments did not yet thoroughly

provide recommendations to support transition or community living.

- Most assessments did not describe clear provider training and competency needs. However, it was very positive to see the behavioral health assessment (BHA) provided detailed recommendations for training.
- Assessments did not fully address/focus on the new community home and day/work settings. For example, the social assessment recommendations were Center-focused and did not appear to have been updated to reflect community needs.
- The OT/PT assessment described Individual #214's medium falls risk, but did not make any specific recommendations with regard to monitoring for recurrence.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: Training provided to community provider staff did not yet meet criterion for this CLDP, as described in detail in Indicator 1. However, given the individual's needs, it was very positive that Center staff reported they devoted most of a day to pre-move training and that it included role-play, demonstration, and return demonstration in the process.

While this was a substantial investment of time and effort, it appeared to have paid dividends in the success of the transition. In particular, it was good to see that even though the individual had behavioral challenges, it appeared the provider staff were aware of those needs and, with ongoing support from the Center IDT, were able to respond appropriately.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: This CLDP met criterion. The IDT included in the CLDP a specific statement with regard to collaboration for nursing and psychiatry. The IDT also developed a post-move support for quarterly collaboration between the Center and community psychiatrists.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. This CLDP included a statement of the IDT's consideration of this need, noting that members of the IDT toured both the home and day program and did not identify any need for further assessment.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. This indicator could not be fully rated. Individual #214's CLDP noted that the opportunities for such activities were limited due to COVID-19 restrictions.

19. The pre-move site review (PMSR) individuals was completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the PMSR did not accomplished this. The PMM relied upon implementation of pre-move training supports to confirm provider staff were prepared to implement supports as needed. As described above regarding Indicator 1, the CLDP included numerous pre-move supports for pre-move training, but these did not yet fully meet criterion for ensuring that provider staff were competent. If Center staff continue

to make progress with regard to the implementation of pre-move training and testing of provider competency, they should then be able to meet criteria for this indicator.

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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