United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Remote Virtual Review: February 14-17, 2022

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## Table of Contents

## 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 2021, the parties submitted to the Court, and the Court approved, various amendments and modification to the 2009 Settlement Agreement (now called the Amended Settlement Agreement). One of the modifications was the allowance of a Center to exit from a numbered provision, rather than solely from an entire lettered section, when sustained substantial compliance is demonstrated.

## Methodology

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

a. Selection of individuals: During the weeks prior to the review, the Monitoring Team 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 Team then chose the individuals to be included in the monitoring review. This non-random selection process is necessary for the Monitoring Team 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 Team used the Microsoft Teams audio and video platform to attend various meetings, conduct interviews of various staff members via Microsoft Teams (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator), and observe individuals and staff.

c. Review of documents: Prior to the 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 review, the Monitoring Team requested and reviewed additional documents.
d. Observations: The Monitoring Team observed individuals in their homes, day/work sites, and other locations at the SSLC during regularly occurring activities. Specific activities were also scheduled and observed, such as administration of medication, implementation of skill acquisition plans, and conduct of mealtimes.
e. Interviews: The Monitoring Team 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 section of the Amended Settlement Agreement. 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 exited status. Exited indicators are not included in subsequent reports. The Monitor also makes a determination of whether an indicator will be moved to the category of requiring less oversight. Indicators that move to this category will not be scored, 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 Amended Settlement Agreement. Specifically, for each of the lettered sections of the Amended Settlement Agreement, the report includes the following sub-sections:

a. A status summary of sections and provisions that have exited and those that are in the category of requiring less oversight.
b. The outcomes and indicators are listed along with the Monitoring Team's scoring of each indicator.

c. The Monitor has provided a summary of the Center's performance on the indicators in the outcome, as well as a determination of whether each indicator will exit, move to the category of requiring less oversight, or remain in active monitoring.
d. The Monitor has provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.

**Executive Summary**

The Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at San Antonio SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Team during the remote review. The Center Director supported the work of the Monitoring Team and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Team; their time and efforts are much appreciated.

## Section C: Protection from Harm - Restraints

Substantial Compliance – Exited Status

All of the provisions of this section met and achieved substantial compliance, with the exception of the nursing-related monitoring indicators of provisions C5 and C6.

Given sustained high performance on these nursing-related indicators for this review period and across successive reviews, these have shown substantial compliance and will be exited from monitoring.

Thus, all of section C is now exited from monitoring.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review.

Section Summary

Nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff provided the needed follow-up to injuries resulting from the restraint and ensured the actions taken met the needs of the individual.

| Nursing: Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff provided the needed follow-up to injuries resulting from the restraint and ensured the actions taken met the needs of the individual. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 392 | 365 | 383 | 95 | | | | | |
| a. | If the individual is restrained, nursing assessments (physical assessments) are performed. | 100% 6/6 | 1/1 | 2/2 | 1/1 | 2/2 | | | | | |
| b. | If the individual is restrained using PMR-SIB: | N/A | | | | | | | | | |
| | 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 | | | | | | | | | |

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| | 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:<br>a. Condition of device; and<br>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:<br>a. A full set of vital signs, including SPO2;<br>b. Assessment of pain;<br>c. Assessment of behavior/mental status;<br>d. Assessment for injury;<br>e. Assessment of circulation; and<br>f. Assessment of skin condition. | N/A | | | | | | | | | |
| c. | The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects. | 100%<br>6/6 | 1/1 | 2/2 | 1/1 | 2/2 | | | | | |
| d. | Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual. | 100%<br>6/6 | 1/1 | 2/2 | 1/1 | 2/2 | | | | | |
| Comments:<br>a, c, d. All individuals who experienced a crisis intervention restraint were provided with a nursing physical assessment. The assessment consistently identified if any injuries or other negative effects occurred because of the restraint and provided vital signs and a mental check immediately post event. If any concerns were noted because of the assessment, nursing took the appropriate action. | | | | | | | | | | | |

| Section D: Protection from Harm – Abuse, Neglect, and Incident Management |
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Substantial Compliance – Exited Status

Three of the provisions of this section met and achieved substantial compliance: D1, D2, and D5.

Thus, the corresponding seven monitoring indicators are no longer monitored or scored: 1-6 and 14.

Given the Center's performance during this review, that is, showing sustained substantial compliance with the indicators that were in the category of requiring less oversight, as well as those that were not yet in that category, and with the reduction in the number and length of late investigation completions, the Center is exited from all five of the provisions of section D.

Sustained High Performance – Less Oversight Status

Nine of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review.

Section Summary

| Outcome 5– Staff cooperate with investigations. | | | | | | | | | | | | |
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| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 7 | Facility staff cooperated with the investigation. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |

| Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 8 | Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | | |
| 9 | Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled. | | | | | | | | | | | |

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| 10 | The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained) | |
| | Comments: | |

| Outcome 7– Investigations are conducted and reviewed as required. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: PI showed much improvement since the last review in the timely completion of investigations. Moreover, when an investigation was completed in more than 10 days, the number of days beyond the 10 days decreased across the review period, too. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 348 | 392 | 383 | | | | |
| 11 | Commenced within 24 hours of being reported. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 12 | Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor/QA specialist (unless a written extension documenting extraordinary circumstances was approved in writing). | 78% 7/9 | 1/1 | 1/1 | 1/2 | 2/2 | 2/3 | | | | |
| 13 | There was evidence that the supervisor/QA specialist had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent. | 89% 8/9 | 1/1 | 1/1 | 2/2 | 2/2 | 2/3 | | | | |

Comments:
12-13. For Individual #348 UIR 22-012, the investigation was completed in 45 days. Apparently PI wanted to complete a lot of interviews to corroborate what was clear on the video. There was no information on the extension requests that would show why getting these interviews done more timely was problematic. With such clear video evidence it seems this investigation could have been completed much sooner. Even so, the facility director review of the extensions was completed (for this and all other investigations that were beyond 10 days to completion).

For Individual #383 UIR 22-031, the investigation was completed in 28 days. Extension requests were completed, but all only indicated due to extraordinary circumstances. Even so, the facility director review of the extensions was completed.

| Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported. | |
|---|---|
| Summary: | Individuals: |

| # | Indicator | Overall Score | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| Comments: | | | | | | | | | | | |

| Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 16 | The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 17 | If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely. | | | | | | | | | | |
| 18 | If the investigation recommended programmatic and other actions, they occurred and they occurred timely. | | | | | | | | | | |
| Comments: | | | | | | | | | | | |

| Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries. | | | | | | | | | | | |
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| Summary: This outcome consists of one facility indicator. Criteria were met. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | |
| 19 | For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending. | Yes | | | | | | | | | |
| Comments: | | | | | | | | | | | |

## Section E: Quality Assurance

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

With agreement of the Parties and the Monitor, monitoring of this section and its provisions is paused while the Center and State are receiving technical assistance and developing the Center and State quality assurance program.

## Section F: Integrated Protections, Services, Treatments, and Supports

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, two additional indicators were moved to this category.

Section Summary

There continued to be strong leadership from the QIDP department. Both the QIDP Coordinator and the QIDP Educator were present at meetings and readily offered support and guidance to IDTs, as needed. Many of the issues identified during the review had already been identified by the QIDP Coordinator and were being addressed through additional monitoring and training.

For the annual ISPs, none of the individuals had goals that met criteria in all six ISP areas. Across the six individuals, personal goals met criteria for 12 goals. This was a decrease from the 27 goals that met criteria for the last review. Healthcare goals were general expectations that did not involve active participation on the part of the individual. More work was needed regarding health and wellness goals to develop actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

Few action plans had been fully implemented and although IDTs met frequently to discuss issues, action was not typically taken by the IDT to address the lack of implementation or to ensure that individuals had the opportunity to achieve goals.

It was positive to see that all individuals had action plans to be implemented in the community. As noted during the last review, action plans requiring community access were put on hold due to COVID-19 restrictions and guidelines. IDTs had not considered revising training so that individuals could continue to develop new skills despite not have consistent community access for the past two years.

More work was needed to develop individualized action plans to educate individuals and their LARs about living options and to address barriers to living in a less restrictive setting.

Staff were knowledgeable about the individual's support needs and services; this was good to see.

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas. Across the six individuals, there were 12 goals that met criteria. Four individuals did not have relationship goals, and all had barriers (communication and behavioral) that were affecting their ability to build relationships with others. More work was also needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

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

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

Individuals:

| # | Indicator | | Overall Score | 95 | 348 | 392 | 383 | 343 | 347 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 0%<br>0/6<br>40%<br>12/30 | 1/5 | 2/5 | 4/5 | 4/5 | 1/5 | 0/5 | | | |
| | | Health goals | 0%<br>0/6<br>0%<br>0/17 | 0/3 | 0/3 | 0/3 | 0/2 | 0/3 | 0/3 | | | |
| 2 | The personal goals are measurable. | Personal goals | 0%<br>0/6<br>50%<br>6/12 | 0/5<br>0/1 | 2/4<br>1/2 | 2/4<br>2/4 | 3/5<br>3/4 | 1/4<br>0/1 | 0/4<br>0/0 | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 31%<br>8/26 | | | | | | | | | |
| | | Health goals | 0%<br>0/6<br>6%<br>1/17 | 0/3 | 0/3 | 1/3 | 0/2 | 0/3 | 0/3 | | | |
| 3 | ISP action plans support achieving the individual's personal goals. | | 17%<br>1/6<br>25%<br>3/12 | 1/1 | 1/2 | 1/4 | 0/4 | 0/1 | 0/0 | | | |

Comments:

Individual #95 was 31 years old, she had lived at San Antonio SSLC since 2007. She exhibited increased aggressive behaviors while living at home and was admitted to the Southwest Mental Health Center in 1999 then readmitted in 2003 before being transferred to the San Antonio State Hospital. She returned home and was then placed in a group home. She was readmitted to the San Antonio State Hospital and discharged into a HCS home in 2004 where she remained until 2007. She had three admissions to San Antonio State Hospital for aggression and self-injurious behaviors before moving to San Antonio SSLC in September 2007. Her diagnosis included Cornelia de Lange Syndrome and Profound Intellectual Disability. Individual #95 had a limited verbal vocabulary, so she communicated primarily with facial expressions, physical gestures, and body movements, but could say yes or no when making choices. Individual #95's mother/guardian (although guardianship status had lapsed) previously visited Individual #95 several times a month, but recently experienced a health decline following a fall in 2020 and was residing in a nursing facility. The QIDP had facilitated communication between Individual #95 and her mother via video technology, so they could maintain contact. Aside from her mother, Individual #95 had no other family or friends actively involved in her life. Individual #95 did not participate in virtual interviews during the week, but was observed on several occasions. Over the past year, Individual #95 had been involved in numerous peer-to-peer aggression events either as the aggressor or the victim, had several allegations of abuse/neglect, and numerous self-injurious and aggressive behavioral incidents; one in 2021 which resulted in a detached retina and loss of vision in her right eye. There had been IDT discussion as to the appropriateness of Individual #95's placement at San Antonio SSLC and some IDT members questioned whether a move to a different facility was warranted. This issue was sent to the Resolution Committee and, per 9/8/21, minutes it was determined that the Committee did not recommend a move to another facility. The IDT had determined that Individual #95 required significant behavior and psychiatric supports to prevent injury from aggression and self-injurious behavior that were not readily available in a less restrictive setting and, therefore, did not recommend referral for community transition.

Individual #348 was born on 9/12/87 at a military base in Japan. The family returned to the United States when Individual #348 was three years old and lived in Hawaii for six years. Individual #348 lived at home with his parents until his aggressive behavior became unmanageable for his family. He was admitted to the San Antonio SSLC in 2007. Individual #348 was diagnosed with Autistic Disorder and Obsessive-Compulsive Disorder. He had a Positive Behavior Support Plan that provided strategies to address aggression, taking items, and refusals. Individual #348 communicated through eye contact, facial expressions, body movements, gestures, and used some basic signs. Individual #348 enjoyed taking walks around campus and was observed taking walks during the review week. Individual #348 had experienced an increase in falls/injuries due to suspected seizure-like activity. He received multiple trials with various helmets and had been wearing a purple one. However, on 12/14/21, he experienced a fall when he was not wearing the helmet that

resulted in a serious injury, including a fractured jaw and nasal bone. The IDT determined that Individual #348 could not be served in a less restrictive setting and did not recommend a referral for community transition due an increase in drop seizures which required polypharmacy for treatment and an upward trend in all target behaviors. Individual #348's mother requested that he remain at San Antonio SSLC.

Individual #392 moved to San Antonio SSLC from the San Angelo SSLC on 9/15/21. He was born on 9/6/79 and had one brother and two sisters. Individual #392 was born with a hearing impairment, but could hear with right ear if spoken to in a loud voice. He did have a hearing aid and had recently been recommended for bilateral hearing aids. He was reported to have had a head trauma at age seven from falling off his bicycle, but no documentation was available aside from visible scars on the front of his head and a psychiatric assessment from San Antonio State Hospital 4/5/00 that noted some skull deformities. Individual #392 reported being in a car accident requiring brain surgery when he was 19. Beginning at the age of 15, he had a history of over 20 admissions to state hospitals and multiple failed community group home placements. Individual #392 did not have a legal guardian/representative, but did have family to support him in making informed decisions. Individual #392 communicated well in both Spanish and English and was independent with all ADLs. Individual #392 indicated he would like to have community employment in either landscaping or a janitorial type of job. While he had expressed that he would like to live in a group home in the San Antonio area near his family, the IDT determined that while he was undergoing medication changes and demonstrated targeted behaviors, he could not be supported in a less restrictive setting and, therefore, did not recommend a referral for community transition.

Individual #383 was born on 9/6/01 in Abilene, the middle of five sisters. Developmental delays were noted, and she did not walk until she was 18 months old and did not speak until she was three. At that time, she was diagnosed with an intellectual disability. She attended school through special education classes until the 11th grade when she dropped out. According to her social history, her parents were divorced, and Individual #383 lived at home with her mother until she was 11 when she witnessed her mother's murder. She went to live with her father and stepmother until the family sought alternative placement when she was around 15 years old due to unmanageable behavior and assault on her teacher and her stepmother. Thus began a history of community placements and psychiatric admissions. Following a discharge from a psychiatric hospital in March 2020 she returned to the group home and hung herself. She was admitted to Hendrick Medical Center and intubated due to acute respiratory failure. It was determined Individual #383 would benefit from inpatient treatment and was transferred to Big Spring State Hospital in April 2020. Emergency placement at San Antonio SSLC was secured on 1/20/21. Individual #383 communicated well and could read/write at approximately a paragraph level. She had no previous opportunities for employment exploration, but expressed that she would like to work as a cashier. She participated in the transition program at San Antonio SSLC where she could learn about competitive employment, academics, and social skills. Individual #383 liked music, especially Country and Hip Hop, and indicated her favorite artist was Kane Brown. The IDT determined that Individual #383 would benefit from remaining at the San Antonio SSLC to allow for stability as a new admission while addressing behavioral concerns and monitoring psychiatric medication changes.

Individual #343 was born on 10/2/61 in San Antonio. Intellectual disability was suspected at age seven months in conjunction with a seizure disorder. She was placed at the Richmond State School on 10/30/69 after her parents determined they could not provide the care she required. On 2/2/70, Individual #343 was transferred to the Austin State School and then after an opening became available at the San Antonio SSLC in 1980, she moved there to be closer to family. She communicated through facial expressions, body movements, laughter, and loud vocalizations. She used a wheelchair and required full staff assistance for her personal care. She liked to manipulate

items, go for wheelchair walks outside, listen to music and soothing sounds, shake things like maracas, and preferred her environment to be quiet. Individual #343 received all nutrition and medications via a g-tube. Individual #343 did not have a guardian/LAR. It was noted in the ISP that Individual #343's sister was important to her, but did not attend her annual ISP meeting. According to the CLOIP Worksheet dated 9/3/21, the Service Coordinator was unable to reach her sister for input. As documented in the ISP, the IDT was not recommending referral for community transition due to Individual #343's complex medical needs/supports. The IDT was not aware of any alternate/less restrictive community living option that were able to support her needs.

Individual #347 was born on 6/5/59 in San Antonio, the youngest of five siblings. At nine months of age, Individual #347's mother noted twitching muscles, her eye turned to the right, and she did not use her right hand. She was admitted to Santa Rosa Hospital where she underwent exploratory surgery and was found to have a thick subdural membrane on her left side. At 10 months old, she had a subdural hematoma. She was diagnosed with Kempe Syndrome. Developmental milestones were delayed or not achieved. Individual #347 lived with her mother until she was seven years old when was placed at Abilene State School in October 1966 by Child Protective Services. Individual #347 moved to the San Antonio SSLC in April 1980. She had no documented further contact with her family. Her diagnoses included bipolar disorder, seizure disorder, and profound I/DD. Individual #347 used a wheelchair and liked to propel herself. She understood English and Spanish and communicated with some words or short phrases, facial expressions, and body gestures. She could use a Keurig machine, feed herself, and was able to indicate her wants and needs. Her ISP indicated that Individual #347 required considerable medical supports that could be met in a less restrictive setting and therefore did not recommend a referral for community transition.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 27 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and were aspirational. For this review, a decrease was noted with 12 goals meeting this criterion:

- Recreation/Leisure: Individual #348, Individual #392, and Individual #383
- Job/School/Day: Individual #392, Individual #383
- Independence: Individual #95, Individual #348, Individual #392, Individual #383, and Individual #343
- Living Option: Individual #392 and Individual #383

For most individuals, goals and action plans appeared to be connected to individual preferences, however, did not provide exposure to new opportunities to broaden the individual's base of experience and identify new preferences. Additionally, community-based activities were limited or on hold due to COVID-19 restrictions that greatly impacted implementation of nearly all goals.

Recreation/Leisure*:*
Individual #348, Individual #392, and Individual #383 had recreation and leisure goals based upon interests and were reflective of community integration. Goals were Individual #348 will purchase his own meal at a preferred restaurant in the community once a month, Individual #392 will go to six sporting events in San Antonio within the next year, and Individual #383 will attend a live Kane Brown concert.

Goals that did not meet criterion for the indicator did not reflect specific preferences, strengths, interests, and needs nor did they provide opportunities to try new activities or learn new skills:

- Individual #95 had a goal to go swimming in the community.
- Individual #343 had a goal to attend two live music events in the community.
- Individual #347 had a goal to attend live musical events in the community twice per year.

Relationships:
Four of the six individuals, Individual #348, Individual #392, Individual #343, and Individual #347 did not have relationship goals. Their ISPs reflected few personal relationships, significant barriers to developing relationships, and communication barriers. The IDTs had not adequately considered the development of strategies and supports to increase their ability to communicate with others or manage interpersonal relationships, which in turn could potentially lead to increasing their ability to build interpersonal relationships. During interviews, the QIDP Coordinator and the Monitoring Team talked about that it was more than just whether they have relationships with peers and staff at the facility, but that interpersonal skills and relationship building are components of community integration, work skills, and gaining independence. The QIDP Coordinator stated this shortfall was currently being worked on with teams and upcoming ISP meetings.

- Individual #348's IDT determined that a relationship goal was not needed because his mother was very involved in his life. Individual #348 had a preference to spend time by himself absent of peers, but did like to give hugs to preferred staff. In the past, Individual #348 had frequent weekend family visits at San Antonio SSLC and his parents often took him off campus. Since the passing of his father, these visits had decreased.
- For Individual #392, the IDT indicated he could choose to spend time with whom he wished and when he wished, though he had many disagreements with peers and staff over seemingly mundane topics, such as small amounts of money that were not repaid or cigarettes. Individual #392 had expressed an interest in joining the local Special Olympics organization and competing in bowling activities. He also was encouraged to attend relationships training to discuss disagreements more productively with others and avoid them if possible (which was an action plan, although there was no goal). He had expressed an interest in resuming regular visit with his family and his family had begun visiting him at San Antonio SSLC. Individual #392 had issues with his new relationships amongst peers on campus. He would at times be very friendly, but at other times would assume an aggressive or threatening tone if he believed some slight has been perpetrated against him.
- For Individual #343, the IDT determined a goal was not needed in the area of relationships. Her mother had not been able to visit her much this past year, but she did enjoy visits from family. Individual #343's ISP documented opportunities at the Center to develop relationships with peers included evening activities at the DC Gym, seasonal and holiday events, peers' birthday parties, open houses, Easter Parade, Bible School, rummage sale at the pavilion, etc. She was not involved in any community groups. When she attended community outings, she had informal opportunities to meet people and develop new relationships. This was also not a priority goal for the previous year's ISP.
- Individual #347's IDT determined she did not show an interest in generating new relationships with her peers or staff and did not have any active family or LAR. She did not go into the community often enough to develop new relationships.
- Individual #95's goal to indulge in spa services at local day spas did not specify how this would lead to development of new or maintenance of relationships.
- Individual #383's goal to make and send crafts to elderly at nursing homes or community centers had good intent, but it did not promote her taking the crafts to the nursing homes or centers to meet the recipients. It should be noted that she had not participated in this goal, but had sent cards and gifts to peers from a previous group home placement and to people in prison.

Job/School/Day*:*
Two individuals (Individual #392, Individual #383) had goals that met criteria, were aspirational, and offered opportunities for gaining employment in a less restrictive environment.

Individual #95's goal to complete the entire task of her towel contract was not indicative of the type of work or day program she would like to have. This was the same for Individual #348's goal to complete a vocational task in A-37 at the Developmental Center daily and Individual #347's goal to develop her own sensory box and stock it with items she chose. Finally, Individual #343's goal of performing at two live music performances on campus did not describe what type of day program she had or would like to have.

Independence:
Five individuals had goals that met criteria for indicator 1 in terms of being based upon their preferences.

- Using automated technology, Individual #95 will order her preferred meal from McDonald's
- Individual #348 will make his own snacks (3) daily
- Individual #392 will manage his own diabetic care needs
- Individual #383 will cook her preferred meal independently
- Individual #343 will request two preferred activities during her leisure time daily.

Individual #347's goal "to create three different art forms to display on campus" was not specific in terms of how creating this art reflected her specific preferences, would lead towards greater independence, or how it would provide her with opportunities to try new activities or learn new skills.

Living Option:
Two goals met criteria. Individual #392 identified that he wanted to live in a group home in San Antonio to be close to his family. Yet, the ISP did not document if the IDT had discussed the supports needed for Individual #392 to overcome barriers to accomplish this goal. Similarly, Individual #383 stated that she wanted to live in an apartment in San Antonio, but the ISP did not identify the supports needed to accomplish the goal. The LAR was reportedly aware of less restrictive living options, but did not participate in the ISP meeting and discussion.

For the other four individuals, goals were not specific or aspirational and/or did not clearly address barriers to living in a less restrictive setting or address skills needed to live more independently.

- Individual #95 will independently go about her routine with a daily schedule she creates.
- Individual #348 will live at Home 671 Sycamore Lane where he will have personalized room décor.
- Individual #343 will live at Home 673 Yellow Rose at the San Antonio State Supported Living Center.
- Individual #347 will furnish her bedroom.

Goals for Individual #348 and Individual #349 to furnish/decorate their rooms were good short term activities that should be accomplished within the ISP year and skill development was likely, however, they did not address the long term goal to live more independently or in a less restrictive environment.

Health/Safety:
It was nice to see that one individual had a goal to support participation in improving or maintaining their own health and wellness. Individual #392 had a goal to lose one to two pounds per month in the next year. The goal, however, did not describe how she would be involved in managing her weight loss.

For five individuals, health risks had been identified with goals for clinical outcomes (e.g., medical, nursing, dental; see bulleted list below), but none included actions in which the individual might engage to address health and safety risks. The following risk areas were assessed for the inclusion of personal goals:

- Individual #95: dental, weight, gastrointestinal/GERD/constipation
- Individual #348: dental, osteoporosis/fractures/falls, medication side effects
- Individual #343: dental, aspiration, osteoporosis/fractures/falls
- Individual #347: dental, weight, skin integrity
- Individual #383: dental, weight, medication side effects

2. There were nine measurable goals. Of the 12 personal goals that met criterion for indicator 1, six also met criterion for measurability:

- Recreation/Leisure: Individual #348, Individual #392, and Individual #383
- Relationships: none
- Job/School/Day: Individual #383
- Independence: none
- Living Option: Individual #392, Individual #383, Individual #348, and Individual #343
- Health/Safety: Individual #392

For goals that were not measurable, the goal was not written in observable, measurable terms, did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. For example,

- Individual #383 and Individual #348 had goals to make snacks daily and cook a preferred meal independently (respectively). As written, neither goal specified how long/how many trials the individuals were to complete the activities before achievement could be determined. Additionally, Individual #348's goal to make a snack was broadly stated and did not describe skills that he would master (e.g., use, oven, microwave, blender).
- Individual #343's goal to request two preferred activities during her leisure time daily was similarly absent of specificity.
- Individual #343 and Individual #347 had recreation goals to attend events in the community. The goal did not specify action that the individual would take or what level of supports were necessary to master the goal.

3. For the 12 goals that met criterion for being personal and individualized, three had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals.

Goals that had action plans that were likely to lead to achievement of the goals were:

- Recreation/Leisure: Individual #348

- Independence: Individual #95 and Individual #392

Examples of goals that did not meet criteria:

- Individual #392's work goal to work in the community performing custodial duties in San Antonio had accompanying action plans to attend VAT once weekly, be assessed on the TX DOT Off-Campus Grounds Crew for mowing, wear a mask in work area, complete janitorial assessment, and attend job fairs that included custodial jobs. Action plans did not integrate strategies to reduce risk and address barriers.
- Individual #348's independence goal to make his own snacks (3) daily included two action steps, one of which was a SAP to make a smoothie by independently using a blender three of four trials for three consecutive months. The other action plan was a service objective to place his toothbrush in his mouth and staff would assist with brushing. Neither of these action plans included all necessary steps with specific detail to support implementation and assessment of progress.

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

Summary: Developing detailed action plans that provided sufficient details for consistent implementation and documentation was still an area that needed more work. Indicator 5 was scored for the six goals that met criteria for indicator 1 and 2. There continued to be a lack of data in regard to progress towards goals. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 348 | 392 | 383 | 343 | 347 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur. | 0%<br>0/3<br>0%<br>0/3 | 0/1 | 0/1 | 0/1 | | | | | | |
| 5 | There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals. | 0%<br>0/3<br>33%<br>2/6 | | 0/1 | 1/2 | 1/3 | | | | | |

Comments:

4. In general, action plans lacked clear implementation strategies, necessary supports, or criteria for documenting and evaluating progress. None of the individuals had a comprehensive set of action plans that met criterion for the indicator and were supportive of their respective goals.

5. For the six goals that met criteria for indicator 1 and 2, two had reliable and valid documentation and data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. Findings included:

- For Individual #383's independence goal, the QIDP noted in monthly reviews that there was a delay in implementation of action steps because the SAP had not been developed timely. It was written and staff were trained on implementation nearly six months after the ISP meeting date. Data were not provided to reflect implementation.

- Individual #392's recreation/leisure goal included a step for the IDT to meet and discuss training to use internet searches. His QIDP month review indicated that the IDT met on 12/14/21 and a SAP was implemented on 1/7/22.
- For the other four goals, the QIDP commented "no supporting data" on implementation of action plans, therefore, it was not possible to determine if action plans had been implemented or if progress had been made towards achievement of goals.

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

Summary: Overall, individuals were not making progress towards their goals and IDTs were not taking action to address barriers to implementation and progress by revising the ISP to make progress more likely. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 348 | 392 | 383 | 343 | 347 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | The individual met, or is making progress towards achieving, his/her overall personal goals. | 50%<br>1/2<br>50%<br>1/2 | | | 1/1 | 0/1 | | | | | |
| 7 | If personal goals were met, the IDT updated or made new personal goals. | N/A | | | | | | | | | |
| 8 | If the individual was not making progress, activity and/or revisions were made. | 0%<br>0/1 | | | | 0/1 | | | | | |

Comments:

6. Individual #392 had made some progress towards his recreation/leisure goal when the IDT completed an assessment and developed a SAP for searching the internet. The SAP, however, had not been in place long enough to determine what progress had been made towards learning a new skill. For the most part, QIDP monthly reviews documented that action plans had not been consistently implemented, thus, individuals had not made progress towards their goals.

7. None of the individuals had achieved an ISP goal.

8. Although QIDPs were reviewing action plans monthly, action was not always identified and taken to address the lack of progress or to revise action plans when indicated.

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

Summary: Implementation of ISPs within 30 days, meeting attendance, and ensuring that assessments are completed prior to the annual ISP meeting continued to be areas where more work was needed. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 348 | 392 | 383 | 343 | 347 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9 | a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year). | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| | b. The ISP was implemented within 30 days of the meeting or sooner if indicated. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 10 | The individual and all relevant IDT members participated in the planning process and attended the annual meeting. | 33%<br>2/6 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | | | |
| 11 | a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| | b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting. | 17%<br>1/6 | 0/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | | | |
| | c. Assessments were updated as needed in response to significant changes. | 0%<br>0/1 | | 0/1 | | | | | | | |

Comments:

9b. The ISP was not fully implemented within 30 days of the meeting for any of the individuals. For all individuals, multiple action plans had not been implemented. For example:

- Individual #383: Her action plan to participate in water activities at her home once a month had not been scheduled, her SAP for preparing her spa was not implemented timely, and her SAP for towel contract work was not developed or implemented timely.
- Individual #348: His SAPs for trading money for an item and making a smoothie were not implemented timely.
- Individual #392: His assessment for internet search and corresponding IDT discussion to develop training were not timely. His SAP was implemented 1/7/22, nearly three months after the target date.
- Individual #383: Her action plan to research different nursing homes or community centers was not implemented. Action plans to send crafts to nursing homes or community centers did not occur, but she did send to crafts to previous housemates and people in prison. Her goal and action plans were not revised to reflect this change.
- Individual #343: Her action plan to activate a Big Mac button to request to go outside was not implemented timely.
- Individual #347: Her SAP to paint a canvas had no corresponding data to validate implementation.

10. Two of the six individuals had an appropriately constituted IDT for the planning process that was based on their strengths, needs and preferences (Individual #95, Individual #343). It was good to see that for the three individuals with communication barriers (Individual #348, Individual #343, Individual #347) an SLP was present was present to discuss support needs for individuals to develop or enhance their communication skills.

- Individual #348 was not present at his ISP meeting. The ISP indicated he was in the living room with staff and in good spirits, but showed no interest in participating in his ISP meeting held via teleconference to promote social distancing. Individual

#348's LAR/mother was not in attendance due to prior commitments, but as noted by the QIDP, expressed concern over his increased number of reported seizures and lack of toothbrushing/oral hygiene. The ISP did not indicate that a DSP participated. The ISP also did not reflect that the PCP or psychiatry was present to guide and inform the team relative to Individual #348's increased seizure activity, falls, and complex medical issues.

- Individual #392 did not attend his ISP meeting. The ISP did not reflect that vocational staff were present to discuss and plan for Individual #392's desire for community employment.
- While Individual #383 did attend her ISP meeting, her father/LAR did not. The ISP indicated "he prefers not to attend meetings but liked to be updated via email or phone call with any changes to plans." There was no indication that he had any input regarding planning for her services and supports. Her ISP preparation document indicated that he did not attend the 30-day ISP and had not attended subsequent meetings.
- Individual #347 was not present at her ISP meeting. The ISP did not reflect that day program staff were present to support the team in developing an adequate goal for day programming services. Individual #347 did not have a LAR or any known family.

11b. For five individuals, required assessments were not obtained at least 10 days prior to the IDT meeting:

- Individual #95: vocational assessment
- Individual #348: audiological assessment and neurological exam
- Individual #392: comprehensive psychiatric evaluation, vocational assessment, and annual dental exam
- Individual #383: annual dental assessment and comprehensive psychiatric evaluation
- Individual #347: annual dental exam

11c. According to documentation and interviews, there had been no PNM assessment to address Individual #348's recent increase in falls related to his seizure activity and unsteadiness.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: IDTs need to continue to focus on ensuring that there is a robust discussion of living options available to support individual needs. IDTs were still struggling to identify and address barriers to living in a less restrictive setting. ISP action plans encouraged community participation. This has been the case for successive reviews and, as a result, indicator 13a will be moved to the category of requiring less oversight. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 95 | 348 | 392 | 383 | 343 | 347 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | There was a thorough examination of living options. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 13 | a. ISP action plans integrated encouragement of community participation and integration. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. | 33%<br>2/6 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | | | |
| 14 | ISP action plans included individualized-measurable plans to educate the individual/ LAR about community living options. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 15 | IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition. | 0%<br>0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

12. None of the ISPs included a thorough examination of living options and how living in the community might benefit the individual.

13a. ISPs for all six individuals had action plans designed to support and increase community integration. However, many of these action plans/activities were on hold due to COVID-19 precautions, which greatly impacted individual's ability to participate in implementation. It was positive to see that several individuals had action plans to use technology, such as tablets and computer access for researching community activities.

13b. Two ISPs (Individual #392, Individual #383) considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day and work opportunities were limited for most individuals and focused on what was available at the facility without focusing on building skills that could potentially lead towards employment or meaningful day programming in a more integrated setting.

14. None of the ISP action plans included individualized measurable plans to educate the individual/LAR about community living options. Additionally, when individuals were not represented by a LAR or had active family involvement, there was no plan to seek independent advocacy or representation for the individual to ensure informed decision-making regarding community living options. Individuals had broadly stated action plans to provide information to the individual and LAR annually, attend provider fairs, and/or go on community tours.

15. IDTs had not created individualized, measurable action plans to address identified obstacles to referral. Action plans were broadly stated and did not address a path for living in a less restrictive setting.

| Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed. | |
|---|---|
| Summary: Staff were knowledgeable of individual's support needs, strengths, preferences, and goals. This was good to see and was the case for two of the last three reviews, too. Therefore, indicator 16 will be moved to the category of requiring less oversight. Overall, training opportunities were limited for individuals. The implementation of action plans continued to be problematic. Although, QIDPs were completing a monthly review of services and supports for all individuals, | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| action was not evident when there was a gap in ISP implementation or other recommended supports (i.e., medical appointments). These indicators will remain in active monitoring. | | | | | | | | | | | |
| # | Indicator | Overall Score | 95 | 348 | 392 | 383 | 343 | 347 | | | |
| 16 | Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. | 100% 6/6 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | | |
| 17 | Action plans in the ISP were consistently implemented. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| 18 | The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |

Comments:

16. Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. While remote observations were limited, somewhat awkward, and difficult, staff were providing respectful and positive interactions.

17. For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. For nearly all individuals, IDTs had developed numerous action plans to support goals across five areas (recreation/leisure, relationships, job/school/day, independence, and living options). A total of 126 action steps were evaluated. Of those, 44 (35%) were on hold due to COVID-19 community gathering restrictions and behavioral/health concerns that impacted individual's ability to participate in implementation. There was no evidence that IDTs considered alternate training opportunities while action plans were on hold. Of the 82 action plans that could be implemented, eight (10%) had documentation to show consistent implementation.

| Individual | # of Action Steps in ISP | Action Steps Implemented | Action Steps On Hold | Action Steps Not Fully Implemented |
|---|---|---|---|---|
| Individual #95 | 28 | 0 | 10 | 18 |
| Individual #348 | 9 | 0 | 2 | 7 |
| Individual #392 | 25 | 2 | 5 | 18 |
| Individual #383 | 30 | 3 | 13 | 14 |
| Individual #343 | 13 | 3 | 4 | 6 |
| Individual #347 | 21 | 0 | 10 | 11 |

18. None of the individuals met criterion for the indicator. QIDPs did not ensure that individuals received required monitoring/review and revision of treatments, services, and supports. Monthly reviews were lacking substantive and qualitative commentary in terms of assessing needed revisions, barriers to full implementation, and progress or lack of progress. The QIDP Coordinator recognized quality issues with monthly reviews and monitoring of services and supports. She noted that this was due in part to staffing issues in the QIDP department over the past several months. The Monitoring Team also recognized and appreciated this awareness by the QIDP Coordinator.

## Section G: Integrated Clinical Services

Substantial Compliance – Exited Status

None of the provisions of this section had met and achieved substantial compliance.

Due to sustained high performance, the four indicators that comprise provision G2 (medical 7a-d) met and maintained substantial compliance and are exited from monitoring.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary
None of the individuals received dental or medical pre-treatment sedation in the six months prior to the review.

For all consultations with community providers, the PCP review was timely and well documented. IDTs met as necessary to review recommendations and document decisions and plans for follow-up.

| Dental: Outcome 6 – Individuals receive dental pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: None of the individuals received dental pre-treatment sedation. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| a. | If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed. | N/A | | | | | | | | | |
| b. | If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed. | N/A | | | | | | | | | |
| Comments: | | | | | | | | | | | |

| Medical: Outcome 11 – Individuals receive medical pre-treatment sedation safely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: None of the individuals received medical pre-treatment sedation. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed. | N/A | | | | | | | | | |
| | Comments: | | | | | | | | | | |

| Medical: Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: For all consultations, the PCP review was timely and well documented. IDTs met as necessary to review recommendations and document decisions and plans for follow-up. Due to sustained high performance, indicator e will be moved to the category of requiring less oversight. The status of indicators a-d is described above, that is, these indicators comprise provision G2 and are now exited from monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| 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, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| b. | PCP completes review within five business days, or sooner if clinically indicated. | 100% 14/14 | 2/2 | 2/2 | 2/2 | 2/2 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 |
| c. | The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT. | 100% 14/14 | 2/2 | 2/2 | 2/2 | 2/2 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 |
| d. | If PCP agrees with consultation recommendation(s), there is evidence it was ordered. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| e. | As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans. | 100% 11/11 | 1/1 | | 2/2 | 2/2 | 1/1 | 1/1 | 2/2 | 1/1 | 1/1 |

Comments:
For the nine individuals, the Monitoring Team reviewed 14 consultations:

- For Individual #343: gynecology on 10/15/21 and pulmonology on 10/11/21
- For Individual #255: urology on 11/29/21 and dermatology on 11/1/21
- For Individual #277: neurology on 10/8/21 and pulmonology on 11/22/21
- For Individual #347: cardiology on 8/17/21 and rheumatology on 11/2/21
- For Individual #392: ophthalmology on 12/15/21
- For Individual #365: endocrinology on 8/12/21
- For Individual #142: neurology on 11/29/21 and gastroenterology on 10/7/21
- For Individual #348: epileptology on 11/29/21

- For Individual #258: gastroenterology on 9/13/21

b. For all consultations, the PCP completed a review within five business days, or sooner when clinically indicated.

c. The PCP wrote an IPN that explained the reason for the consultation, significance of the results, agreement, or disagreement with the recommendations, and determined whether there was a need for referral to the IDT for all consultations.

e. For all individuals, the IDT reviewed the recommendations and developed an ISPA documenting decisions and plans, as needed.

## Section H: Minimum Common Elements of Clinical Care

Substantial Compliance – Exited Status

One of the provisions of this section met and achieved substantial compliance: H2.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

## Section I: At-Risk Individuals

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

Most of the individuals were assigned risk rating that were accurate and reflected their current status, however, the risk reviews in the event of a change in status were inconsistent in their timeliness.

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

Summary: Most of the individuals were assigned risk rating that were accurate and reflected their current status, however, the risk reviews in the event of a change in status were inconsistent in their timeliness. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 277 | 343 | 255 | 392 | 348 | 258 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's risk rating is accurate. | 83% 10/12 | 1/2 | 2/2 | 2/2 | 1/2 | 2/2 | 2/2 | | | |
| b. | The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs. | 42% 5/12 | 2/2 | 0/2 | 0/2 | 2/2 | 1/2 | 0/2 | | | |

Comments:

a. The majority of the individuals had accurate risk ratings. Exceptions were noted for the following individuals.

- Individual #277's IRRF contained limited GI related history and clinical because it only went back to September 2021 and did not reflect on experience prior to that period.
- Individual #392's IRFF was lacking information regarding the justification for the high rating for cardiac, particularly when the RNCM recommended a medium risk level and the PCP had discontinued one of his two antihypertensive meds at admission. In addition, the PCP recommended a Low risk level in the ISP according to 10/14/21 documentation.

b. Slightly less than half of the individuals had an IRRF completed in a timely manner.

- Individual #342's IRRF did not include updated information on the aspiration events that occurred October 2021 and again in January 2022. Additionally, the IRRF was not updated with information from her skin problems and RSV infection that occurred on 1/3/22.
- Individual #255's IRRF was not reviewed to update risk until after the individual's second pneumonia that occurred in June 2021. The IRRF also did not include an update past the November 2021 episode of eight loose stools/emesis/potential medication interaction.
- Individual #258's IRRF was not updated until 10/1/21 in response to a pneumonia hospitalization that occurred 7/5/21.

## Section J: Psychiatric Care and Services

Substantial Compliance – Exited Status

Six of the provisions of this section met and achieved substantial compliance: J2, J3, J6, J7, J12, and J15.

Thus, the corresponding 18 monitoring indicators are no longer monitored or scored: 1-3, 12-16, 25-27, 36, 40-43, and 47-49.

Sustained High Performance – Less Oversight Status

Nine of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, four additional indicators were moved to this category.

Section Summary
The psychiatry department was well staffed (with the exception of a psychiatry nurse).

For psychiatric indicators and psychiatric goals:

- The psychiatry department was identifying indicators for reduction and increase as well as defining these indicators.
- The psychiatry department was consistently writing goals associated with each indicator.
- The relationship of the indicator to the individual's psychiatric diagnosis was not always clear or intuitively determined.
- The goals were not consistently entered into or updated in the facility's overall treatment program, the ISP or IHCP.

Quarterly evaluations were being performed in a timely manner. There was evidence of review of PSPs and PBSPs noted in the quarterly documentation.

Psychiatry maintained involvement in the ISP process. Review of the IRRF documents, however, revealed that the psychiatric elements were not consistently included in the IRRF.

Psychiatry clinics included appropriate IDT members. Overall, discussion was thorough and comprehensive.

The psychiatrists had good relationships with behavioral health services staff.

Polypharmacy justifications were generally included in the psychiatry clinical documentation, and there was evidence that individuals were reviewed quarterly if medication adjustments were in progress. There was, however, a long delay for the review of newly admitted individuals meeting criteria for polypharmacy.

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

Summary: At San Antonio SSLC, there was progress in the sub-indicators of each of the indicators in this outcome. The psychiatry department was identifying indicators for reduction and increase as well as defining these indicators and was consistently writing goals associated with each indicator. The relationship of the indicator to the individual's psychiatric diagnosis was not always clear or intuitively determined. The goals were not consistently entered into or updated in the facility's overall treatment program, the ISP or IHCP. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Psychiatric indicators are identified and are related to the individual's diagnosis and assessment. | 56% 5/9 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 1/2 | 1/2 | 0/2 | 1/2 |
| 5 | The individual has goals related to psychiatric status. | 100% 9/9 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 | 2/2 |
| 6 | Psychiatry goals are documented correctly. | 22% 2/9 | 2/2 | 0/2 | 0/2 | 1/2 | 0/2 | 0/2 | 2/2 | 0/2 | 0/2 |
| 7 | Reliable and valid data are available that report/summarize the individual's status and progress. | 22% 2/9 | 2/2 | 1/2 | 1/2 | 1/2 | 0/2 | 2/2 | 0/2 | 1/2 | 1/2 |

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.

San Antonio SSLC showed progress in this area as all individuals in the review group had one or more psychiatric indicators related to the reduction of psychiatric symptoms. The indicators for reduction were also sometimes identified as behavioral health PBSP target behaviors. There was a need to document how the indicators for reduction were related to a specific diagnosis. In some cases, where an indicator of aggression was associated with a diagnosis of an Autism Spectrum Disorder, it was possible to determine the relationship intuitively. In other cases, it was not possible to determine how the identified indicator related to a diagnosis. For five individuals, it was possible to intuitively determine how an indicator was related to a specific diagnosis. For example, regarding Individual #392, it was not clear how an indicator for reduction, identified as aggression, related to stability of Schizophrenia. For Individual #385, it was not clear how an indicator for reduction, identified as aggression, related to stability of Bipolar Mood Disorder.

All of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. In six examples, these were designated as stable days or days free of specific symptoms or target behaviors. For some individuals with stable days indicators, it was possible to intuitively determine how the absence of a specific symptom related to a diagnosis. For others, this could not be intuitively determined. For example, regarding Individual #385, stable days was defined as days free of aggression, disruptive behavior, and sleep disturbance. With the exception of sleep disturbance, it was not possible to intuitively determine the relationship between these symptoms and a diagnosis of Bipolar Mood Disorder. In other examples, indicators for increase were not identified as stable days. In one example, regarding Individual #381, the indicator for increase was days free of sleep disturbance. For Individual #296, the indicator was work attendance. For a work attendance indicator, the psychiatry clinic staff needs to specifically define what is required by attendance so that data can be collected accordingly.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for seven individuals in the review group and for six of the individuals for psychiatric indicators for increase.

5. Psychiatric goals:

The Monitoring Team looks for:

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

The psychiatric goals regarding the indicators for increase and decrease met monitoring criteria in that they included a measurement, the modality or scale that would be used to obtain the measurement, and a time metric. The psychiatry goals grid indicated who was responsible for the gathering or trending of data specifically that data would be compiled/analyzed by behavioral health staff, and then analyzed by psychiatry or the psychiatry compliance nurse.

As the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered.

Thus, both sub-indicators were met for all of the individuals in the review group for goals for reduction and for goals for increase.

6. Documentation:
The Monitoring Team looks for:

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

At San Antonio SSLC, goals for reduction and increase were written for the identified indicators and documented in the psychiatry goals grid. But, the goals were not consistently incorporated into the Center's overall documentation system, the IHCP. In some cases, the goals were included in the ISP document, but these goals were not regularly updated or tracked. It is important that the psychiatry department use the integrated document, the IHCP, to allow for goal updates and tracking. There were two individuals who had current, up-to-date goals regarding both the indicators for reduction and decrease documented in either the ISP or the IHCP, Individual #296 and Individual #95.

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 San Antonio SSLC, data were reported for psychiatric indicators for reduction and increase. These data, while generally graphed for the presentation in psychiatry clinic were then included in the psychiatry clinical notes as a list of months with totals of events occurring during that period of time. Data presented in clinical and review meetings were generally up-to-date and, as noted above, were graphed and trended. A review of the IOA reports for the data included in the psychiatry clinical documents revealed that all data reviewed were reliable. There were some indicators that were not reviewed and thus reliability could not be determined. For example, for Individual #367, the one indicator for reduction was stripping, and there were no IOA data available regarding this. Individual #296 did not have IOA data to review. As he has a PSP, behavioral health reportedly does not monitor data reliability or validity.

With regard to indicators for increase, many individuals in the review group had an indicator of stable days. As stable days were essentially the number of days where a specific behavior or symptom did not occur, data regarding stable days would be reliable as the source data were reported as reliable. For Individual #348, stable days were defined as days free from aggression, but there were no IOA data reported regarding aggression. Regarding individuals without stable days indicators, Individual #141 had an indicator for increase regarding the use of a replacement behavior. There were no IOA data presented regarding this. Individual #381 had an indicator for increase specifically days free of sleep disturbance. There were no IOA data presented regarding sleep. Individual #296 had an indicator for increase regarding work attendance and participation, but there were no data reliability measures presented.

Thus, reliable data were presented for two individuals, Individual #95 and Individual #392, with regard to both indicators for reduction and increase.

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

Summary: With some improvements in ensuring reliability for psychiatric indicators that are not already in the PBSP, better performance for indicator 8 is likely. It was good to see new goals/objectives being made throughout the ISP year. Due to sustained high performance on this activity, indicator 9 will be moved to the category of requiring less oversight. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals. Indicator 8 will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | The individual is making progress and/or maintaining stability. | 0% 0/9 | 0/2 | 0/2 | 1/2 | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 |
| 9 | If goals/objectives were met, the IDT updated or made new goals/objectives. | 100% 5/5 | 1/1 | | 1/1 | 1/1 | 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. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 11 | Activity and/or revisions to treatment were implemented. | | | | | | | | | | |

Comments:
8-9. Per a review of the individual's goals and indicators as well as available data, there were individuals who were making progress toward their treatment goals. The psychiatry department did a good job of regularly reviewing the available data and the individual's progress toward their treatment goals as well as writing new/updated goals and including them in the psychiatry goals grid. The issue was that the original or updated goals were not included into the overall treatment program, the ISP or IHCP.

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

Summary: Psychiatry showed improvements in meeting the requirements of this outcome. Indicator 20 showed sustained high performance over successive reviews and, therefore, will be moved to the category of requiring less oversight. Indicators 18 and 21 will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | Status and treatment document was updated within past 12 months. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 | Documentation prepared by psychiatry for the annual ISP was complete (i.e., annual psychiatric treatment plan). | 83% 5/6 | 1/1 | | 1/1 | 0/1 | 1/1 | | 1/1 | 1/1 | |
| 19 | Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 20 | The psychiatrist or member of the psychiatric team attended the individual's ISP meeting. | 89% 8/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 |
| 21 | The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting. | 44% 4/9 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | 0/1 |

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Five of the annual evaluations contained all of the required elements. The remaining evaluation, regarding Individual #381, was missing one element, demographic information.

20. The psychiatrist attended the ISP meeting for eight of the individuals in the review group. In general, the psychiatry attendance was not documented on the ISP form, however, psychiatric clinicians authored progress notes indicating their participation in the meeting. This was good to see.

If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

21. In five examples there was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits.

In four examples, regarding Individual #95, Individual #381, Individual #348 and Individual #296, the psychiatric documentation in the ISP/IRRF was complete and addressed the required elements. As noted above psychiatry had started to author progress notes regarding their participation in the ISP meeting. In examples where the IRRF did not include the essential elements, the information contained in these progress notes included more psychiatric information than the finalized ISP/IRRF document and could be used to start the documentation required for this indicator.

| Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 22 | If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided. | 100% 2/2 | | | | | | | 1/1 | | |
| Comments:<br>22. The PSP documents regarding Individual #296 and Individual #346 were reviewed. The PSP documents were brief, but direct, and contained a description of the psychiatric symptoms for monitoring, how to document data, as well as recommendations for staff regarding how to respond to and support the individual. | | | | | | | | | | | | |

| Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Psychiatry worked well with behavioral health services. Sustained high performance over successive reviews was shown for indicator 24, which will be moved to the category of requiring less oversight. The same might happen to indicator 23 after the next review if high performance is sustained. It will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 23 | Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 24 | The psychiatrist participated in the development of the PBSP. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 |
| Comments:<br>23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavior assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors for all of the individuals in the review group receiving psychiatric services.<br><br>24. The psychiatric documentation for eight individuals in the review group who had a PBSP included documentation regarding a discussion of the individual's PBSP. Staff interviews and observation of psychiatry clinic during the monitoring visit revealed that the | | | | | | | | | | | |

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| individual's PBSP was regularly reviewed during the psychiatric clinical encounters. Once the PBSP was finalized, it was signed by the treating psychiatrist. |

| Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Both indicators showed continuing improvement. Both will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 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. | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| 31 | Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered. | 56% 5/9 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |
| 32 | HRC review was obtained prior to implementation and annually. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |

Comments:
30. The risk versus benefit discussion was included in the consent forms in all examples. This included a review of potential drug-drug interactions and cumulative risk concerns.

31. The consent forms for five individuals in the review group included alternate, individualized, non-pharmacological interventions in addition to the PBSP or PSP. For Individual #367, Individual #381, Individual #296, and Individual #383, only the PBSP or the PSP was indicated as an alternative.

| Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Two-thirds of the quarterly reviews met criteria and the three that did not were missing one item each. This indicator will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 33 | Quarterly reviews were completed quarterly. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 34 | Quarterly reviews contained required content. | 67% 6/9 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |

| | | |
|---|---|---|
| 35 | The individual's psychiatric clinic, as observed, included the standard components. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. |

Comments:
34. The Monitoring Team looks for nine components of the quarterly review. Six of the examples included all the necessary components. The remaining three examples were missing one element.

- The quarterly documentation regarding Individual #367 did not include EKG results.
- The quarterly documentation regarding Individual #296 did not include the dates of the MOSES and AIMS assessments.
- The quarterly documentation regarding Individual #385 did not include the dates of the MOSES and AIMS assessments.

| 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 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: The Center maintained high performance for three successive reviews for indicator 44, which will be moved to the category of requiring less oversight. Indicator 46 scored higher than in previous reviews; it will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 44 | There is empirical justification of clinical utility of polypharmacy medication regimen. | 83% 5/6 | 1/1 | 1/1 | | 1/1 | | 1/1 | | 1/1 | 1/1 |
| 45 | There is a tapering plan, or rationale for why not. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 46 | The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication | 67% 4/6 | 1/1 | 0/1 | | 0/1 | | 1/1 | | 1/1 | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | changes, or (b) at least annually if stable and polypharmacy has been justified. | | | | | | | | | | |

Comments:
44. Of the 126 individuals participating in psychiatry clinic at the facility, 47 individuals were prescribed medication regimens that met the definition of polypharmacy. So, almost 40% of the individuals participating in psychiatry clinic met criteria for polypharmacy.

These indicators applied to six individuals, Individual #95, Individual #367, Individual #381, Individual #392, Individual #385, and Individual #383. Polypharmacy justification was appropriately documented in the psychiatric clinical documentation in five examples. The polypharmacy justification was not included for Individual #367 other than a statement that the regimen was stable polypharmacy.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of regular meetings over the last calendar year. Overall, the facility had been reviewing individuals undergoing medication adjustments and/or active medication tapers on a quarterly basis. This was good to see.

Even so, there were ongoing delays in the review of committee review of regimens for newly admitted individuals.

- Individual #367 was admitted in August 2021 and despite prescription of a medication regimen that meets criteria for polypharmacy, had not been reviewed by the committee. In a comment on the draft version of this report, the Center pointed to there being no changes in the incoming medication regimen and that the Monitoring Team's criteria does not specify within what amount of time a new admission should be reviewed by polypharmacy committee. That being said, if a newly admitted individual is on a medication regimen that meets the definition of polypharmacy, one would expect a review in less than one full year after admission. Most Centers add new admissions to polypharmacy committee within three months.
- Individual #381 was reviewed 3/29/21, but this was a review of the medication indications and laboratory examinations. There was no documentation of a review of the justification for the medication regimen.

The polypharmacy committee meeting was observed during the virtual monitoring visit. The prescribing psychiatrist presented the medication regimens for four individuals during the meeting with other information including laboratory examinations and data discussed. Overall, the meeting was comprehensive, but lacked any challenge to the current prescribed regimen. Generally, this meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. Individuals should be scheduled for review annually, or quarterly if medication adjustments are made, or if there is an active medication taper in progress.

## Section K: Psychological Care and Services

Substantial Compliance – Exited Status

San Antonio SSLC achieved and sustained substantial compliance with Section K.

Thus, Settlement Agreement provisions K1 through K12 are exited and no longer monitored.

Thus, the corresponding 30 monitoring indicators (1 through 30) are no longer monitored or scored.

## Section L: Medical Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, 12 additional indicators were moved to this category.

Section Summary

COVID and the outbreaks were well managed resulting in limited adverse outcomes the last year. This was consistent with almost all individuals becoming fully vaccinated with booster vaccinations in a timely manner.

Medical staff were readily available and willing to see the individuals in a timely manner and address presenting concerns. Cross coverage appeared equally thorough and follow-up was not delayed waiting for their PCP.

Annual medical assessments (AMA) and periodic medical reviews were present, and timely. The Center needs to continue to focus on the quality of AMAs and periodic reviews. Annual medical assessments need to include, as applicable, updated active problem lists and thorough plans of care for each active medical problem.

For the most part, recommended preventative care was completed for individuals. PCPs need to ensure that there is a clear medical plan in place to provide alternate monitoring for breast cancer when a mammogram is not recommended.

The Center needs to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. Few of the IHCPs included detailed medical plans to address identified risks.

It was good to see that, for all individuals, medical practitioners had reviewed and addressed the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic and endocrine risks. There needs to be additional collaboration between psychiatry and medical providers when making decisions to minimize the risk of polypharmacy.

Hospitalizations and liaison communications were managed by nursing staff. Although there was an initial physician to physician transfer when time allowed, and a final physician to physician contact after the decision to return had been made, that was not optimal management of a hospitalization. In a comment on the draft version of this report, the State wrote : "There is no community standard of care on communication with hospitalists daily. An UpToDate review revealed that there are no standards

for provider-to outpatient provider communications. A systematic review in the Journal of General Internal Medicine found no literature on provider-to-provider communication during transitions from outpatient to acute care showing improved outcomes (JGIM 31:417-25, 2016). Could the monitor provide a medical reference demonstrating that daily communication between primary care physicians and rotating hospitalists leads to optimum management on the part of the PCP in the care of a hospitalized individual or that such communication constitutes the current, generally accepted professional standard of care as required under the terms of the amended settlement agreement or the Texas Medical Practice Act?" The Monitor's response is that the residents are generally not as well educated as the medical staff at the facilities, and since the medical staff are the most educated and knowledgeable about practicing medicine at the facilities, it is logical that the individual's PCP help coordinate the care with hospital staff as professional peers. In the past, the PCP would round on their hospitalized patients to ensure care was coordinated, now this can be done from their offices to ensure the PCP shares their knowledge about the specific needs of the individuals they care for. Poor communication between medical providers is a common source of inadequate care. This is summarized in an editorial below. All patients are better served when their PCP is personally coordinating their care and ensuring all concerns are covered, especially when the individuals are ones who cannot advocate for themselves.
Hospitalists and the Family Physician - Editorials - American Family Physician (aafp.org)

PCPs were reviewing consultations in a timely manner. Documentation included all required components and IDTs reviewed all recommendations and developed a plan to address when necessary.

| Outcome 2 – Individuals receive timely routine medical assessments and care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: There were improvements in the timeliness of annual medical assessments and periodic reviews. All individuals had AMAs completed within 365 days of their last annual assessment. Periodic medical reviews were also documented and timely. Due to sustained high performance over successive reviews, both indicators b and c will be moved to the category of requiring less oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| 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. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| 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. | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | | 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 | 100% 9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |

Comments:
b. All annual medical assessments were timely.

c. All individuals had timely periodic medical reviews based on their needs.

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

Summary: 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. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives quality AMA. | 44% 4/9 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| b. | Individual's diagnoses are justified by appropriate criteria. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| c. | Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months. | 83% 10/12 | 1/2 | 1/1 | 2/2 | 2/2 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |

Comments:
a. Four individuals had an AMA that included all the necessary components and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Those that met criteria were Individual #347, Individual #365, Individual #348, and Individual #258.

For the remaining five individuals, problems varied, including:

- For Individual #343, her active problem list did not include restrictive lung disease with hospitalization for aspiration pneumonia or reference her g-tube. Additionally, her exam showed that she was functionally blind, but this was not added to her diagnoses. Pulmonary disease was referred to in several areas, such as summary/recommendations.
  Indications for medications were given, but the risks from side effects versus benefits were not clear, especially when they appeared as an ADR, and were still in use. Major side effects of seizure medications were frequently mentioned, but no there was no justification or plan to address that risk to her health by the PCP or the IDT.
  Separating the inactive problem list added more details and was helpful. Significant past events were similar to current issues (e.g.., pneumonia), but a medical care plan to address the cause was not developed. For example, the plan was to accept reoccurring emesis, which leads to reoccurring aspiration pneumonia. When hospitalized again for the same condition, there was no clear plan to address the possible cause of the events.
  The AMA had less detail than items found in some of the interval reviews, which included distant past events that would be best described in the AMA. Hospitalization should be briefly summarized at interval reviews, so it can be summarized in the next AMA to bolster a better medical care plan.

A rectal exam was deferred with no reason. Given the severity of GI issues, it seemed important to address any possible evaluation, especially after the IDT and consultants decided to not perform any diagnostic studies such as a colonoscopy. There was no clear discussion of the actual risk/benefits of not addressing the cause of her reoccurring pneumonia and hospitalizations.

- For Individual #255, his active problem list did not include his gastrostomy for feeding tube. His physical examination noted that genitourinary and rectal exams were deferred. No reason for deferment was recorded and given his age, both would be important.
- For Individual #277, the active problem list needed to be updated to include his tracheostomy and g-tube.
- For Individual #392, traumatic brain injury was not included in his active problem list, though it significantly impacted his behavior.
- For Individual #142's seizure type (Lennox-Gastaut according to recent EEG and consult) had not been updated on his active problem list.

c. For 10 of 12 chronic or at-risk conditions, individuals received quality periodic medical reviews, based on their individualized need.

The exceptions were for Individual #343 and Individual #258.

- For Individual #343, there was evidence that she had reoccurring emesis and constipation was present, there was no clear plan for evaluation or changes to address the issue and the subsequent emesis and aspiration pneumonia.
- For Individual #258, the PCP and IDT should be reviewing any x-rays and bowel logs for patterns suggesting constipation, especially with a past medical history of ileus and pneumonia, and the recent findings on her colonoscopy.

Outcome 4 – Individuals receive preventative care.

Summary: Six of eight individuals received the full set of preventative care they needed. One individual was missing recommended preventative screenings in two areas. The completion of breast cancer screens for those at risk continued to be an area of needed improvement. It was good to see that for all individuals, medical practitioners had 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. Due to sustained high performance, six of the seven preventative care indicators will be moved to the category of requiring less oversight: a.i, ii, iv, v, vi, and vii. The other indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives timely preventative care: | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | i. Immunizations | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| | ii. Colorectal cancer screening | 100% 5/5 | 1/1 | 1/1 | 1/1 | 1/1 | | | 1/1 | | |
| | iii. Breast cancer screening | 33% 1/3 | 0/1 | | | 0/1 | | 1/1 | | | |
| | iv. Vision screen | 100% 8/8 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| | v. Hearing screen | 88% 7/8 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| | vi. Osteoporosis | 100% 7/7 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | |
| | vii. Cervical cancer screening | 100% 3/3 | 1/1 | | | 1/1 | | 1/1 | | | |
| b. | The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. | 100% 7/7 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | |

Comments:

a. Six of the eight individuals received recommended preventative care.

- For Individual #343, her last hearing screen was dated 11/23/19 with a recommendation to return annually. A repeat hearing screen was initially delayed by COVID, and then delayed due to cerumen on 12/17/21. Individuals can easily be checked for cerumen before audiology visits to ensure the testing can be completed. Her last mammogram was in September 2016. Exams were discontinued due to her risk for sedation and positioning. There was no evidence that the physician had considered alternate monitoring for breast cancer or a medical care plan if she developed breast cancer.

b. For all individuals, medical practitioners had 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.

| 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: One individual had a DNR order in place that met criteria for being consistent with the State Office Guidelines. This indicator will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines. | 100% 1/1 | | | 1/1 | | | | | | |
| Comments:<br>a. For one individual with a DNR order, there was a clear description of his ongoing medical risks and reasoning for the order. Care was provided consistently with the family input. | | | | | | | | | | | |

| Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The Center had made progress in conducting follow-up assessments and documentation of continued treatment for acute medical issues. Further work is needed to ensure that adequate assessments are completed when acute medical issues are first identified and prior to transfer to the infirmary. Recent medical history should be reviewed for potentially related factor. Overall, sustained high performance was demonstrated for three indicators (c, g, h) and all three will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| 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. | 55% 6/11 | 0/2 | 1/1 | 1/2 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 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. | 82% 9/11 | 1 /2 | 1/1 | 1/2 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 |
| c. | If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition. | 100% 5/5 | 2/2 | 1/1 | 1/1 | | | | | 1/1 | |
| d. | As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN. | 40% 2/5 | 0/2 | 0/1 | 1/1 | | | | | 1/1 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| e. | Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care. | 80% 4/5 | 2/2 | 1/1 | 1/1 | | | | | 0/1 | |
| f. | If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| g. | Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. | 80% 4/5 | 2/2 | 1/1 | 1/1 | | | | | 0/1 | |
| 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% 4/4 | 1/1 | 1/1 | 1/1 | | | | | 1/1 | |

Comments:

For the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center:

- Individual #343 (rash on 9/27/21 and viral URI on 9/30/21)
- Individual #255 (low blood pressure on 12/1/21
- Individual #277 (chronic aspiration on 8/16/21 and diarrhea on 10/3/21)
- Individual #347 (leg swelling on 8/14/21)
- Individual #392 (choking 10/20/21)
- Individual #365 (ear pain on 11/28/21)
- Individual #142 (left hand edema on 11/1/21)
- Individual #348 (diarrhea on 12/25/21)
- Individual #258 (loose stool on 7/21/21)

a. For the following six of 11 acute issues, PCPs assessed them according to accepted clinical practice

- Individual #255 (low blood pressure on 12/1/21)
- Individual #277 (diarrhea on 10/3/21)
- Individual #347 (leg swelling on 8/14/21)
- Individual #392 (choking 10/20/21)
- Individual #365 (ear pain on 11/28/21)
- Individual #142 (left hand edema on 11/1/21)

Regarding those that did not meet criteria:

- For Individual #343, regarding her rash on 9/27/21, the PCP did not clearly address her respiratory issues from two days prior or review her recent pattern of oxygen use. There was no consideration of the possible correlation between her rash and respiratory distress and/or treatment. Additionally, there was no plan for further evaluation or monitoring. The evaluation to

assess her URI on 8/16/21 included a review of her labs, but did not reference that she was recently seen for similar chronic symptoms.
- Individual #277 was assessed for chronic aspiration on 8/16/21. The physician did not fully review recent past medical history that might have been relevant including recent exposure to COVID-19 and related monitoring data or pulmonary issues from May 2021.
- Individual #348 was seen for diarrhea on 12/25/21. Significant history that was not considered included recent prophylactic therapy for a right jaw fracture with Augmentin that has a common side effect of diarrhea.
- Individual #258 was evaluated for loose stool on 7/21/21. Documentation did not include a review of related past medical history that included hospitalization and intubation within the past few weeks or a summary of all findings. A plan for further evaluation, treatment, and monitoring was not documented.

b. There was evidence that the PCP conducted follow-up assessments and documentation, as necessary, until the problem was stabilized or resolved for eight of 11 acute illnesses/injuries:
- Individual #343 (viral URI on 9/30/21)
- Individual #255 (low blood pressure on 12/1/21)
- Individual #277 (chronic aspiration on 8/16/21 and diarrhea on 10/3/21)
- Individual #347 (leg swelling on 8/14/21)
- Individual #392 (choking 10/20/21)
- Individual #365 (ear pain on 11/28/21)
- Individual #142 (left hand edema on 11/1/21)
- Individual #348 (diarrhea on 12/25/21)

For three, there was no evidence that the PCP conducted necessary follow-up until the problem was resolved:
- Individual #343 (rash on 9/27/21)
- Individual #277 (chronic aspiration on 8/16/21)
- Individual #258 (loose stool on 7/21/21). There was no clear resolution, nor follow-up, on recent significant hospitalization.

c. Five of five individuals received timely evaluation prior to transfer to ED or hospitalization or within one business day.

d. For two of five transfers to the ED or hospital, there was a quality assessment documented prior to hospitalization, when appropriate.
- Individual #343 was transferred to the ED on 11/12/21. Notes did not address her recent history of emesis and possible association to pneumonia and chronic lung disease. On 1/1/22, she was again transferred to the ED with an upper respiratory infection. Notes of the telephone call to transfer her did not provide a history of her recent symptoms, her vital signs, or reason for transfer.
- Individual #255 was sent to the ED for evaluation of hypoxia. Notes regarding his transfer did not mention his recent hospitalization for aspiration pneumonia.

e. In four of five cases, the individual received timely treatment and /or interventions prior to transfer to the hospital or ED.
- For Individual #348, results of a positive x-ray for a fracture were not reported overnight to the PCP.

g. Four of five individuals had a post-hospital ISPA that addressed follow-up medical, and health care supports to reduce risks, as appropriate. The following exceptions were noted:

- For Individual #348, the IDT held a post-hospital ISPA to address his new fracture, however, there was no plan developed to assure that x-rays would be reported to the PCP after hours.

h. For all individuals, there was 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 upon return to the facility.

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. Additional interdisciplinary collaboration was needed to address the broad range of factors that might contribute to high risk ratings for individuals. For five of the 12 chronic or at-risk conditions, PCPs had 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 was a slight increase from the previous round. This indicator will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 42% 5/12 | 0/2 | 0/1 | 2/2 | 0/2 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 |

Comments:

For nine individuals, 12 of their chronic and/or at-risk diagnoses were selected for review:

- Individual #343: gastrointestinal issues and aspiration.
- Individual #255: aspiration
- Individual #277: aspiration and polypharmacy
- Individual #347: polypharmacy and gastrointestinal issues
- Individual #392: polypharmacy
- Individual #365: polypharmacy
- Individual #142: falls
- Individual #348: falls
- Individual #258: gastrointestinal issues

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 #392 – polypharmacy
- Individual #347: polypharmacy and gastrointestinal issues
- Individual #365 – polypharmacy
- Individual #348 – falls

Comments regarding those that did not meet criteria for this indicator:

- For Individual #343, the frequent emesis that caused reoccurring hospitalizations needed to be addressed further. Minor changes in enteral tube feedings were suggested, but the posible cause of the emesis was not adequately investigated.
- Individual #255 had two hospital admissions within a month for aspiration pneumonia requiring intubation. Physician notes from the second hospitalization in July 2021 noted that NPO orders were not followed after the first hospital discharge on 6/2/21. The NPO order was not noted at his AMA on 6/30/21 or in ISPA documentation. Additionally, there was no evidence that the PCP considered medication changes that might decrease his risk.
- For Individual #347, multiple work-ups, including cardiology, rheumatology, and neurology had not initiated medication changes to reduce risks associated with polypharmacy. Regarding her risk for gastrointestinal issues, the colonoscopy prep in March 2020 caused a reduction in her behaviors and a 4/10/21 abdominal CT scan indicated significant constipation. This suggested that the behaviors requiring psychotropic medications might be due to the medications used to treat the behaviors. Coordination of medical and behavioral care was indicated.
- Individual #142 had an increasing number of falls over the past year with 41 falls documented between 7/7/21 and 1/12/22. Although identified in his AMA, falls were not documented as a significant issue. He had been referred to the PNMT and protective measures had been put into place, including a padded helmet and wheelchair. Per ISPAs, supports had been effective at reducing injuries, however, documentation did not support that there had been an integrated effort to reduce falls by looking at contributing factors, including polypharmacy, seizures, physical weakness, and behaviors. Further interdisciplinary assessment/discussion was needed.
- Individual #258 was at risk for gastrointestinal issues including constipation and bowel obstruction, in part, due to inactivity because of limited mobility. Given her hospitalization history, further evaluation of medication that may contribute to her risk would be warranted.

| Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions and are modified as necessary. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Improvement was needed regarding the inclusion of medical plans to address identified risks in individuals' ISPs/IHCPs. These indicators will continue in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| a. | The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other | 18% 2/11 | 0/2 | 0/1 | 2/2 | 0/2 | 0/1 | 0/1 | 0/1 | 0/1 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | current standards of practice consistent with risk-benefit considerations. | | | | | | | | | | |

Comments:
For eight individuals, 11 of their chronic and/or at-risk diagnoses were selected for review:

- Individual #343: gastrointestinal issues and aspiration.
- Individual #255: aspiration
- Individual #277: aspiration and polypharmacy
- Individual #347: polypharmacy and gastrointestinal issues
- Individual #392: polypharmacy
- Individual #365: polypharmacy
- Individual #142: falls
- Individual #348: falls

a. Four of 11 ISPs/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.

Risk conditions that were not adequately addressed were:

- For Individual #343, there was no clear clinical care plan to address reoccurrences of aspiration with further decline in her health. Her IHCP included a broadly stated outcome to maintain her respiratory health. Similarly, there was no clear plan to address her gastrointestinal issues. IHCP outcomes were to maintain GI health and improve bowel health. Her IHCP did not include strategies to address her risk or to meet her outcomes.

- Documentation did not reflect that Individual #255's IDT recognized the significance of his aspiration risk over the past few years, given repeated bouts of aspiration pneumonia requiring intubation and ventilatory supports. Discharge instructions for NPO were not addressed until he required hospitalization twice within a month due to aspiration. His IHCP included broadly stated outcomes (e.g., enteral feeding without aspiration for the year and would have no hospitalizations due to aspiration), however, the IDT did not include specific supports to minimize his risk.

- It was not evident that Individual #347's IDT had sufficiently addressed her risk for polypharmacy by considering a review/reduction in her medications that placed her at risk. Her IDT had also not considered reducing her risk for gastrointestinal issues by reviewing the risk associated with her medications.

- Individual #392's ISP/IHCP did not address his weight gain associated with his medication side effects. The IDT should consider incorporating weight management strategies through diet management and exercise.

- Individual #142's ISP/IHCP included one action plan that addressed protective measures to prevent injuries resulting from falls, however, action plans did not include integrated strategies to reduce the occurrence of falls.

- Similarly, the ISP/IHCP for Individual #348 identified his risk for falls, but did not include action plans to reduce the occurrence of his falls. Action plans were using PNMP supports to minimize injury, would have no falls from seizures resulting in serious injuries, would have a bone density scan, and would give fall data to his physician at his next epileptology appointment. None of these action plans specifically addressed strategies to reduce the number of falls.

- Individual #365's IHCP did not include strategies to reduce her risk for polypharmacy. She had one broadly stated outcome: would have no adverse effects from psychotropic medications. Her medications were high risk and contributed to her obesity, which was not under control due to noncompliance with diet (significant gain despite restrictive diet not followed). Her ISP did not address the ineffective diet plan or the added risks to her health from medications.

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

Summary: When specific medical interventions were assigned to the PCP, interventions were completed. In most cases, the IHCP did not include necessary interventions to be carried out by the PCP. IDTs need to ensure that all supports and services to reduce risk are outlined in the IHCP. This indicator will remain in active monitoring until comprehensive plans to address risks are developed and implemented.

Individuals:

| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions. | 100% 4/4 | | | 2/2 | 1 /1 | 1/1 | | | | |

Comments:

a. This indicator was met for four of four risk conditions reviewed. As noted above, individual's IHCPs often did not include a full set of action plans to address individual's medical needs. The IDTs did not adequately coordinate with the PCP to address the health issues that placed individuals at high risk.

Most did not include specific medical interventions to be implemented by the PCP and, therefore, were not scored for this indicator. For example,

- For Individual #343, there was no clear clinical care plan to address reoccurrences of aspiration with further decline in her health. Similarly, there was no clear plan to address her gastrointestinal issues and no action assigned to her PCP.
- For Individual #347, a more aggressive evaluation of her risk for gastrointestinal issues was needed. Her IHCP included one broadly stated action assigned to the PCP to complete an interval review every three months. Her IHCP did not include strategies to reduce her risk for polypharmacy.
- Individual #255's ISP/IHCP did not assign medical interventions to the PCP to address his risk of aspiration.
- Individual #142 and Individual #348's ISP/IHCPs did not include a comprehensive set of action plans to reduce the risk for falls. Action plan for medical interventions were not included in their IHCPs.

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: More work was needed on developing a comprehensive set of action plans based on all findings and recommendations from mortality reviews. The relevant reviews were completed timely for this review period and for previous review periods, too. Therefore, indicator a will be moved to the category of requiring less oversight. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 93 | 194 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% 2/2 | 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% 0/2 | 0/1 | 0/1 | | | | | | | |
| c. | Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |
| d. | Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |
| e. | Recommendations are followed through to closure. | 0% 0/2 | 0/1 | 0/1 | | | | | | | |

Comments:
a. Two deaths were reviewed, Individual #93 and Individual #194. For both individuals, a clinical death review was completed timely.

b-d. For Individual #93, recommendations/action plans were written for nursing staff related to obtaining vital signs and availability of nursing staff. The review noted that signs and symptoms related to the cause of death were not recognized as possibly serious. In retrospect, the cause of death fit the subtle symptoms, but symptoms could have easily been dismissed. Recommendations did not include providing additional training that would help staff understand how an acute abdominal emergency may present as a subtle change in status. Training should be based on the actual cause of death and help staff understand how to recognize an acute abdominal emergency.

For Individual #194, the plan of correction was for nursing to complete training on development of a comprehensive IRRF and IHCP. Other disciplines were not identified as being part of the comprehensive care plan, but had a role in offering additional services to the individual.

Based on the findings during the death review, these recommendations should have included more disciplines for training opportunities to improve interdisciplinary care for individuals. Additional considerations by the external medical reviewer on 6/11/21 recommended additional supports including a protocol for elective blood transfusions, faxing labs to the hematologist, and offering the family guidance and consultation for palliative care to identify goals for the family. These recommendations were not addressed.

e. For Individual #93, the repositioning of nurses as recommended did occur, but the opportunity for others to learn from this was more important. The death review should start with the cause of death as verified by medical staff, and then during the investigation to look for ways to improve care, diagnosis, and management of any issues connected to the cause of death.

For Individual #194, as noted above, other issues needed to be addressed.

## Section M: Nursing Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, no additional indicators were moved to this category.

Section Summary

A little more than half the individuals received a nursing assessment as indicated by an acuter illness. When an event occurred, the physician was consistently notified by nursing in a timely manner.

All the assessments were completed in a timely manner in response to a new admission or in time for their quarterly/annual reviews/assessments. Issues noting noncompliance were quarterlies not being completed when due, or comprehensives being done before the PE.

Overall, individuals did not receive a quality annual or quarterly record review.

Individuals did not consistently have a plan developed that set forth to clearly mitigate the at-risk condition. Goals were often not measurable and contained actions steps that did not clearly support the objective or goal.

Individuals' IHCPs were either not implemented beginning within 14 days of finalization or sooner or did not have nursing interventions were implemented thoroughly.

Medications were routinely explained by nursing to the individual and they received overall safety in the form of good documentation and infection control practices

| 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: A little more than half the individuals received a nursing assessment as indicated by an acute illness. When an event occurred, the physician was | Individuals: |

consistently notified by nursing in a timely manner, however, the documentation was often not in SBAR format as per SSLC guidelines. Approximately two-thirds of the acute care plans met the individuals' needs and were implemented. Overall, some indicators showed higher scores and some lower scores compared with the last review. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | 277 | 343 | 255 | 392 | 348 | 258 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed. | 60% 3/5 | 1/1 | 0/1 | | 1/1 | 0/1 | 1/1 | | | |
| 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. | 83% 5/6 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | | | |
| c. | For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments. | 50% 3/6 | 1/1 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | | | |
| d. | For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments. | 60% 3/5 | 1/1 | | 0/1 | 1/1 | 0/1 | 1/1 | | | |
| e. | The individual has an acute care plan that meets his/her needs. | 67% 4/6 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | | | |
| f. | The individual's acute care plan is implemented. | 67% 4/6 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | | | |

Comments:
The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals: Individual #277 –S/P head injury, Individual #343-pneumonia, Individual # 255-aspiration, Individual #392-COVID 19+, Individual #348-TMJ fracture, and Individual #258-pressure ulcer.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed were in accordance with applicable nursing guidelines for 60% of the individuals. Exceptions were noted for Individual #343 who experienced an emesis episode post enteral intake. The nurse did not provide comprehensive assessment as the nurse did not assess abdominal /bowels sounds on 9/26/21. Individual #348 fell with impact to the head, possibly due to a seizure, but the nurse did not include pupils, last BM, and anti-epileptic medications per Nursing Guidelines.

b. Most of the applicable individuals that had an acute illnesses/occurrences had their licensed nursing staff timely inform the practitioner/physician of signs/symptoms, however, these were not consistently documented in SBAR format as per SSLC guidelines. Lack of following SBAR format was the issue for all records except for Indvidual#343. Due to the quality of the information present, the

Monitoring Team gave a 1 score, however, the Center may want to consider implementing a plan to improve their documentation to meet the use of the SBAR format and their own written guidelines.

Individual #343 had one event where there was a lack of documented communication regarding PCP notification of an emesis episode on 9/26/21.

c-e. The following provides some examples of findings related to these indicators:

- Individual #343's IPN was missing details to help mitigate risk outside of directives for staff to contact nursing or for nursing to notify the PCP. The acute care plan for emesis did not include details of the emesis, or immediate actions to take, such as getting out of bed.
- For Individual #255, no nursing IPNs were found for 7/3/21 as well as no respiratory assessments that met the needs of individual's overall medical status.
- Individual #348's acute care plan lacked GI/last BM, elimination, how much fluid he needed related to "plenty of fluids," and measurable specifics for heavy lifting (such as number of pounds, or specific to the usual items he likes to carry). The ACP also did not include specifics for measuring "proper supervision to prevent further injury," nor a frequency for nurse to monitor the interventions.
- Positives of acute care plans included Individual #392 whose plan addressed COVID and showed good assessment and follow through by nursing, and Individual #258 who returned from the hospital with skin integrity issues that were assessed and treated per the ACP in a prompt manner and through resolution on 7/23/21.

f: A little more than half of the individuals had an acute care plan that was implemented. The exceptions were for Individual #255 who had a gap in the occurrence of his respiratory monitoring on 7/17/21. He was measured twice at 0700 and again at 1930, but then a gap occurred and he was not measured again until 7/18/21 at 1215. Individual #348's ACP did not adequately provide measurable interventions for staff to implement.

| Outcome 3 – Individuals have timely nursing assessments to inform care planning. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: All the assessments were completed in a timely manner in response to a new admission or in time for their quarterly/annual reviews/assessments. Some quarterlies were not completed when due, or comprehensives were done before the PE. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 277 | 343 | 255 | 392 | 348 | 258 | | | | |
| a. | Individuals have timely nursing assessments: | | | | | | | | | | | |
| | i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission. | 100%<br>1/1 | | | | | 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. | 80% 4/5 | 0/1 | 1/1 | 1/1 | 1/1 | | 1/1 | | | |
| | iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due. | 67% 4/6 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | | | |

Comments:

a. Most of the individuals received timely nursing assessments that could be utilized to inform the care planning process. For example:

- The newly admitted individual was provided with a comprehensive review and physical assessment within 30 days of admission.
- Most of the individuals received an annual comprehensive nursing review and physical assessment that were completed at least 10 days prior to the ISP meeting. The exceptions were:
  - Individual #277, whose physical exam was completed after the review, so it did not inform the annual assessment. Additionally, there was no evidence of a review or physical exam that was due in September 2021.
  - Individual #255's Q1 review and PE which was due in September 2021 was not found.

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

Summary: Overall, individuals did not receive a quality annual or quarterly record review. Pervasive issues were noted regarding the lack of family, social and procedure history, and the inclusion of lab and diagnostic testing requiring review. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 277 | 343 | 255 | 392 | 348 | 258 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives a quality annual nursing record review. | 0% 0/6 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | | |
| b. | Individual receives quality annual nursing physical assessment, including, as applicable to the individual:<br>i. Review of each body system;<br>ii. Braden scale score;<br>iii. Weight;<br>iv. Fall risk score;<br>v. Vital signs;<br>vi. Pain; and<br>vii. Follow-up for abnormal physical findings. | 33% 2/6 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| c. | For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk. | 0%<br>0/12 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | | | |
| d. | Individual receives a quality quarterly nursing record review. | 0%<br>0/12 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | | | |
| e. | Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual:<br>i. Review of each body system;<br>ii. Braden scale score;<br>iii. Weight;<br>iv. Fall risk score;<br>v. Vital signs;<br>vi. Pain; and<br>vii. Follow-up for abnormal physical findings. | 50%<br>3/6 | 0/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | | | |
| f. | On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk. | 0%<br>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 nursing protocols or current standards of practice. | 90%<br>9/10 | 2/2 | 1/2 | 1/1 | 1/1 | 2/2 | 2/2 | | | |

Comments:

a. None of the individuals received a quality annual nursing record review. Pervasive issues were noted regarding family history, procedure history, and lab and diagnostic testing. For example:

- Lack of appropriate family history was noted for Individual #277, Individual #255, Individual #392 and Individual #258.
- Procedure history as well as social/smoking/drug/alcohol history were missing from the reviews for Individual #277, Individual #255, and Individual #392.
- Lab and diagnostic results were missing from the reviews for Individual #342, and Individual #348.
- Consultation summaries were missing from the reviews for Individual #277 and Individual #343.

b. Thirty-three percent of the individuals received a quality annual physical assessment.

- Individual #277's assessment was missing information regarding vital signs, blood pressure, pulse/cardiac, weight, and bowel sounds.
- Individual #255's physical exam notes in IView indicated suspected pain, but provided no additional detail. The PE also indicated lung sounds anterior with fine crackles in all lobes, but did not provide further explanation and no follow-up.
- Individual #348's assessment indicated no orthostasis, however, the physical exam was missing the BP/positions data to support the statement. Additionally, the physical exam was missing his weight.
- For Individual #392, the physical exam was missing a Braden score and fall score in addition to other areas.

c. For the annual ISP, none of the nursing assessments completed addressed the individual's at-risk conditions and were sufficient to assist the team in developing a plan responsive to the level of risk.

- For Individual #277 (resp compromise), his annual comprehensive nursing assessment had an updated list of events that occurred in the previous year related to respiratory, and a conclusion that he did not meet his goals. However, there was not an appropriate analysis or discussion to address the chronic risk and promote amelioration of the condition to the extent possible. Regarding GI issues, the assessment included data, however, no indication of trending the data to analyze outcomes from one review period to the next was noted.

- For Individual #343 (aspiration), her first goal of not having a hospitalization was not met. Nursing stated that the goal would be revised in this next ISP, however, the documentation in the comprehensive nursing assessment did not reflect clear nursing recommendations or information on what revisions would be made to the new ISP. Regarding infections, her goal was revised due to nonachievement, but the action items all remained unchanged.

- For Individual #255 (aspiration and GI issues), his annual comprehensive nursing assessment for aspiration/respiratory risk did include comparative data to previous quarters, but the analysis summary concluded only with the statement "regressed, over the past period." There were no details regarding the regression or documented consideration of potential causes, and no new interventions were considered.

- For Individual #392 (diabetes and circulatory), his assessment did not contain recommendations regarding treatment, interventions, and strategies. Since his admission in September 2021, the nurses had become more familiar with his strengths and challenges. An opportunity may be to assess ways to increase his knowledge of managing his chronic conditions starting with basic components of care for diabetes.

- For Individual #258 (aspiration and GI issues), the assessment included comparative data, with positive outcomes, and displayed the foundation for further analysis, but did not include an analysis that explored the individualized trends to consider potentially new interventions.

- For Individual #348 (falls), the assessment provided a summary that concluded supports were effective despite a significant increase in falls during the last quarter. While it was documented that he agreed to use helmet, the documentation did not display a more individualized analysis considering details specific to each fall such as location, what was happening before the fall, and what new approaches and strategies from the nursing perspective could be recommended. Regarding seizures, there were no anti-epileptic drug levels included in the comprehensive annual review. On multiple occasions, labs were drawn, but there was no reference found in the nursing comprehensive review.

d. None of the individuals received a quality quarterly nursing review as applicable. Issues noted included absence of family history, social history, immunizations, and lab and diagnostic testing,

e. Half of the quarterly nursing assessments were comprehensive.

- Individual #277 and Individual #255's assessment was missing components, such as weight and abdominal circumference.
- Individual #348's assessment was also missing information regarding weight and abdominal circumference, but was also missing was information regarding BP, SPO2, and its relation to orthostatic hypotension.

f. On a quarterly basis, none of the nursing assessments were complete, addressed the individual's at-risk conditions and were sufficient in assisting the team in maintaining a plan responsive to the level of risk.

- For Individual #277 (resp compromise and GI issues), the quarterly assessment and physical exam due in September 2021 were not completed.

- For Individual #343 (aspiration), her assessment did include status updates related to aspiration/respiratory risks, as well as a comparison of the number of incidents with the previous quarter. However, there was no analysis of the pattern between feedings and the onset of coughing followed by emesis along with the subsequent development of acute respiratory symptoms/PNA to drive individualized interventions in efforts to reduce the risks to individual. Regarding infections, the data collected were substantial, however, they were not analyzed. Analysis of what interventions were successful might assist in the identification of individual specific approaches to be integrated into her individualized plan.

- For Individual #255 (aspiration and GI issues), the analysis statement "regressed over the past period" was not sufficient because it did not explore possible trends, or new approaches/strategies to reduce the identified risks.

- For Individual #392 (diabetes and circulatory), the assessment did not include analysis of the data or discussion of potential new interventions to ameliorate risks. No new recommendations were found other than "Nursing IHCP Recommendation ISP: I recommend continuing current IHCP supports and assess as needed."

- For Individual #258 (aspiration), comparisons were present in the assessment, however, analysis did not document any findings/trends that could help identify potential interventions to further reduce risks of aspiration for the individual. An analysis of the PNA event in June 2021 could lead to consideration of individualized trends that might lead to additional ways to decrease risks and increase wellness for the individual. Regarding GI issues, there was no reference or consideration for hemorrhoids found during the colonoscopy on 8/23/21. Additionally, there was no discussion of preventative approaches to future GI complications. Further analysis of the interventions, and the use and results of the dietary fiber recommended by GI may help with fine tuning the right dosing to reach max benefit and to achieve further risk reduction related to the risk of an ileus/other complications. of the dietary fiber

- For Individual #348 (falls), the assessment lacked an adequate analysis or any recommendations to assist in the reduction of falls or related injuries. Regarding seizures, the assessment did not provide adequate details needed for analysis, (e.g., length of time of the seizure, type of seizure or description of the symptoms noted). Additionally, there were no new nursing recommendations offered to reduce the risk of seizures.

g. Most of the individuals that had a change in status, received a nursing assessment that was completed in accordance with nursing protocols/standards of practice. The exception was for Individual #343 whose assessment did not meet SSLC nursing guidelines for

vomiting as lung sound assessments did not occur at the required. Additionally, it was not clear the level of oxygen being delivered to the individual. This confusion was due to multiple entries by nursing that oxygen was set at 2 lpm, which conflicted with the documentation by RT that indicated 4 lpm.

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: Individuals did not consistently have a plan developed that set forth to clearly mitigate the at-risk condition. Goals were often not measurable and contained actions steps that did not clearly support the objective or goal. The frequency of monitoring to ensure effectiveness of the plan was not clearly stated within the ISP. Overall, however, all indicators scored higher than at the last review, thus, demonstrating some improvements. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 277 | 343 | 255 | 392 | 348 | 258 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 25% 3/12 | 0/2 | 1/2 | 0/2 | 0/2 | 0/2 | 2/2 | | | |
| b. | The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition. | 42% 5/12 | 1/2 | 2/2 | 0/2 | 0/2 | 0/2 | 2/2 | | | |
| 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). | 33% 4/12 | 1/2 | 1/2 | 0/2 | 0/2 | 0/2 | 2/2 | | | |
| d. | The IHCP action steps support the goal/objective. | 58% 7/12 | 1/2 | 2/2 | 0/2 | 2/2 | 0/2 | 2/2 | | | |
| e. | The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements). | 25% 3/12 | 1/2 | 1/2 | 0/2 | 0/2 | 0/2 | 1/2 | | | |
| f. | The individual's ISP/IHCP identifies the frequency of monitoring/review of progress. | 33% 4/12 | 1/2 | 0/2 | 0/2 | 2/2 | 0/2 | 1/2 | | | |

Comments:
a-b. While all the individuals did have IHCPs in place, one of the 12 IHCPs sufficiently addressed the health risks and needs in accordance with applicable SSLC nursing protocols or current standards of practice; and five of the 12 included preventative approaches to minimize the at-risk conditions.

c. A third of the IHCPs included measurable objectives to fully address the at-risk condition /allow the team to track progress in achieving the plan's goals.

d. Fifty-eight percent of the IHCP nursing action steps supported the goals/objectives.

e. A quarter of the IHCP interventions included specific clinical indicators to be monitored.

f. Thirty-three percent of the IHCP interventions included frequency of monitoring/review of progress.

Some comments about these indicators:

- For Individual #277 (resp compromise), the IHCP included preventative CPT, proper positioning, flu vaccination, and TB monitoring, however, the IHCP action steps did not include measurable interventions and indicated frequency, or where to document interventions. Regarding GI issues, nursing outcomes were unclear and did not correlate with the interventions. For example, the outcome of no GI bleeding and no symptoms of GERD do not correlate with interventions such as "encourage fluids" for an individual who was NPO and relied on their GT for all fluids/nutrition.

- For Individual #343 (aspiration), multiple action items were noted that were relevant to the risk, however, the plan(s) did not have a clear frequency or method to monitor progress. Regarding infections, the IHCP did not include SMART goals with measurable outcomes. Most interventions lacked the desired frequency of implementation and the location for information to be documented.

- For Individual #255 (aspiration), interventions listed in the IHCP were not sufficient to reduce the risk to the individual. Interventions lacked measurability to allow the team to track progress. One of the interventions listed "comprehensive assessment September for Q1," but this assessment could not be located. Interventions, such as "Follow dietary restrictions" were too vague to be measurable and were unclear for an individual with enteral feedings. Additionally, the HCP did not include the signs and symptoms of aspiration (i.e., triggers like coughing, watery eyes, emesis, elevated temperature, etc.). Regarding GI issues, the IHCP did not include a method of GI assessment, including bowel sounds, abdomen, abdominal binder, etc. It also did not include basic nursing interventions regarding frequency for GT use/care (checking placement, residuals, bowel sounds before use of tube, etc.). The intervention to evaluate bowel regularity was not measurable as written and did not provide the frequency or individualized information to guide the direct care staff in tracking progress, noticing important signs and symptoms, and what to report to the nurse/PCP.

- For Individual #392 (diabetes), the interventions to monitor accu-check did not include fasting, frequency, or what results should be reported to the PCP. Diet orders were not specific, and no consideration was noted regarding the education of the individual to increase his self-management potential. Regarding circulatory, the intervention to assess for edema had no frequency, and "modify diet" was unclear as to how nursing was to implement/measure progress.

- For Individual #348 (fractures), the IHCP did not include goals with measurable outcomes, or interventions not sufficient to address risk of falls/injuries. Regarding seizures, the IHCP did not include SMART goals with measurable outcomes, or basic seizure protocols/actions to take to reduce risks of injury during seizure activity,

- For Individual #258 (aspiration), her nursing outcomes/goals and interventions were thorough and measurable, and included preventative measures, such as COVID booster, and flu vaccine, to reduce the risk of respiratory infection. For training and monitoring of the plan, documentation included individualized training to residential staff about how to implement the IHCP. The Physical Therapist enhanced the monitoring further and documented responsibility for training and monitoring residential staff on proper positioning, and the SLP to monitor nurses on use of suction toothbrush. Regarding GI issues, while the nursing outcomes/goals were appropriate, the interventions to assess abdomen, and monitor bowels lacked a defined frequency to occurrence.

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

Summary: 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. Few of the individuals at high risk for respiratory issues and/or aspiration pneumonia had proper documentation by a nurse of an assessment of respiratory status. On the positive, during most situations in which an individual had a status change, there was evidence that the team took immediate action. These indicators, however, showed some improvement since the last review. They will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 277 | 343 | 255 | 392 | 348 | 258 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 42% 5/12 | 0/2 | 1/2 | 0/2 | 2/2 | 0/2 | 2/2 | | | |
| b. | When the risk to the individual warranted, there is evidence the team took immediate action. | 72% 8/11 | 2/2 | 2/2 | 1/2 | 1/1 | 0/2 | 2/2 | | | |
| 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). | 33% 4/12 | 0/2 | 0/2 | 0/2 | 2/2 | 0/2 | 2/2 | | | |
| d. | 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 | 25% 1/4 | 0/1 | 0/1 | 0/1 | | | 1/1 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | includes lung sounds in IView or the IPNs of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets). | | | | | | | | | | |

Comments:
The Monitoring Team reviewed 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, the IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether they were implemented. 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. The exceptions for implementation were for Individual #392 (diabetes and circulatory) and Individual #258 (aspiration and GI issues), where nurses implemented the interventions in their IHCPs.

Regarding the lack of measurability of the supports. For example, some of the individuals' IHCPs called for supports, but the IHCPs did not define the frequency (e.g., every shift, every day, each Friday, on the first day of the month, etc.). As a result, it was difficult to identify whether and where nurses had documented the findings from the interventions/assessments included in the IHCPs.

b. Overall, when the risk to the individual warranted, the team took immediate action. The exception was noted for Individual #255, and Individual #348.

- For Individual #255 (respiratory compromise), there was a lack of appropriate action due to the absence of documentation of planned assessment through resolution. Additionally, there were no notes regarding possible treatments for the symptoms of the individual who indicated he was in pain/nauseated.
- For Individual #348 (fractures), the ISPA documented that the IDT did not take urgent action following the fall on 7/5/21 with resulting ER visit. The IDT met eight days later on 7/13/21 to discuss the fall/event (in addition to the falls on 7/4/21 and 7/6/21). Notes indicated the "post fall protocol was initiated," but did not include the components of the post fall protocol. The new action taken was that the individual was placed on 1:1 staffing on 7/6/21 on 1st and 2nd shifts in an effort to reduce falls/injury. Regarding seizures, his ISPA indicated a seizure occurring with fall was not discussed until 12/21/21 when notations in the ISPA stated 11/11/21 was his last seizure.

d. Twenty-five percent of the individuals at high risk for respiratory issues and/or aspiration pneumonia had proper documentation by a nurse of an assessment of respiratory status that included lung sounds in IView or the IPNs of the interventions as specified in the IHCP.

- Individual #277's IPN dated 11/4/21 for ACP impaired skin integrity, indicated that the DSP reported to the nurse that after his feeding, he was coughing, had a runny nose and watery eyes. The nurse documented an assessment in IView, however, it did not include lung sounds.
- For Individual #343, documentation of lung sound assessments was not consistently included, however, the Center was documenting other respiratory indicators, such as SP02 monitoring, respiratory rate, suction, and respiratory status.
- Individual #255 experienced a clinical status change involving emesis of formula on 10/10/21. Although the emesis protocol included respiratory assessment/lung sounds QS, it was not implemented as planned every 24 hours per the documentation (IPNs & IView).

| Outcome 7 – Individuals receive medications prescribed in a safe manner. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Nursing did a nice job explaining medications to the individual and ensuring overall safety in the form of good documentation and infection control practices. Areas to focus on should be ensuring that individuals who have respiratory issues are provided the needed lung assessment at a frequency that meets the needs of the individual and ensuring proper infection control techniques. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 277 | 255 | 258 | 365 | 343 | 392 | 347 | 348 | 142 |
| a. | Individual receives prescribed medications in accordance with applicable standards of care. | Not scored | | | | | | | | | |
| b. | Medications that are not administered or the individual does not accept are explained. | Not scored | | | | | | | | | |
| 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 was moved to the category of requiring less oversight. | | | | | | | | | |
| d. | In order to ensure nurses, administer medications safely:<br>For individuals who exhibit signs and symptoms of respiratory issues and/or aspiration during medication administration, the nurse will immediately stop the medication administration and complete an assessment which will include lung sounds and may include a full set of vital signs, pulse oximetry, etc. as indicated at the time of the assessment. | 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. | 50%<br>1/2 | 0/1 | 1/1 | | | | | | | |
| f. | Individual's PNMP plan is followed during medication administration. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |
| g. | Infection Control Practices are followed before, during, and after the administration of the individual's medications. | 75%<br>6/8 | | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| | i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s). | 100%<br>2/2 | | | 1/1 | | 1/1 | | | | |
| | ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action. | 100%<br>2/2 | | | 1/1 | | 1/1 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| h. | Instructions are provided to the individual and staff regarding new orders or when orders change. | N/A | | | | | | | | | |
| 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. | 100%<br>3/3 | | 1/1 | 1/1 | | | 1/1 | | | |
| j. | If an ADR occurs, the individual's reactions are reported in the IPNs. | 100%<br>1/1 | 1/1 | | | | | | | | |
| 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. | 100%<br>1/1 | 1/1 | | | | | | | | |
| l. | If the individual is subject to a medication variance, there is proper reporting of the variance. | 75%<br>3/4 | 1/1 | 1/1 | 1/1 | | 0/1 | | | | |
| 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. | 100%<br>1/1 | 1/1 | | | | | | | | |

Comments:
The Monitoring Team conducted observations of eight individual: Individual #277, Individual #255, Individual #258, Individual #365, Individual #343, Individual #392, Individual #347, Individual #348, and Individual #142. Individual #277 declined medication observation, so only a record review was conducted.

e: Half of the applicable individuals received pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.

- For Individual #277, on 12/5/21, the IPN indicated Tylenol was given for pain, however, no documentation was found as to whether it was effective.

g: Seventy-five percent of the individuals observed (6/8) had Infection Control Practices followed by Nursing before, during, and after the administration of the individual's medications. Example of not following infection control practices were:

- For Individual #258, the nurse washed her hands properly, however, they used the wet paper towel to turn off the faucet resulting in the potential for cross contamination. The nurse auditor provided immediate feedback.
- For Individual #343, the nurse did wash their hands for 20 + seconds as well as followed the proper procedure for drying, however, during the preparation of the medications via GT, several instances of potential cross contamination were identified, including touching the inside of the med cup after touching the individual, and between glove changes/use of sanitizer gel.

i: For all of the occurrences when a new medication was initiated, there was a change in dosage, or after discontinuing a medication, documentation showed the individual was monitored for possible adverse drug reactions.

j.-k. On all occasions, if an ADR occurred, the reactions of the individual were reported in the IPNs and orders/instructions were followed in response to an adverse impact.

l. Seventy-five percent of the individuals who experienced a medication variance had evidence of proper documentation of the variance. The exception was for Individual #343, where it was noted that there was an extra dose found in the medication bin, but did not provide additional detail on the name/dose of the medication.

m. All the individuals that had documented medication variance(s) submitted, had documentation showing the orders/instructions were followed and any change in status reported to the PCP.

## Section N: Pharmacy Services and Safe Medication Practices

Substantial Compliance – Exited Status

Six of the provisions of this section have met and achieved substantial compliance: N1, N2, N3, N4, N5, N7.

Thus, the corresponding nine monitoring indicators are no longer monitored or scored: N1a-b, N2a-e, N4a-b.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary

The Center met criteria for two of the four indicators regarding the reporting and management of an ADRs.

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.

Summary: Performance criteria were met for two of these indicators. Indicator a will be moved to the category of requiring less oversight given high performance in previous reviews, too. The other indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | ADRs are reported immediately. | 100% 1/1 | | | 1/1 | | | | | | |
| b. | Clinical follow-up action is completed, as necessary, with the individual. | 0% 0/1 | | | 0/1 | | | | | | |
| c. | The Pharmacy and Therapeutics Committee thoroughly discusses the ADR. | 0% 0/1 | | | 0/1 | | | | | | |
| d. | Reportable ADRs are sent to MedWatch. | 100% 1/1 | | | 1/1 | | | | | | |

Comments:

b. The suspected medication was continued at the same dose for five days after the reaction and for four more days after the medication was suspected to have caused the reaction.

c. His head injury on 4/3/21 was not considered or discussed, nor any treatments within the emergency department where he was seen for possible other causes of hypoglycemia. His blood glucose readings were to be done four times per day, then daily, and should have been reviewed after the event because the same suspected medication was continued at the same dose until a 25% reduction was ordered on 4/9/21.

e. The Center documented reporting the ADR to MedWatch.

## Section O: Minimum Common Elements of Physical and Nutritional Management

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section had been moved to the category of requiring less oversight. After this review, one indicator was moved to this category.

Section Summary
Most of the individuals in need of PNMT review/assessment were referred either by the IDT or self-referred within five days of an event

In general, PNMT assessments did not contain all of the required content and depth of review.

PNMT needs to ensure that they track measurable progress. Specific data as to how the individual's current progress compares with the previous review should be presented.

ISPs were not clearly and comprehensively addressing PNM at-risk conditions. PNM action plans were not implemented timely and completely. Follow-up did not always occur.

For 80% of the observations, positioning, and dining plans met criteria.

Individuals who received enteral nutrition did not have thorough reviews and plans regarding continued necessity and use of least restrictive method.

| Outcome 1 – Individuals' at-risk conditions are minimized. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: All individuals identified as potentially having a PNM related event/concern were referred to the PNMT as appropriate. This has been the case for three consecutive reviews and, as a result, this indicator will be moved to the category of requiring less oversight. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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; | 100% 7/7 | | 1/1 | 1/1 | 1/1 | | 1/1 | 1/1 | 1/1 | 1/1 |
| | Comments:<br>b. The Monitoring Team reviewed seven individuals who were referred or should have been referred to the PNMT. Out of the seven individuals, it was good to see that all were noted to be referred to, or reviewed by, the PNMT, as appropriate. | | | | | | | | | | |

| Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Most of the individuals in need of PNMT review/assessment were referred either by the IDT or self-referred within five days of an event. Based on the issue, the type or level of review met the needs of the individual. Issues noted were surrounding the timeliness of the review as well as its comprehensiveness. While most of the reviews were considered comprehensive, the comprehensiveness of the PNMT assessment was lacking. Most of these indicators showed improvement from the last review. All will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
| a. | Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT. | 100% 7/7 | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| b. | The PNMT review is completed within five days of the referral, but sooner if clinically indicated. | 100% 7/7 | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| c. | For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely. | 80% 4/5 | | 1/1 | 1/1 | 1/1 | | 0/1 | | 1/1 | |
| d. | Based on the identified issue, the type/level of review/assessment meets the needs of the individual. | 86% 6/7 | | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | |
| e. | As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results. | 83% 5/6 | | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | | |
| f. | Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue. | 100% 8/8 | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| g. | If only a PNMT review is required, the individual's PNMT review at a minimum discusses: | 67% 2/3 | | 0/1 | | 0/1 | | | | | 1/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | • Presenting problem;<br>• Pertinent diagnoses and medical history;<br>• Applicable risk ratings;<br>• Current health and physical status;<br>• Potential impact on and relevance to PNM needs; and<br>• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. | | | | | | | | | | |
| h. | Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary. | 0%<br>0/6<br>76%<br>48/63 | | 0/1<br>9/11 | 0/1<br>7/11 | 0/1<br>9/11 | 0/1<br>7/10 | 0/1<br>8/11 | | 0/1<br>8/9 | |

Comments:

a. through g. For all individuals that should have been referred to and/or reviewed by the PNMT, their reviews/assessments were all completed in a timely manner, except for Individual #347. The assessments/reviews consisted of all the needed team members to address the identified PNM issues. Two of three reviews were considered to meet the needs of the individuals. The exception was for Individual #255 who had a comprehensive assessment completed on 7/8/21 while in the hospital and a review completed upon return. The review did not address issues related to pleasure feedings that were resumed immediately upon discharge from the first hospitalization. For Individual #348, it was unclear with his significant history why a comprehensive assessment was not provided earlier than 1/20/22.

h. The following summarizes some of the strengths and weaknesses noted with the six assessments that the PNMT completed:

Indicators that were noted as commonly missed and the percentage in which they were missed included

- Recommendations for measurable goals/objectives, as well as indicators and thresholds. (83%)
- Discussion as to whether existing supports were effective or appropriate. (100%)
- The individual's behaviors related to the provision of PNM supports and services; (25%)

Indicators that were noted as consistently present across all the assessments included:

- 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.
- Discussion of medications that might be pertinent to the problem, and discussion of the relevance to PNM supports and services.
- Evidence of observation of the individual's supports at his/her program areas.
- Assessment of the individual's current physical status.

Some specific examples included:

- For Individual #347, her assessment did not offer discussion regarding whether there was a behavioral component to her pulling out her tube. The discussion within the assessment primarily focused on potential behavioral impacts on supports, but not as a potential cause. There was no discussion to help prevent this from happening in the future or if the GT was clearly needed and/or indicated. Regarding aspiration, Individual #347's assessment stated that supports were effective AEB her last aspiration episode that occurred in May 2010. The PNMT did not address effectiveness leading up to the most recent hospitalization and the need for PEG tube placement. The individual refused meals prior to the first hospitalization from 2/18/21 to 2/24/21 along with lethargy and erratic sleep. The supports were listed and included oral meals on her PNMP/DP, but indicated that all medications were to be administered enterally (although she returned to the facility without her tube being replaced). There was no discussion of other supports and their effectiveness beyond a general statement that she had not experienced aspiration pneumonia since 2010.

- Individual #343 was identified as congested prior to her event of coughing, vomiting, and O2 desaturation the morning of 6/7/21. Her diagnoses were listed as aspiration pneumonia. The PNMT reported that she had a history of reflux and would stick her hand in her mouth at times resulting in vomiting, however, there was no more definitive determination made. The assessment did not include data-based discussion of potential contributing factors, such as intake volume, residuals, or constipation, for which there was a history. Additionally, no discussion to address fair oral hygiene status.

- Individual #258's assessment did not report observation of medication administration or oral hygiene during the assessment process. Oral hygiene was described as poor and there was a report by the IDT OT that they observed a nurse lowering the head of bed for medication administration.

- For Individual #348, the PNMT described that the softshell helmet was of variable effectiveness if the chin straps were untied, because it can come off his head before impact while falling. The gait belt was also described as having limited effectiveness because staff must be present to provide support when he is unsteady. The individual was to always wear the gait belt, but staff always providing hands-on assistance when walking was not viewed as a viable option because he preferred to move freely without staff being in his personal space. He had a significant fall that revealed a chronic fracture of the left nasomaxillary as well as chronic fractures of the distal bilateral nasal bones form previous falls. A radiological series on 10/20/20 indicated diffuse osteoporosis in the facial bones, with further serious risk of fracture likely with additional falls, such as what occurred on 12/14/21, when he suffered a mandibular fracture with dislocation after a fall. There was no discussion as to the status of gait belt use, falls and/or injury, use of helmet, and falls with/without injury.

- For Individual #255, there was insufficient discussion regarding the purpose of several the supports. The PNMT did not identify that the current nutrition/hydration intake via g-tube was not effective as he had gained 57+ lbs. in the last year. The team failed to address pleasure feeding effectiveness before and since hospitalization. They documented in general terms, such as "all supports were effective." There was no adequate consideration for safety related to his immediate return to oral pleasure feedings.

- For Individual #277, her assessment focused on the impact of behavior on supports, but not the behavior potentially causing the issue regarding tube removal.

Overall, there was significant improvement was noted across all PNMT assessments. Areas to focus should be on gathering the information from the assessment and developing an effective plan based on comparative analysis and with clear recommendations for implementation.

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

Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports and, often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. Plans did not include individualized triggers and actions to take when they occurred. Also lacking were the clinical indicators necessary to measure if the goals/objectives are being met. The frequency of monitoring was not well defined outside of the nurse's responsibilities. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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). | 11%<br>2/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 1/2 |
| b. | The individual's plan includes preventative interventions to minimize the condition of risk. | 24%<br>4/17 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 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. | 22%<br>2/9<br>92%<br>115/125 | 0/1<br>12/<br>13 | 1/1<br>14/14 | 0/1<br>11/<br>14 | 0/1<br>13/14 | 0/1<br>13/14 | 0/1<br>13/<br>14 | 0/1<br>12/14 | 1/1<br>14/14 | 0/1<br>13/<br>14 |
| d. | The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective. | 11%<br>2/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 1/2 |
| e. | The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met. | 11%<br>2/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 1/2 |
| f. | Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable. | 6%<br>1/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 1/2 | 0/2 |
| g. | The individual ISP/IHCP identifies the frequency of monitoring/review of progress. | 17%<br>3/18 | 0/2 | 0/2 | 1/2 | 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 were IHCPs related to: Individual #392 – weight and choking; Individual #348 -falls and choking; Individual #343 – aspiration, and fractures; Individual #255 – aspiration and falls; Individual #258 – aspiration and skin integrity; Individual #347 – aspiration and weight; Individual #277 – aspiration and weight; Individual #365 – falls and choking; and Individual #142 – falls and choking.

a. Overall, ISPs/IHCPs did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The positive exceptions were for Individual #365 – falls, and Individual #142 – choking.

Some specific examples of IHCPs/ISPs not addressing PNM needs included:

- For Individual #392, his weight goal stated he would lose one to two lbs. per month in the next year., however, no interventions were identified. For choking, the IHCP stated that he would not overfill his mouth with food in 100% of the completed monitorings and have no choking episodes in the next year. The IHCP again identified no supporting interventions.

- For Individual #348, his choking goal was to not experience any choking episodes related to the intake of medications and meals over the next 12 months as well as to respond to verbal and physical prompts to pace eating/drinking in 80% of monitoring. There was no reference to PNMP monitoring to measure progress or change in status related to choking.

- For Individual #343, her fracture goal was to maintain Vitamin D level (30-100) in the next 12 months and have zero episodes of fractures related to falls in the next 12 months. The IHCP offered no individualization of any outcomes or interventions.

- For Individual #255, his fall goal was to remain free of serious injury during transfer AEB no falls/fractures in the next 12 months. There was no reference to an outcome related to his home walking program as identified in the OT/PT assessment and reference to his PNMP and supports including monitoring of this program or his PNMP for compliance and effectiveness by Habilitation.

- For Individual #258, her skin integrity goal was to maintain pressure related skin integrity with supports, but these were not fully outlined in the IHCP statement. Her COS outcome was that she would not have any pressure-related skin breakdown by April 2022, with an airflow mattress. Neither of these was measurable. There were no interventions related to checking the mattress for inflation on a routine basis to ensure that it was working properly and no reference to PNMP monitoring by Hab Therapy. There were no interventions to address prevention of future skin breakdown with future hospitalizations, such as provision of equipment, PNMP, and monitoring of their use and application.

- For Individual #347, her goal was to maintain her weight within 10% of her EDWR in the next year. The IHCP stated that the PCP will complete an interval review every three months, but this was inconsistent with the PNMT recommendations as of November 2021, which indicated her to main weight with her EDWR of 87-107 lbs.

- For Individual #277, his IHCP for aspiration was initiated on 12/31/21 and was an acute care plan for risk for impaired gas exchange. No other IHCP was submitted related to aspiration risk.

- Individual #365's IHCP for choking did not contain interventions for a SAP or specifics to address her inattention, impulsivity, overfilling of spoon, and her fast rate of eating. Additionally, there was no reference to monitoring of the PNMP.

- Individual #142's fall IHCP did not address how his falls would be tracked with correlation to seizure activity versus those that were related to other issues. Fall documentation did not clearly delineate this with any consistency. There were no actions related to assessing the effectiveness of supports to prevent falls, protect him from injury, or to establish effectiveness of SO for balance and LE strengthening exercise as it may relate to fall risk and prevention or reduced injury to justify continued implementation.

b. Overall, ISPs/IHCPs did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The positive exceptions were for Individual #343 - aspiration; Individual #365 –falls; and Individual #42 – choking and falls.

Some examples of ISPs/IHCPs that did not include the needed interventions included:

- Individual #348's goal for falls was related to increasing the use of his wheelchair as his primary method of mobility, yet the ISP/IHCP referenced it as a PRN wheelchair. For his choking IHCP, there was no reference to strategies to improve his slow rate of eating outside of staff prompting.

- Individual #343's IHCP for fractures did not address an individualized approach to the prevention of fractures. There was no reference to specific supports, equipment, and precautions from the PNMP, including no right side-lying, not pulling on her legs due to fragile bones, two staff for repositioning, and two-person mechanical lifts.

- Individual #255's IHCP for aspiration did not contain discussion related to having resumed oral pleasure feedings. No plan or measurable criteria were developed to track his status. There was no identified monitoring for this activity despite his continued risk for aspiration associated with this activity. There was no evidence of discussion regarding risk versus benefit. For falls, there was no reference to the PNMP. The preventative measures were to intervene for unsafe behaviors and to evaluate the environment quarterly.

- For Individual #258, her IHCP for skin integrity did not include the recommendation to stay up and out of bed for most of the day as per follow-up by PNMT on 9/2/21 for respiratory health and as wounds were fully healed. Additionally, there was nothing to address how they might prevent future hospital acquired wounds in the future. Her aspiration IHCP only referenced to follow the PNMP and did not offer specific strategies.

c. Nine individuals in the review group had PNMPs/Dining Plans. Two of nine individuals had a comprehensive PNMP. Elements most missed from the PNMP included accurate photographs, oral hygiene, and communication, Common components missed and the percentage in which they were missed included:

- Photographs (56%)

Specific examples are noted below:

- For Individual#392, the PNMP stated that he had a hearing loss in his left ear, yet he wore bilateral hearing aids.
- For Individual #343, her photo for right side-lying included for enteral feedings, yet the PNMP stated that there should be no right side-lying. Additionally, her PNMP stated that oral hygiene should be provided at 45 degrees if completed in bed. Other documentation, such as the 9/7/21 OT/PT assessment, did not address this, therefore, it was not clear as to what was accurate.
- For Individual #255, the PNMP showed lateral flexion to his right when seated in wheelchair. Due to him being enterally nourished and having a severe swallowing disorder, it would be important to show him in a more upright position to demonstrate for staff the most upright position for intake, medication administration, and oral hygiene
- For Individual #258, her legs were crossed in the bed position photos. This would not be an acceptable practice to ensure proper alignment of lower extremities and for skin protection from breakdown due to contact of the lower legs. There was no support under the legs in supine.

d. Two of 18 IHCPs included the steps necessary to meet the measurable goal/objective related to Habilitation Therapies.

Some examples of IHCPs not including the needed steps:

- For Individual #348, there were no steps related to him transitioning to the full-time use of a wheelchair as his primary means of mobility. The IHCP did not address the use of the helmet other than the prompting by staff prompts. There was no exploration as to its effectiveness in preventing serious injuries to the head or face.
- Individual #343 and Individual #255's IHCPs had no reference to their established goals from PNMT.
- Individual #258 and Individual #347's IHCPs lacked reference of inclusion of PNMP monitoring to assist in the measurement of progress.
- Individual #392's IHCP contained no interventions to support the outcome.

e. Two of 18 IHCPs identified the necessary clinical indicators related to PNM related supports. Examples of IHCPs that contained appropriate clinical indicators were for Individual #365 and Individual #142 for falls.

f. One of 18 IHCPs identified triggers and actions to take should they occur. A positive example was Individual #365/s IHCP that identified clutter, ill-fitting shoes, wearing crocs, obesity, lack of postural awareness, and pedestrian skills as related triggers. An example of an IHCP not containing the right type of trigger was for Individual #142 for falls that did not address how to track falls related to seizure activity, the frequency of analysis, and the actions to be taken.

g. Three of the IHCPs included the frequency of PNMP monitoring/review of progress. Those that met criteria were for Individual #343–aspiration; Individual #365 – falls; and Individual #142-choking.

| Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely. | |
|---|---|
| Summary: None of the IHCPs included all the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that the individuals receive the PNM supports they require. In | Individuals: |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| less than a quarter of the instances, the IDTs took immediate action when individuals' PNM risk increased, or they experienced changes of status. Improvement was noted in the discharge process of the PNMT back to the IDT where all of the discharge meetings were noted to be comprehensive in nature. These indicators will remain in active monitoring. | | | | | | | | | | | |
| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
| a. | The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps. | 0% 0/18 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 | 0/2 |
| b. | When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action. | 23% 3/13 | 0/2 | 0/2 | 1/1 | 0/2 | 1/2 | 0/2 | 1/2 | 0/1 | 0/1 |
| c. | If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT. | 100% 6/6 | | 1/1 | | | 2/2 | 2/2 | | 1/1 | |

Comments:
a-b. For the 18 risks, none met criteria regarding whether the individuals' ISPs provided evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provided an explanation for any delays and a plan for completing the action steps. Three of the 13 risks contained evidence that the IDT met and acted because of a change in status.

Some examples of the IDT not meeting and addressing the change in status include:

- For Individual #392 (weight), upon admission, he weighed 186 lbs. His weight increased to 194.2 in the 30 days prior to his ISP held on 11/2/21 and risk was deemed high in this area. The IHCP developed in this area did not adequately address his obesity and that he was 28% above his EDWR of 127-156 lbs. Regarding choking, he experienced a choking event on 10/20/21, but no IHCP interventions were developed to mitigate further risk. A mealtime observation was provided, and a dining plan was initiated to reflect choking risk to medium. However, this was not modified in the IRRF or IHCP.

- For Individual #348 (falls), due to the high frequency of his falls it was not clear why he had not been assessed by the PNMT sooner, though he had been followed by the team since a review conducted on 3/25/21 and clearly falls were not resolved. Though drop-seizure activity was attributed to most of the falls, the descriptions did not clearly describe s/s of seizure activity. For example, one fall observed in a video described him as falling face forward while holding a green basket, with no additional rationale for why it was a drop-seizure. There were other fall descriptions that did not reflect seizure activity, such as standing on a chair to reach the TV and falling on his buttocks and hitting his head. The data used to guide the IDT's decision-making, actions and interventions were not consistent and not well-documented. Likewise, without a clear system to track his falls and correlate them to his seizures, efforts to track the effectiveness of supports and interventions will be difficult. Most of the falls discussed in ISPAs related to falls with injury rather than an analysis of all of his falls. Per documentation submitted, he

experienced 19 true falls, with no delineation of how many, if any, of these were attributed to seizure activity. Regarding choking, there was an ISPA related to his COS post mandibular fracture and an acute care plan that was developed in the IHCP. The choking risk care plan was not modified and there was no detail as to how often he would be monitored by Hab for the six weeks he was to be given a pureed diet.

- When Individual #255 (aspiration) was discharged from the hospital, the IDT quickly resumed pleasure feedings the day after he was discharged home with no clear plan documented. An observation of his intake was not conducted until the next day when he had already had multiple intakes. There was no discussion of this in the PNMT assessment or review. He was returned to the hospital by 7/4/21. Regarding falls, there was no update of the IHCP to reflect his change of status related to a series of hospitalizations in May, June, and July 2021. Each had an impact on his functional mobility and safety for transfers and ambulation.

- For Individual #258 (aspiration), after discharge from the hospital on 7/5/21, an ISPA was held on 7/6/21. The IDT reviewed her care plan and made a referral to the PNMT. There was no discussion of revisions needed to the IHCP, but this was noted to be completed.

- For Individual 347 (aspiration), there was no evidence of IHCP revisions as only the newest IHCP was submitted with a date for 5/18/21 implementation. An ISPA on that same date stated that her volatile health issues required 24-hour nursing and residing on her existing home may pose a risk. Her IHCP did not reflect the support needs of a person matching that description and did not reflect adequate supports for maintaining her status related to aspiration or preventing further episodes. There was no COS IHCP submitted. Regarding weight, detailed review was held on 7/27/21 to address excessive sedation and hypoglycemia, hypothermia, hypotension, and hypoxia. Concurrent with these issues was ongoing evidence of weight gain (despite measures in place to achieve the PNMT discharge goal of maintaining her weight within the EDWR of 87-107 lbs. by 7/1/21). There was also evidence of right lower extremity swelling though this was not discussed relative to her weight gain. The PNMT stated her weight (113.5lb.) was stable with a 2.5 lb. gain over August 2021 and that the action was complete, and the goal was met, but there was no explanation as to why the goal was considered met when she exceeded the EDWR.

- For Individual #277 (weight), the revised IHCP did not reflect sufficient interventions and strategies to address his needs given his recent health status. There were more specific strategies, such as order for biweekly weights per the ISPA pre discharge summary, but these were not addressed in an updated IHCP. There was no evidence of a more updated IHCP as of 2/1/22, though he had been discharged and returned home by 1/18/22.

- For Individual #365 (falls), many of the issues identified by the PNMT were issues that existed prior to her referral to the team. It was not clear why this type a comprehensive assessment was not completed sooner well. Her history of falls dated back to January 2020. She experienced 14 falls from January-March 2020, eight falls from September-October 2020, 11 falls from January-February 2021, and 23 falls from April-August 2021. The PNMT stated that her supports were effective because most of her falls were related to behavior (which demonstrated the ineffectiveness of her behavior supports), but this was not adequately discussed and addressed. There was the identification at the time of the PNMT assessment of her non-behavior

related falls had increased. On a positive note, with referral and assessment by the PNMT, she received direct PT and additional supports for prevention of falls unrelated to behavior and protection from injury.

- For Individual #142 (falls), the number of his falls declined in October and November 2021 but there was no analysis to discuss what had impacted this change.

c. All the individuals discharged from the PNMT had an ISP/ISPA reflected comprehensive discharge/information sharing between the PNMT and IDT. Some examples included:

- Individual #258 (aspiration) had an ISPA held on 12/8/21. During the ISPA, recommendations and follow-up related to wound prevention versus aspiration risk were discussed. Completed actions were reviewed and follow-up was extended due to second episode of skin breakdown. The IDT addressed changes to the transfer strategies and positioning schedule.
- Individual #347 (weight) was recommended for discharge on 11/4/21 with an ISPA held on 11/9/21. The PNMT recommended that the IDT continue to track her weight, and follow-up with rheumatology for Lupus workup.

| Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked and are implemented thoroughly and accurately. | | | |
|---|---|---|---|
| Summary: An increased number of individuals had their dining plans and positioning plans implemented. Performance has shown an improvement of 16$ since the previous review. | | | |
| # | Indicator | Overall Score | |
| a. | Individuals' PNMPs are implemented as written. | 80%<br>32/40 | |
| b. | Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP. | Not rated | |

Comments:

a. The Monitoring Team conducted 40 observations of the implementation of PNMPs/Dining Plans. Overall, the implementation of dining plans was consistent across all observations. Based on these observations, individuals' dining plans were implemented correctly with 90% (19/21) consistently. Thirteen of 17 (77%) individuals were positioned correctly and according to their PNMPs.

The following provides more specifics about the observations:

- Regarding Dining Plan implementation, the few errors that occurred were related to staff and the individuals not positioned correctly at mealtime or eating at too fast of a rate.
- Regarding the few problems with positioning, individuals were not positioned correctly. It was positive that necessary adaptive equipment/supports were present, and staff used equipment correctly.

Individuals that Are Enterally Nourished

| Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The ISP/IRRF did not consistently document the clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and the discussion regarding the potential of the individual's return to oral intake. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 258 | 277 | | | | | |
| 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. | 50% 2/4 | 0/1 | 0/1 | 1/1 | 1/1 | | | | | |
| b. | If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely. | 0% 0/1 | | 0/1 | | | | | | | |

Comments:

a. and b. Four individuals in the review group received enteral nutrition. Half had clinical justification for the continued medical necessity and none had a plan to progress along the continuum to oral intake, as appropriate.

- For Individual #343, her OT/PT assessment offered additional information related to her oral motor control and swallowing deficits that would have been useful in providing a stronger rationale for continued medical necessity in the IRRF. Clinical justification should include input from a variety of specialties, including the Occupational Therapist. The ISP/IRRF did not include this information and primarily referenced the MBSS.
- For Individual #255, per the IRRF update with COS in July 2021, it outlined the issues related to recent hospitalizations and the lack of response to dysphagia therapy, however, there was inconsistency regarding oral intake and whether he was NPO after the June 2021 hospitalization as some documentation stated he received pleasure feedings until the hospitalization on 7/4/21. Additionally, there was no clear plan in place to resume pleasure feedings upon return from hospital with aspiration pneumonia on 6/14/21.

| 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 monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 258 | 277 | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented. | N/A | | | | | | | | | | |
| Comments:<br>a. Due to the absence of measurable plans this indicator was rated as N/A. | | | | | | | | | | | | |

## Section P: Physical and Occupational Therapy

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Six of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

The majority of individuals did not have clinically relevant and measurable goals integrated as part of the ISP progress reports. Documentation of progress was often noted within the IPNs and not noted within the ISP monthlies.

None of the individuals received a comprehensive screening or assessment that met their identified needs. Common components missing included a functional description of fine, gross, sensory, and oral motor skills, and ADLS. Clear clinical justification of the benefit of supports and recommendations to address identified needs were also needed.

Individuals' ISPs did not include consistent functional descriptions of the individual's' status from an OT/PT perspective. The IDT did not fully review and approve PNMPs and did not meet consistently when a new OT/PT service or support was initiated outside an ISP. 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.

All action plans and strategies were not integrated into the ISP monthlies. Notation of progress was done in isolation in the IPNs by the providing therapist. The presence of an ISPA in response to a discharge by OT/PT occurred in half the times appropriate.

Most of the individuals had assistive and adaptive equipment that was of proper fit.

| 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: The majority of individuals did not have clinically relevant and measurable goals integrated as part of the ISP progress reports. Documentation of progress was often noted within the IPNs and not noted within the ISP monthlies. These indicators will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 40% 4/10 | | 0/1 | 0/1 | 2/2 | 0/1 | | 0/1 | 2/3 | 0/1 |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion. | 30% 3/10 | | 0/1 | 0/1 | 1/2 | 0/1 | | 0/1 | 2/3 | 0/1 |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal. | 0% 0/10 | | 0/1 | 0/1 | 0/2 | 0/1 | | 0/1 | 0/3 | 0/1 |
| d. | Individual has made progress on his/her OT/PT goal. | 0% 0/10 | | 0/1 | 0/1 | 0/2 | 0/1 | | 0/1 | 0/3 | 0/1 |
| e. | When there is a lack of progress or criteria have been achieved, the IDT takes necessary action. | 0% 0/10 | | 0/1 | 0/1 | 0/2 | 0/1 | | 0/1 | 0/3 | 0/1 |

Comments:
Three individuals received OT/PT related goals/objectives and four individuals were identified as potentially needing such services, but were not provided. The other two individuals were identified as having functional skills and, therefore, did not require a goal/objective.

- For Individual #348, his assessment completed on 8/26/21 noted him as independent with bed mobility skills, but always requiring a shower chair and a gait belt to minimize falls. Over the past ISP year, he experienced an increasing number of falls and related injuries. There were three ER visits for lacerations and facial trauma, on 3/18/21, 7/5/21, and 8/19/21. He was issued a soft-shell helmet on 7/29/21. Though the numbers and dates of falls varied somewhat across different sources, it appeared that he had at least nine falls in June and July 2021 with an additional seven to 10 falls documented in August 2021, the month of the evaluation. There were 14 falls reported in the OT/PT assessment from 10/19/20 through 5/31/21 and from 6/1/21 through 8/25/21 there were at least 16 falls with two of the injuries requiring ER. From October 2020 through 8/26/21, there were at least 12 injuries to the face or head. In one case, he hit his head, but no injuries were reported. The assessment offered no clear rationale as to why direct therapy services were not recommended or would have been appropriate. Further, the individual experienced a fall with fracture of the right-side jaw and nose on 12/15/21. The individual required assistance and was experiencing falls, but there was no justification provided as to why the individual would not benefit form PT services as many of the falls were not related to seizures and were dure to loss of balance, unsteady gait, etc.

- Individual #343's assessment was completed on 9/7/21, but lacked clear rationale for not providing OT/PT services. The assessment stated it was due to a diagnosis of microcephaly and profound IDD, but offered no additional functional detail related to identified motor deficits.

- Individual #255 had two related OT/PT goals. One goal focused on increasing ambulation with his rolling walker and the other focused on his ability to perform the Sit-Stand process. While both goals were clinically relevant, only the Sit-Stand goal was measurable. There was no documentation of progress or status from the start date of 7/23/21 to his discharge on 8/6/21 in the QIDP monthly summary or PT progress notes until 9/14/21 when the PT stated he had returned to baseline. IPN also stated that he would maintain his performance by working with Hab Techs, but this was not carried over and was not noted in the ISP monthlies.

- Individual 258's assessment, completed on 3/24/21, did not provide adequate justification for not providing OT/PT intervention for identified motor performance deficits.

- The goal for Individual #277 was not clinically relevant because there was insufficient documentation of rationale. The goal was not measurable due to the time frame for completion not being specific. The SO for walking was not addressed in the ISP, ISPA, or IHCP.

- Individual #365 had two OT/PT related goals. The first goal focused on increasing right knee strength and the second on improving upper extremity strength. Both goals were clinically relevant and measurable, but there was no evidence of review by the QIDP in the ISP monthlies.

- Individual #142's goal for balance and lower extremity strengthening was not measurable or clinically relevant. There was no goal with criteria to measure any progress with his balance or LE strengthening exercises. The SO had been implemented prior to the annual OT/PT assessment being completed, yet the effectiveness of this intervention had not yet been determined. Although there were no data to support it, the SO was recommended to continue. The rationale was that the neurologist (consult on 11/29/21) had recommended PT intervention as he indicated that two of three of falls were noted to be mechanical due to lower extremity deconditioning and spotty medication use. The PT did not adequately justify why he would not benefit from direct PT, but rather only an SO with no established measurable goals beyond reducing falls that were mechanical in nature.

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

Summary: None of the individuals received a comprehensive screening or assessment that met their identified needs. Common components missing included a functional description of fine, gross, sensory, and oral motor skills and ADLS. Clear clinical justification of the benefit of supports and recommendations to address identified needs were also needed. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| | 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. | | | | | | | | | | |
| | 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. | | | | | | | | | | |
| b. | Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs. | | | | | | | | | | |
| c. | Individual receives quality screening, including the following:<br>• 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;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Posture;<br>▪ Strength;<br>▪ Range of movement;<br>▪ Assistive/adaptive equipment and supports;<br>• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait;<br>• Participation in ADLs, if known; and<br>• Recommendations, including need for formal comprehensive assessment. | 100%<br>1/1 | 1/1 | | | | | | | | |
| d. | Individual receives quality Comprehensive Assessment. | 0%<br>0/8<br>53%<br>42/80 | | 0/1<br>7/10 | 0/1<br>5/10 | 0/1<br>5/10 | 0/1<br>6/10 | 0/1<br>5/10 | 0/1<br>1/10 | 0/1<br>6/10 | 0/1<br>7/10 |
| e. | Individual receives quality OT/PT Assessment of Current Status/Evaluation Update. | N/A | | | | | | | | | |

Comments:
c. Screenings were identified as being needed and provided by OT/PT for one of the individuals. The screening for Individual #392 addressed all the need components.

d. Comprehensive assessments were recommended for eight individuals with none of the eight receiving an assessment that consisted of all the needed components to be considered comprehensive. Common components missing as well as the percentage in which they were noted as absent were:

- Functional description of fine, gross, sensory and oral motor skills and ADLs (37%).
- Discussion of pertinent health risks (37%).
- Comparative analysis of current function (37%).

- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment) (75%).
- Clear clinical justification as to whether the individual would benefit from OT/PT supports and services (87%).
- As appropriate to the individual's needs, inclusion of recommendations (87%).

Some individual examples are as follows:

- Individual #277's assessment lacked discussion of health risks other than stating he had a history of falls and aspiration. He was listed as high risk for aspiration, GI, and falls, but the details and extent of the risk was not covered. The information provided by the Center continued to lack an analysis of why supports were needed in relation to the risk.
- Individual #343's assessment contained no description of posture or functional movement. There was reference that she moved her head, but it was not clear that she did anything else. The description of functional status primarily addressed her equipment. A description of her hand use and manipulation of preferred sensory items was noted, as well as new tremors.
- Individual #347's assessment stated that she initially had decreased abilities in her left arm/hand, which was her functional arm. The context of this decrease was not described and there was no discussion of hand skills beyond holding a spoon or shower head.
- Individual #277's assessment contained no discussion of gait, mobility, or need for staff assistance while walking. There was minimal description of motor performance. For example, it stated that his sitting balance was good because he did not require supports to maintain this position. Posture or movement in either standing or sitting were not described. Additionally, his level of participation in ADLs was not described.
- Individual #255's assessment lacked discussion of his direct PT intervention. He was observed multiple times for both effectiveness (11x) and compliance (16x), but the comments for both related to staff making no mistakes and not to the effectiveness of the supports.
- Individual #348's assessment cited numerous issues, such as decreased core stability and dynamic balance as well as decreased spatial and bodily awareness that may impact falls and could be addressed via therapy. There was no rationale for why direct services were not indicated.

It was positive that most, but not all met criteria, as applicable, regarding:

- The individual's preferences and strengths were used in the development of OT/PT supports and services.
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services.
- If the individual required 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).

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.
- 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 the individual would benefit from OT/PT supports and services.

- 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: Individuals' ISPs did not include consistent functional descriptions of the individual's' status from an OT/PT perspective. The IDT did not fully review and approve PNMPs and did not meet consistently when a new OT/PT service or support was initiated outside an ISP. 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 remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's ISP includes a description of how the individual functions from an OT/PT perspective. | 33% 3/9 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 0/1 | 0/1 |
| b. | For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate. | 56% 5/9 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 0/1 | 1/1 | 0/1 | 1/1 |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment. | 33% 2/6 | | | | 0/1 | | | 0/1 | 2/3 | 0/1 |
| d. | When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation. | 0% 0/6 | | | | 0/1 | | | 0/1 | 0/3 | 0/1 |

Comments:

a. ISPs did not consistently include concise, thorough descriptions of individuals' OT/PT functional statuses. For six of nine individuals, the ISPs did not provide a clear description of the individuals' level of independence or their gross and/or fine motor skills. Some examples of ISPs that did not include a full description were:

- Individual #392's ISP did not contain discussion of his functional motor skills or sensory concerns.
- Individual #343's ISP focused more on the supports rather than her overall function.
- It was unclear in the ISP if Individual #277 utilized a wheelchair if he was ambulatory or both.
- For Individual #365, there was no discussion of her ADLs, fine motor skills, or mealtime information.

b. For five individuals, the ISP documented a review of the PNMP and/or Positioning Schedule. Examples of PNMP reviews not documented include:

- For Individual #343, it stated that supports were discussed during the IRRF discussion, but there was no evidence of specific HOBE or shower position to address aspiration risk. Hab recommended HOBE, but did not specify the degree of elevation. HOBE elevation varied related to activity: 45 degrees for oral care (per PNMP), but 30 degrees HOBE for bed positioning and meals. HOBE was not specified per the PNMP for bathing. Additionally, the PNMP stated no right side-lying, yet there was a photo of her in right side-lying on her DP. This information was not clearly stated in the PNMP discussions and there was no evidence of a review that caught the discrepancy in her plan related to positioning.
- For Individual #347, her evaluation stated that she needed a photo of her heavy-duty shower chair, however, this was not mentioned in the ISP. Additionally, the ISP stated that they will determine the need to include a mechanical lift and new instructions during mealtime. These were not discussed or recommended in the evaluation and no rationale was offered in the ISP narrative.
- For Individual #365, the IDT identified that no changes were indicated and approved the PNMP. However, per the OT/PT annual assessment, it was recommended that she have a standard height bed to ease transition from sit to stand and that she has bed rails added to aid with transition to stand up and sit down on the bed. There was no evidence that the IDT discussed these supports or that this was identified as a change in the PNMP.

c. Individual's ISP/ISPA did not consistently include strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.

- For Individual #255, on 6/25/21, he was to participate in an HEP consisting of assisted walking with the goal of increasing distance walked by 100 feet each week with Hab techs with progress to be monitored. This was included as an OT/PT recommendation in the ISP, but was not included as an action plan or in the most current IHCP (7/27/21). There was an additional IHCP goal recommended by OT/PT that he will safely walk 300 feet with stable balance, with SBA assistance of one staff, in 100% of trials during monitoring in the next year. While the IHCP goal statement was included in the ISP as a recommendation by OT/PT, it was not included in either the ISP Action Plan or most current IHCP (7/27/21). For PT, he was to participate in direct PT then a HEP upon reaching his direct therapy goals. Per PT IPN dated 8/31/21, he had met his goals and he would continue physical activity with Hab Techs with the goal of achieving 500 feet daily or at least three times weekly. There was no formal goal statement and the goal was not included in the IHCP.
- Individual #277, Individual #365, and Individual #142's ISP/ISPA did not include discussion of their goals/strategies.

d. None of the individuals who needed to have plans revised and approved were discussed by the IDT. For example:

- There was no evidence that an ISP/ISPA was held prior to adding direct PT services for Individual #255.
- For Individual #277, the goal was never identified as an aspect of the ISPAs or ISP, and was only established in an IPN by the PT on 5/17/21.
- For Individual #365, the QIDP referenced PT IPNs, but offered no discussion of progress.
- For Individual #142, a neuro consult on 11/29/21 recommended PT to address lower extremity deconditioning be implemented on 12/14/21 with recommendations to continue per ISP held on 1/21/22. The PT did not adequately justify why he would not benefit from direct PT.

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

Summary: All action plans and strategies were not integrated into the ISP monthlies. Notation of progress was done in isolation in the IPNs by the providing therapist. The presence of an ISPA in response to a discharge by OT/PT occurred in half the times appropriate. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented. | 0% 0/9 | | | | 0/2 | 0/1 | 0/1 | 0/1 | 3/3 | 0/1 |
| b. | When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change. | 50% 3/6 | | | | 1/2 | | | 0/1 | 2/3 | |

Comments:

a. None of the individuals had evidence of their measurable strategies and plans included in the ISP/ISPA implemented. For example:

- Individual #255 had no evidence of goals implemented according to the ISP monthlies for June, July, and August 2021.
- For Individual #258, documentation stated the description of the service objective to prevent further loss of ROM and strength in her upper extremities and that she would participate for 15 minutes. The data submitted indicated that she participated for 10 minutes. Data reported in the monthly summary indicated that she enjoyed when her arms were moved, but there was no progress noted in function.
- For Individual #365 and Individual #142, there was no evidence of progress with her goal within the ISP monthlies, and the PT IPNs were only referenced.

b. Fifty percent of the individuals did not have an ISPA in response to being discharged from Occupational/Physical Therapy. For example:

- For Individual #255, his discharge summary indicated that he participated from 6/15/21 to 6/21/21 and again from 7/16/21 to 8/9/21. Inconsistency was noted regarding discharge as a PT IPN, dated 7/29/21, stated he was discontinued with skilled intervention as of today, but per ISPA, dated 8/25/21, the IDT agreed to discontinue this service on that date.
- For Individual #277, there was no consistent documentation as to when or why the service objective was stopped.
- For Individual #365, there was a very complete discharge summary by the PT, dated 12/7/21, with evidence reflecting that the IDT reviewed this discharge. The OT/PT assessment described that this program was to improve her hand strength and that ball play would be added to her HEP. There was no further description of what that program involved, though it was recommended to continue. It was not possible to determine if this program continued or had been discontinued at the time of the monitoring review due to no documentation and no reference to this in the ISP monthlies or ISPAs.

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

| Summary: Most of the individuals had assistive and adaptive equipment that was of proper fit. With sustained high performance, this indicator might be moved to the category of requiring less oversight. It will remain in active monitoring. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | | | | | | | | | |
| a. | Assistive/adaptive equipment identified in the individual's PNMP is clean. | Due to the Center's sustained performance, these indicators were moved to the category of 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. | 82% 14/17 | | | | | | | | | |

Comments:

c. Overall, the individual's assistive/adaptive equipment was seen to be the proper fit for all but a few individuals. Those were:

- Individual #345's trunk was not aligned in the chair, and she was not seated squarely into the seat. Positioning did not match her PNMP photos.
- Individual #106's arm rests appeared to be high as his shoulders and not at a position to promote good posture.
- Individual #213 was not well aligned but she did report that her new wheelchair was due for delivery the week of this review.

## Section Q: Dental Services

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Ten of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, three additional indicators were moved to this category.

Section Summary

There were some issues with timeliness due to a gap in dental service providers at the Center but with the assistance of outside providers and a new provider who was present for a short time, most exams were completed. There were still some delays in follow-up restorative care.

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

| Summary: There were some issues with timeliness due to a gap in dental service providers at the Center, but with the assistance of outside providers and a new provider who was present for a short time, most exams were completed. Further work was needed to ensure that dental summaries addressed all elements of care, including the need for a desensitization plan. These two indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
| a. | Individual receives timely dental examination and summary: | | | | | | | | | | |
| | i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| | ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting. | | | | | | | | | | |
| | iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting. | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| b. | Individual receives a comprehensive dental examination. | 78%<br>7/9 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 |
| c. | Individual receives a comprehensive dental summary. | 67%<br>6/9 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | 0/1 |

Comments:
b. Seven of the nine annual dental examinations included all required components.

- Individual #343's annual exam did not include the number of teeth present/missing.
- Individual #277 did not have an annual exam.

c. Six of nine dental summaries included all required components.

- For Individual #347, Individual #392, and Individual #258, the need for desensitization or another plan was not addressed.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Annual exams and routine oral care had been completed with the opening of some outside providers and a new provider who was present for a short time. Given sustained high performance over this and the previous three reviews (with some exceptions due to COVID restrictions), these three indicators will be moved to the category of requiring less oversight.

Individuals:

| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 100%<br>9/9 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 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. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| c. | Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines unless a justification has been provided for not conducting x-rays. | | | | | | | | | | |
| d. | If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year. | 100%<br>2/2 | | | | | | 1/1 | 1/1 | | |
| e. | If the individual has need for restorative work, it is completed in a timely manner. | 100%<br>3/3 | | | | | 1/1 | 1/1 | 1/1 | | |
| f. | If the individual requires an extraction, it is done only when restorative options are exhausted. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |

Comments:

| Outcome 7 – Individuals receive timely, complete emergency dental care. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| a. | If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | | |
| b. | If the dental emergency requires dental treatment, the treatment is provided. | | | | | | | | | | | |
| c. | In the case of a dental emergency, the individual receives pain management consistent with her/his needs. | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |

| Outcome 9 – Individuals who need them have dentures. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Due to the Center's sustained performance, indicator a moved to the category requiring less monitoring. Dentures were recommended for one individual and received in a timely manner. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 343 | 255 | 277 | 347 | 392 | 365 | 142 | 348 | 258 | |
| a. | If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s). | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| b. | If dentures are recommended, the individual receives them in a timely manner. | 100% 1/1 | | 1/1 | | | | | | | | |
| Comments:<br>b. Individual #255 received dentures in a timely manner. | | | | | | | | | | | | |

## Section R: Communication

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

Assessments showed some improvement, but remained lacking the needed components to be considered comprehensive and to effectively meet the needs of the individuals. Often, individuals via assessments were identified with communication barriers but did not develop a program to help improve their skills and bridge communication gaps.

AAC assessment and implementation is an area that was lacking and should result in an increased focus by the Center.

Existing AAC devices were generally available, but would benefit from increased access and utilization via SAP development.

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: All goals, except for two, were lacking in their clinical relevance and their measurability. The monthly progress reports did not consistently include specific data or meaningful analysis. There was little to no progress since the last review. These indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions. | 17% 1/6 | | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | | |
| b. | Individual has a measurable goal(s)/objective(s), including timeframes for completion | 33% 2/6 | | 0/1 | 1/1 | 0/1 | 1/1 | 0/1 | 0/1 | | |
| c. | Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s). | 17% 1/6 | | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 0/1 | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| d. | Individual has made progress on his/her communication goal(s)/objective(s). | 0%<br>0/6 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | |
| e. | When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action. | 0%<br>0/6 | | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | 0/1 | | |

Comments:
a. and b. Seven individuals had identified needs requiring formal communication supports. Five individuals (Individual #392, Individual #348, Individual #255, Individual #347, and Individual #277) were identified as needing supports, but were not provided with any goal/plan.

All goals, except for two, were lacking in their measurability and, except for one, were lacking in their clinical relevance. The iPad goal/objective for Individual #258 was an example of a measurable and clinically relevant and meaningful goal, however, the data that were acquired and what was discussed within the ISP monthly did not consistently match and there were no actions taken after lack of progress for three consecutive months

c. through e. Except for Individual #258, the monthly progress reports did not include specific data or meaningful analysis. This was due to in part to individuals not having a goal developed when needed.

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

Summary: All screenings provided were of sufficient quality and comprehensiveness to meet the needs of the individuals. None of the individuals' annual assessments contained the components needed to be considered comprehensive. There was improvement on indicator c compared with previous rounds. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Individual receives timely communication screening and/or assessment: | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| | i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment. | | | | | | | | | | |
| | ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission. | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication. | | | | | | | | | | |
| b. | Individual receives assessment in accordance with their individualized needs related to communication. | | | | | | | | | | |
| c. | Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:<br>• Pertinent diagnoses, if known at admission for newly-admitted individuals;<br>• Functional expressive (i.e., verbal and nonverbal) and receptive skills;<br>• Functional aspects of:<br>▪ Vision, hearing, and other sensory input;<br>▪ Assistive/augmentative devices and supports;<br>• Discussion of medications being taken with a known impact on communication;<br>• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and<br>• Recommendations, including need for assessment. | 100%<br>3/3 | 1/1 | | | | | | | 1/1 | 1/1 |
| d. | Individual receives quality Comprehensive Assessment. | 0%<br>0/6<br>60%<br>21/35 | | 0/1<br>2/9 | 0/1<br>2/8 | 0/1<br>2/9 | 0/1<br>4/8 | 0/1<br>6/9 | 0/1<br>5/9 | | |
| e. | Individual receives quality Communication Assessment of Current Status/Evaluation Update. | N/A | | | | | | | | | |

Comments:
c. Three individuals in the review group required or received a screening. All screenings discussed the issues to the depth and complexity necessary.

d. None of the individuals' annual assessments contained the components needed to be considered comprehensive.

Components commonly missing and the percentage of assessments in which it was missing included, but were not limited to:
- Discussion of pertinent diagnoses, med history, and status, including relevance of impact on communication (33%).
- The individual's preferences and strengths are used in the development of communication supports and services (83%).

- 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 (50%).
- A comparative analysis of current communication function with previous assessments (33%).
- The effectiveness of current supports, including monitoring findings (83%).
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clinical justification as to whether the individual would benefit from communication supports and services (100%).
- Recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized (100%).

It was positive that most, but not all met criteria, as applicable, regarding:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.
- A comparative analysis of current communication function with previous assessments.

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

- 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.
- The effectiveness of current supports, including monitoring findings.
- Assessment of communication needs (including AAC, Environmental Control or language-based) in a functional setting, including clinical justification as to whether the individual would benefit from communication supports and services.

As appropriate, recommendations regarding the way strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal, and informal teaching opportunities) to ensure consistency of implementation among various IDT members

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

Summary: ISPs did not thoroughly describe communication and include plans and strategies as recommended in the communication assessment. It was positive that improvement was noted as it related to the IDT reviewing and approving of the communication dictionary. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 67% 6/9 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times. | | | | | | | | | | |
| b. | The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication. | 86% 6/7 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | | |
| c. | Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment. | 100% 2/2 | | | 1/1 | | 1/1 | | | | |
| d. | When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation. | N/A | | | | | | | | | |

Comments:

a. For 67% of the individuals, it was positive that the IDT included a general description of how the individual communicated and how staff can assist in bridging gaps in communication.

Areas requiring improvement included:

- Individual #255's description indicated that he had VODs for toileting assistance and to use at work. Per the SLP, these were not being used and should be discontinued.
- Individual #365's ISP contained basics of how she communicated but lacked clear information regarding how others can help bridge the identified gaps in communication.
- Individual #142's ISP was incomplete and lacked information as it related to his receptive language and how staff should communicate with him.

b. Six of the seven individuals that required communication dictionaries had those dictionaries appropriately reviewed by the IDT.

- There was no evidence of IDT discussion regarding Individual #343's communication dictionary.

c. For two of the individuals, it was positive that, as applicable, IDTs included in the individuals' ISPs/ISPAs the communication strategies, interventions, and programs recommended in assessments or initiated outside of an annual ISPA. It was good to see this indicator score 100%. It remains in active monitoring because there were few opportunities for assessing this indicator, that is, the denominator was small due to performance on other indicators in this section.

| Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: The individual must have measurable goals that are consistently implemented, with an ISP/ISPA that documents the rationale for the therapy discharge. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 392 | 348 | 343 | 255 | 258 | 347 | 277 | 365 | 142 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented. | 0%<br>0/2 | | | 0/1 | | 0/1 | | | | |
| b. | When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination. | 0%<br>0/1 | | | | 0/1 | | | | | |

Comments:

a. The Monitoring Team reviewed the ISP integrated monthly reviews to determine whether the measurable strategies related to communication were implemented. As described above regarding Outcome 1, two individuals (i.e., Individual #343 and Individual #258) had a measurable goal.

- For Individual #343, plans were included in the QIDP monthly summaries through October 2021, but stated that there were no data in November 2021, with no explanation. Additionally, there was no monthly summary for December 2021.
- For Individual #258, the data that were acquired and what was discussed within the ISP monthly did not consistently match, therefore, it was difficult to determine frequency of implementation.

The remaining applicable individuals (i.e., who needed formal communication supports) did not have measurable goals/objectives integrated in their ISPs/ISPAs.

b. For Individual #255, there was evidence of termination of the VODs per the PNMP discussion, but this lacked adequate data and insufficient rationale for discharge. There was no evidence that the SLP had completed observations of these devices in context and no data provided other than staff report. No alternate options were offered for consideration beyond encouraging signs.

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: Approximately half of the individuals had their communication device present and used in a functional manner. Performance decreased since the last review. Both indicators will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 112 | 331 | 258 | 151 | 121 | 217 | 284 | 392 | 352 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | 78%<br>11/14 | 0/1 | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 |
| b. | Individual is noted to be using the device or language-based support in a functional manner in each observed setting. | 55%<br>6/11 | 0/1 | 1/2 | 1/1 | | 1/1 | | 0/1 | 0/1 | 1/1 |
| | | | Individuals: | | | | | | | | |
| # | Indicator | | 213 | 389 | 142 | 327 | 191 | | | | |
| a. | The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual. | | 0/1 | 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. | | 0/1 | | 1/1 | 1/1 | | | | | |

Comments:
a. and b. Based on observations, 11 of 14 individuals had their AAC devices with them, and six of 11 individuals were using their language-based supports in a functional manner.

- Individual #331'a switch was not within reach and staff indicated that the individual did not use the device.
- Individual #284's device to request a head rub was never attached to her chair and had to be presented to her by staff.
- Individual #392 did not have his hearing aid.
- Individual #213's device to "request a walk" could not be initially found by staff. It was eventually found in a cabinet. The device was not readily available to the individual. There was no access to the switch throughout the day.
- Individual #112's device to express pain and to watch tv was not readily accessible outside of her bedroom.

## Section S: Habilitation, Training, Education, and Skill Acquisition Programs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Ten of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

Most SAPs were judged to be practical, functional, and meaningful. Many were newly developed and/or newly implemented and, thus, data on implementation were not yet available and/or IOA was not yet assessed. About two-thirds of the SAPs for which IOA could have been assessed were shown to have good reliability.

Few SAPs had enough data to determine progress. Of those that did, less than half showed progress, none were met, and actions were not taken when there was no progress.

SAP content continued to improve.

About half of the individuals were engaged when observed, and about half of the treatment sites regularly demonstrated good levels of engagement.

IDTs were addressing many, but not quite all of the required topics when reviewing PTS. Further, some strategies to reduce future use of PTS were not implemented.

| 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: Most SAPs were judged to be practical, functional, and meaningful. Many were newly developed and/or newly implemented and, thus, data on implementation were not yet available and/or IOA was not yet assessed. About two-thirds of the SAPs for which IOA could have been assessed were shown to have good reliability. These indicators will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 89% 16/18 | 3/3 | 3/3 | 0/2 | 3/3 | 2/2 | 1/1 | No SAPs | 2/2 | 2/2 |
| 5 | Reliable and valid data are available that report/summarize the individual's status and progress. | 71% 5/7 | | 1/1 | 1/2 | | | | No SAPs | 2/2 | 1/2 |

Comments:

4. Individual #141's operate a fan and operate his CD SAPs were judged not to be practical or functional because they are the same SAPs he has had for over a year without any progress or revisions.

5. Individual #367's call his family, Individual #141's operate a fan, Individual #383's make a bracelet, and Individual #385's complete his TSI worksheet and follow a recipe SAPs had interobserver agreement (IOA) demonstrating that the data were reliable.

Individual #383's prepare chicken wings and Individual #141's operate his CD SAPs did not have IOA assessments.

The majority of SAPs, however, did have integrity/reliability assessments that were not due because they had not been implemented (e.g., Individual #95's order a meal) at the time of the document review, or were recently implemented (e.g., Individual #381's purchase an item) and an IOA assessment was not yet due.

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

Summary: Few SAPs had enough data to determine progress. Of those that did, less than half showed progress, none were met, and actions were not taken when there was no progress. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | The individual is progressing on his/her SAPs. | 40% 2/5 | | | 0/2 | | | | No SAPs | 1/1 | 1/2 |
| 7 | If the goal/objective was met, a new or updated goal/objective was introduced. | N/A | | | | | | | No SAPs | | |
| 8 | If the individual was not making progress, actions were taken. | 0% 0/3 | | | | | | | No SAPs | | |
| 9 | (No longer scored) | | | | | | | | | | |

Comments:

6. Individual #383's make a bracelet and Individual #385's follow a recipe SAPs were progressing. Individual #383's prepare chicken wings SAP, and Individual #141's operate his fan and operate his CD SAPs were judged to not be progressing.

Thirteen of the 18 SAPs had insufficient data (e.g., Individual #367's call his family SAP) to determine progress (i.e., less than three data points) or were not implemented at the time of the document review (Individual #95's prepare a spa SAP) to evaluate progress.

7. No individuals achieved a SAP objective.

8. None of the three SAPs that were not progressing (i.e., Individual #383's prepare chicken wings SAP, and Individual #141's operate his fan and operate his CD SAPs) included actions to address the lack of progress. San Antonio SSLC should prioritize timely action (e.g., retrain staff, modify the SAP, discontinue the SAP) when the individual is not progressing.

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: This indicator will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 to the IDT at least 10 days prior to the ISP. | 88% 7/8 | 1/1 | | 1/1 | 1/1 | 1/1 | 1/1 | 1/1 | 0/1 | 1/1 |
| 12 | These assessments included recommendations for skill acquisition. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | |

Comments:
11. Individual #385's vocational assessment was late. Individual #367 was in school and did not require a vocational assessment.

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

Summary: SAP content continued to improve. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

| # | Indicator | Overall Score | Individuals: 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | The individual's SAPs are complete. | 94 % 17/18 | 2/3 27/30 | 3/3 30/30 | 2/2 19/19 | 3/3 29/29 | 2/2 19/19 | 1/1 10/10 | No SAPs | 2/2 19/ 19 | 2/2 20/ 20 |

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

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

Ninety-four percent of the SAPs reviewed were judged to be complete (e.g., Individual #348's make a smoothie SAP). This represents an improvement from the last two reviews when 61% and 82% percent, respectively, of the SAPs were found to be complete.

It was also good to see the variety of SAP procedures San Antonio SSLC utilized. For instance, there were multiple step forward chaining SAPs (e.g., Individual #95's prepare a spa SAP), and SAPs utilizing the training of one step at a time (e.g., Individual #367's operate his TV remote SAP). The Monitoring Team found the majority of these SAPs to be very well written, and to contain all 10 of the components necessary.

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
- specific consequences for correct responses
- specific consequences for incorrect responses
- documentation methodology.

Individual #95's put the bag in the jig SAP was a multiple step SAP, however, it did not indicate how staff should respond (document) if Individual #95 needed assistance with a previously mastered step. This SAP also did not include the teaching schedule including the number of trials, days per week, etc. Finally, Individual #95's put the bag in the jig SAP did not include a maintenance or generalization plan.

| Outcome 5- SAPs are implemented with integrity. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 14 | SAPs are implemented as written. | 80% 4/5 | 0/1 | Refused | 1/1 | 1/1 | 1/1 | Attempted | No SAPs | 1/1 | Refused |
| 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. | 71% 5/7 | | 1/1 | 1/2 | | | | No SAPs | 2/2 | 1/2 |
| Comments: | | | | | | | | | | | |

14. The Monitoring Team observed the implementation of five SAPs. Individual #385's follow a recipe, Individual #348's purchase an item, Individual #141's operate a CD, and Individual #381's operate a DVD SAPs were all judged to be implemented with integrity and scored accurately.

Individual #95's prepare a snack SAP, however, was not implemented as written. The DSP implementing her SAP did not follow the correct prompting instructions. The SAP instructions stated that prompts should occur after one minute, however, Individual #95's staff verbally prompted her to prepare her snack after only a few seconds following the initial instruction.

The Monitoring Team also attempted to observe Individual #383's make a bracelet SAP, and Individual #367's operate his TV remote SAP, however, they both refused multiple attempts to participate with conducting the SAP. Individual #392's conduct an internet search SAP was not observed because, at the time of the remote review, he had an internet restriction. Lastly, Individual #296 did not have a SAP.

15. San Antonio SSLC established that each SAP will have an integrity measure at least twice every year. Additionally, they established 80% as the minimum level of an acceptable integrity score. They achieved this goal for five SAPs (e.g., Individual #385's follow a recipe SAP). Individual #383's prepare chicken wings and Individual #141's operate his CD SAPs did not have IOA assessments. Thirteen SAPs were either recently implemented, or not implemented at the time of the document review and, therefore, integrity/reliability measures were not due.

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

Summary: Few SAPs were implemented long enough for there to be implementation and a monthly review. About two-thirds of those that did have enough implementation had a monthly review. This indicator will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | There is evidence that SAPs are reviewed monthly. | 71% 5/7 | | 1/1 | 0/2 | | | | No SAPs | 2/2 | 2/2 |
| 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. Individual #383's prepare chicken wings and make a bracelet SAPs, Individual #367's call his family SAP, and Individual #385's complete his TSI worksheet and follow a recipe SAPs were implemented at the time of the most recent QIDP monthly report and were reviewed. Individual #141's operate a fan and operate a CD SAPs, however, were last reviewed in September 2021 and, therefore, were scored as not being reviewed monthly.

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

| Summary: About the same as last time, about half of the individuals were engaged when observed, and about half of the treatment sites regularly demonstrated good levels of engagement. Both indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 18 | The individual is meaningfully engaged in residential and treatment sites. | 44% 4/9 | 0/1 | 1/1 | 0/1 | 0/1 | 0/1 | 1/1 | 0/1 | 1/1 | 1/1 |
| 19 | The facility regularly measures engagement in all of the individual's treatment sites. | Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. | | | | | | | | | |
| 20 | The day and treatment sites of the individual have goal engagement level scores. | | | | | | | | | | |
| 21 | The facility's goal levels of engagement in the individual's day and treatment sites are achieved. | 67% 6/9 | 1/1 | 1/1 | 0/1 | 1/1 | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 |

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in their residences during the review week. The Monitoring Team found Individual #367, Individual #392, Individual #383, and Individual #385 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

21. Engagement scores were based on available residential engagement data over the last six months. The facility's average engagement indicated that Individual #383, Individual #367, Individual #381, Individual #348, Individual #95, and Individual #385's residences achieved their goal level of engagement.

| Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: Due to COVID precautions in effect during the review period, activities related to these indicators were suspended. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 |
| 22 | For the individual, goal frequencies of community recreational activities are established and achieved. | Not rated due to Covid | | | | | | | | | |
| 23 | For the individual, goal frequencies of SAP training in the community are established and achieved. | Not rated due to Covid | | | | | | | | | |

| | | | | | | | | | | | | |
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| 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 rated due to Covid | | | | | | | | | | |

Comments:
22-24. In an attempt to mitigate the effects of COVID 19, the facility suspended all community outings in March 2020. San Antonio SSLC was in the process of reinitiating community outings during the remote review week and, therefore, these indicators will not be scored.

Although these indicators were not scored for this review, the Monitoring Team was encouraged by the fact that eight of the nine individuals had community outing objectives, and that all individuals had SAP community training objectives or rationales of why community SAPs were not developed.

| Outcome 9 – Students receive educational services and these services are integrated into the ISP. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | | | | | | | | | | |
| 25 | The student receives educational services that are integrated with the ISP. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| Comments: | | | | | | | | | | | | |

| PTS: Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary: IDTs were addressing many, but not quite all of the required topics when reviewing PTS. Further, some strategies to reduce future use of PTS were not implemented. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | | |
| # | Indicator | Overall Score | 95 | 367 | 141 | 381 | 348 | 392 | 296 | 385 | 383 | |
| 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% 2/4 | 0/1 | | 1/1 | | 1/1 | | | | 0/1 | |
| 2 | If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual. | Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. | | | | | | | | | | |
| 3 | If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying | 75% 3/4 | 1/1 | | 1/1 | | 1/1 | | | | 0/1 | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format. | | | | | | | | | | |
| 4 | Action plans were implemented. | 33%<br>1/3 | 0/1 | | 1/1 | | 0/1 | | | | |
| 5 | If implemented, progress was monitored. | 100%<br>1/1 | | | 1/1 | | | | | | |
| 6 | If implemented, the individual made progress or, if not, changes were made if no progress occurred. | 0%<br>0/1 | | | 0/1 | | | | | | |

Comments:
This outcome and its indicators applied to Individual #95, Individual #141, Individual #348, and Individual #383.

1. Available documentation provided evidence that Individual #141's and Individual #348's IDTs' discussed PTS usage and effectiveness during the past 12 months, discussed behaviors observed during the procedure, other supports and interventions provided, the risk-benefit of the procedure, and documentation of informed consent. Available documentation for Individual #95 and Individual #383's, however, did not include evidence of risk-benefit of PTS.

3. Individual #95, Individual #141, and Individual #348's treatment strategies were based upon the hypothesized cause, and written as a SO. Treatment strategies were not in the ISP or ISPA for Individual #383.

4. There was no evidence that Individual #95 or Individual #348's action plans were implemented.

5. There was documentation of data reviews on progress of Individual #141's treatment strategies

6. Available data indicated that Individual #141's teeth were not consistently brushed twice a day. There was no documentation of action to address this lack of progress

## Section T: Serving Residents in the Most Integrated Settings Appropriate to Their Needs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

The Center completed one transition during this review period, but had 17 referrals. Four of those individuals were at the point of provider selection. This was good to see.

At the time of the previous review, the APC had just begun her duties in that position. Since that time, she had taken the initiative to sit in on CLDPs and shadow transition staff from another Center. She then began to implement improvements at San Antonio SSLC, with an emphasis on working with disciplines to improve transition assessments. The Monitoring Team could see some of these improvements reflected in certain assessments.

Overall, transition staff should focus their efforts on assisting the IDTs to develop measurable supports that address individuals' needs in a comprehensive manner.

- In particular, one focus area should include pre-move training supports for provider staff. Achievement of many of the remaining indicators, such as post-move monitoring (PMM) and the Pre-Move Site Review, will flow naturally from having developed this foundation.
- IDTs should also focus on ensuring that post-move supports are comprehensive and address all of an individual's important needs, especially in health and safety and behavioral health needs.

While there we some good examples of follow-up by the PMM, there were also instances for which follow-up should have been completed, but was not. For example, it was positive to see that the IDT developed some pre and post-move supports that addressed the stringent requirements of Clozaril administration for the individual we reviewed, but the PMM did not document sufficient follow-up for either set of supports.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: There was one transition since the last review. Transition planning and the CLDP addressed many topics of importance to the individual's transition, however, as detailed in the comments below, the CLDP did not adequately define community provider staff training, and it did not contain all of the necessary supports. These indicators will remain in active monitoring.

Individuals:

| # | Indicator | Overall Score | 285 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | The individual's CLDP contains supports that are measurable. | 0%<br>0/1 | 0/1 | | | | | | | | |
| 2 | The supports are based upon the individual's ISP, assessments, preferences, and needs. | 0%<br>0/1 | 0/1 | | | | | | | | |

Comments: The Center completed one transition since the previous review. Individual #285 transitioned to his mother's home under the HCS host home program. The Monitoring Team reviewed this transition and discussed it in detail with the San Antonio SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- **Pre-move supports:** The IDT developed 13 pre-move supports in the CLDP for Individual #285. It was positive that Center staff created two measurable pre-move supports to ensure procedures were in place to ensure he could continue to receive a prescribed medication without interruption. The two supports called for the community psychiatrist and pharmacy to be registered in the Clozaril Risk Evaluation and Mitigation Strategy (REMS) registry, a protocol required for providers to be able to prescribe and dispense that medication, and stated this must be verified prior to transition. Otherwise, supports were not measurable. For example, two pre-move supports were for Center nursing staff to provide information to the provider staff (i.e., a nurse-to-nurse collaboration and the provision to the provider nurse of information about needed medical and health care referrals). In both instances, Center staff generally listed topics to be covered, but did not provide details about the important individual-specific information that needed to be shared. The remaining pre-move training supports addressed pre-move training for provider staff. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. Previously, the Monitoring Team found that Center staff needed to prioritize ensuring that all pre-move training supports provide specific

competency criteria for each topic. For this review, pre-move training supports typically only provided topics to be addresses and did not provide specific criteria by which competency could be measured. The following provides examples:

- Pre- move training supports for provider staff knowledge and competency indicated the topics to be covered included his social history, nursing/health care needs, dining safety needs, and a skill acquisition plan (SAP) for identifying auto parts. None provided specific criteria by which to measure expected staff learning or competencies. The pre-move supports did not include training for his Psychiatric Support Plan (PSP) and/or his behavioral history, despite significant staff knowledge needs. However, it appeared that Center staff did provide some related training.
- The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively evidenced staff knowledge and competence, based on the individual's assessments. Overall, the testing still did not fully address many of the assessed needs or what provider staff would likely need to know, or know how to do. The exception was the training for the SAP, which appeared to be thorough and reflect appropriate criteria for provider staff demonstration of knowledge. The following provides examples:
    - As described above, the CLDP did not specify any behavioral/psychiatric pre-move training supports, but it appeared that Center staff did provide training in this area. A six question quiz probed some of the requirements of his PSP, but not all. For example, the quiz asked provider staff to name only one of his psychiatric diagnoses, one of the targeted behaviors, one setting event/antecedent, and the first intervention to try when he refuses to bathe. There was no rationale provided for testing partial provider staff knowledge rather than ensuring knowledge of all the PSP components. The testing did not cover any of his psychiatric and/or behavioral history.
    - The OT/PT competency test consisted of six questions and was not sufficiently comprehensive to address important needs. Based on assessments, Individual #285 independently fed himself, but required supervision due to an elevated choking risk. His required food texture was ground, with foods cut to the size of one-quarter inch, and a liquid consistency of regular/thin with no restrictions. The dining instructions on his Physical Nutritional Management Plan (PNMP) stated that staff should provide verbal prompts to take small bites and eat slowly and provide verbal prompts to drink liquids throughout his meal to minimize his chances of pocketing food. The quiz asked that provider staff identify two of the reasons for his elevated risk, for which the correct answers were identified as eating too fast and his edentulous status, but did not reference pocketing of food. The quiz also asked provider staff to name two of the instructions in his dining safety plan, but all three (i.e., remind to take small bites, remind to chew slowly, encourage to drink liquids when eating) were important. They potentially became even more critical for dining safety when his food texture was upgraded after transition. Also of note, the pre-move support did not call for training of day program staff, but should have.
    - The nursing pre-move training support consisted of six questions. This did not address many of his needs or did so only in a very broad manner that would not test provider staff knowledge of the important things they needed to do as a result of those needs. Four of the questions focused on adverse reactions or side effects of medications, but these were not consistently comprehensive. For example, the quiz asked staff to list two possible side effects of two medications when there were more they needed to be aware of, did not test knowledge of potentially serious side effects of another medication (i.e., as described in more detail with regard to Indicator 2 below), and did not test staff knowledge of any interventions or monitoring requirements

they might need to implement. The test posed a question asking for two of his medical diagnoses, but did not ask provider staff to demonstrate awareness of associated signs and symptoms to monitor and/or when to notify the nurse.

- **Post-Move Supports:** The respective IDTs developed 33 post-move supports for Individual #285, although some appeared to be duplicative. Many post-move supports were measurable, but there continued to be examples of post-move supports that used vague language and did not provide clear expectations about needed staff actions or about outcomes. The following provides examples:
  - The CLDP included some post-move supports that did not provide needed criteria or parameters for implementation. For example, a post-move support called for monitoring his blood pressure every three months, but did not provide any parameters by which provider staff could judge if they needed to take action (e.g., notify the nurse).
  - Two post-move supports to encourage smoking cessation and daily physical exercise, but provided no measurable criteria for what would constitute encouragement.
  - A post-move support indicated the individual should be prompted to complete personal hygiene as necessary, but provided no further guidance.

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 CLDP did not fully and comprehensively address support needs and did not meet criterion. It often did not include post-move supports across many areas of identified need. The following provides examples:

- **Past history, and recent and current behavioral and psychiatric problems:** This sub-indicator did not meet criterion. Based on documents provided for review, his PSP addressed hiding and refusals and he had a relatively recent history of elopement and self-injurious behavior. In addition, his history included attempting to set fire to his mother's house, aggression and threats of bodily harm toward family members, and cruelty toward animals. Individual #285's CLDP did not include any supports for PSP implementation or to probe provider staff knowledge of his behavioral and psychiatric needs and/or history.

- **Safety, medical, healthcare, therapeutic, risk, and supervision needs**: The IDT developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criterion, the IDTs still needed to develop comprehensive supports across all needed areas. Individual #285's Integrated Risk Rating Form (IRRF), PNMP and assessment included many requirements in these areas, but the CLDP included very few related supports and did not meet criterion. The following provides examples:
  - The CLDP did not include any post-move supports for nursing assessment after the seventh day following transition, although, based on his IRRF, he had needs that required such assessments on a quarterly and annual schedule (e.g., constipation, metabolic syndrome, skin integrity, etc.). In addition, the IRRF indicated he required monthly vital sign monitoring, a quarterly Braden scale assessment, a quarterly abdominal girth, and a semi-annual MOSES and quarterly AIMS. The CLDP only a included a support for the AIMS.
  - The CLDP did not include any supports for the host home provider or provider direct support professionals (DSPs) with regard to monitoring or reporting of signs/symptoms related to his medical diagnoses (e.g., constipation, metabolic syndrome, asthma, gastro-esophageal reflux).

- Based on his IRRF, he was at high risk for medication side effects. His nursing transition assessment listed side effects for four medications (i.e., Budesonide, Bupropion, Clozapine, and Imipramine) and particularly called out Bupropion for the potential for serious and rare side effects that could include suicidal thoughts. The nursing assessment provided specific instructions to notify the psychiatrist immediately, to consider having him evaluated immediately and to not leave him alone. The CLDP did not include any supports for the host home provider or provider staff with regard to monitoring or reporting any of the potential side effects. Related supports were limited to a pre-move move support that only stated broadly that medications would be included in the information provided in the nurse-to-nurse and to the host home provider. It did not specifically address side effects.
- The CLDP did not include a post-move support for a needed pulmonary consult and a recent recommendation for a Pulmonary Function Test related to his asthma diagnosis.
- His medical assessment provided specific detail about his needs for various medical consultations that should considered by the primary care doctor in the coming year. For example, the assessment noted various overdue consultations, including audiology, a bone density screening, a urology follow-up that needed to be scheduled by December 2021 if COVID restrictions allowed, and an overdue ophthalmology evaluation needed every two years due to the potential effects of his psychiatric medications. While the CLDP included a post-move support for the community primary care provider (PCP) to consider the consultations, it did not provide the information to indicate they were overdue or when they needed to be scheduled.

- **What was important to the individual:** The CLDP stated that IDT agreed Individual #285 would thrive in a home setting with a family-oriented host home provider and would enjoy living in less restrictive environment with his mother and spending time with his extended family. The transition supported this outcome. However, the Monitoring Team reviewed various other documents to identify what else was important to the individual, including the ISP Prep document and Preferences and Strengths Inventory (PSI). The PSI detailed a number of preferences, including liking to work on cars and trucks. He also indicated he would like to work off campus, including housekeeping, stacking food in a grocery store like Walmart or Target, or refurbishing cases (e.g., paint jobs, adding graphics, etc.). He also noted he would like to earn more money. The PSI also stated that he said he liked to work and that he enjoyed making money and knew that in order to make money, he had to go to work. As described further below, the CLDP did not address these outcomes.

- **Need/desire for employment, and/or other meaningful day activities:** The CLDP did not meet criterion. Individual #285's CLDP included one post-move support that indicated he would attend day habilitation Monday through Friday. However, there was a lack of clarity and consistency with regard to his employment needs and desires. In addition to the work-related information found in his PSI, based on his assessments, his ISP included a personal goal to work part-time stocking shelves at an auto store, which seemed to reflect his preferences. His Functional Skills Assessment (FSA) stated he had been working on a SAP to identify car parts and their functions in order to be more successful in his goal of completing an online introductory auto service course. Both his behavioral health assessment (BHA) and psychiatry evaluation documented improved work attendance and his BHA further stated he should attend an online school to start learning the art of vehicle maintenance as soon as possible and to potentially start earning money in an actual vocation. Although his vocational/day program assessment often stated he didn't want to work, it did cite certain work-related strengths. The CLDP did not reflect a meaningful discussion of these various factors. Instead, the IDT agreed that he hadn't shown interest in working in the community, so they did not

develop a related support. A single support (i.e., to participate in an outing once a month) d minimally addressed participation in meaningful day activities in any integrated community settings.

- **Positive reinforcement, incentives, and/or other motivating components to an individual's success:** The CLDP did not include any post-move supports in this area and did not meet criterion.

- **Teaching, maintenance, participation, and acquisition of specific skills:** The CLDP did not fully address the individual's needs in this area and did not meet criterion. It included one post-move support for identification of auto parts. In light of the IDT's determination with regard to employment, it was not clear the SAP had a meaningful purpose. The CLDP did not define any other supports for community-appropriate skill acquisition

**All recommendations from assessments are included, or if not, there is a rationale provided:** This sub-indicator did not meet criterion. The documentation of the IDTs' discussion of assessments and recommendations continued to need improvement. As described throughout this section, the CLDP did not consistently ensure that recommendations from assessments were addressed and/or that the IDT provided a coherent rationale when recommendations were deferred or declined. Transition staff and disciplines should work together to ensure that both the source assessments and the corresponding CLDP summaries specifically highlight all important recommendations and ensure that the CLDP includes the necessary post-move supports for implementation and post-move monitoring to occur.

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

| Summary: Post-move monitoring continued to occur as often as required. There were some good examples of the post-move monitor following-up on needed items, however, overall, post-move monitoring was not thorough or sufficient in ensuring that the individual was receiving the supports he should have received. These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Indicator | Overall Score | 285 | | | | | | | | |
| 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%<br>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%<br>0/1 | 0/1 | | | | | | | | |
| 6 | The PMM's assessment is correct based on the evidence. | 0% | 0/1 | | | | | | | | |

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| | | 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%<br>0/1 | 0/1 | | | | | | | | |
| 8 | Every problem was followed through to resolution. | 0%<br>0/1 | 0/1 | | | | | | | | |
| 9 | Based upon observation, the PMM did a thorough and complete job of post-move monitoring. | Not scored | | | | | | | | | |
| 10 | The PMM's report was an accurate reflection of the post-move monitoring visit. | Not scored | | | | | | | | | |

Comments:

4. Based on review, the PMM Checklists often did not provide reliable and valid data for this individual's support needs, as a result of several practices that needed to be improved. Examples included:

- The post-move supports typically required evidence across three "prongs," including 1) interviews of appropriate staff and, whenever feasible, the individual; 2) review of documentation (e.g., a CLDP Checklist); and 3) observations. This was positive. However, the PMM did not consistently reference all of the requirements in the PMM Checklist comments. For example, a post-move support to encourage smoking cessation called for the PMM to review the CLDP Checklist, but the PMM did not document such a review for any of the three completed PMM periods.
- In addition, as described with regard to Indicator 1 above, IDTs needed to continue to work toward improving measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports.
- IDTs also needed to continue to work on developing comprehensive pre and post-move supports for verifying provider staff knowledge and competence. This would ensure that the PMM would have the necessary prompts to assess whether provider staff were able to meet individuals' needs as described and/or listed in the CLDP, as well as the needed benchmarks for making an accurate assessment. As described with regard to Indicator 2 above, Individual #285 had significant behavioral health and health care needs for which the IDT did not develop supports, which hampered the PMM's ability to determine whether his needs were being met.
- The PMM did not consistently provide comments that addressed all aspects of each support. For example, a post-move support indicated the individual should have monthly follow-ups with the psychiatry provider until he established familiarity, but the PMM provided no documentation related to this at the time of the 45-day or 90-day PMM visits. The only evidence provided was that the host home provider attested that an initial interview was held by tele-med. The support required review of the psychiatric consult and an interview with the provider nurse, but these were not completed. The PMM marked the support as in place, but provided insufficient evidence to support that finding.

5. Based on information the Post Move Monitor collected, the Monitoring Team could often not evaluate or confirm whether individuals had consistently received supports listed and/or described in the CLDP, due to the lack of reliable and valid data. The PMM's comments and evidence should address the full scope of needed supports. As described above with regard to the lack of measurability of some supports (i.e., in Indicator 1), as well as the lack of certain needed formal supports (i.e., in Indicator 2), the PMM comments were often not sufficient to reliably demonstrate that all needed supports were in place. The following provides additional examples of supports that were not place:

- A post-move support called for the individual to have blood work monitored every four weeks for continued Clozaril administration and reiterated that the PCP or psychiatrist need to be enrolled in the REMS registry. At the time of the seven-day PMM visit, the PMM marked the support as not applicable/not yet due. This was incorrect because the REMS enrollment was overdue. The PMM did not reference this portion of the requirement in his comments.
- At the time of the seven-day PMM visit, the individual was not receiving the specified diet texture.

6. The PMM's scoring was not consistently correct. In several instances, the PMM marked supports as in place, even when the available evidence at the time did not so indicate, as described in more detail throughout the indicators in this section of the report. In addition, the IDTs will need to continue to work to improve both the comprehensiveness and measurability of the supports, to support the accuracy of the PMM's work in this area. The following provides additional examples:

- A post-move support called for encouragement of daily physical activity. At the time of the seven-day PMM visit, the PMM marked the support as in place, but provided no evidence. At the time of the 45-day and 90-day PMM visits, the PMM documented "at least one" physical outdoor activity a week and, based on that finding, marked the support as in place.
- A post-move support called for the AIMS to completed at least every three months. After the initial completion on 10/19/21, the PMM indicated he would no longer monitor, but this was incorrect. Monitoring should have continued, with the next due date in January 2022, but the PMM marked the support completed, no longer applicable, and with no further review required. The PMM made the same error for a post-move support that called for blood pressure monitoring at least every three months.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports described or listed in the CLDP are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on whether the PMM has been able to assess the presence of the described or listed supports, and then on the accuracy of the PMM's assessment of whether supports were, or were not, in place.

It was positive to see some good examples of thorough follow-up by the PMM when supports were identified as not met, but this was not consistent. For example, the PMM sometimes erred in determining a support was in place and, therefore, failed to take action. In addition, because the IDT did not consistently create post-move supports to address many significant needs, as described with regard to Indicator 2 above, the PMM often did not document assessing whether all the needs described in the CLDP were in place. In other words, compliance with this indicator requires that follow-up be implemented for the supports described and listed in the CLDP, even when the IDT fails to develop an appropriate post-move support. The following provides examples of appropriate follow-up action as well as of concerns noted:

- It was positive the PMM engaged the IDT to review changes made to Individual #285's diet texture at the time of the 45-day PM visit.

- It was also positive the PMM engaged the IDT to review changes made to a post-move support for an annual dental exam at the time of the 90-day PM visit. The provider indicated the community PCP said a dental exam was not necessary because individual was edentulous, and IDT agreed to discontinue the support. However, the documentation did not indicate the IDT considered how he would receive follow-up screenings for oral cancer, which was of particular significance due to his smoking.

- The PMM did not engage IDT or take needed follow-up action with regard to what appeared to be a significant weight gain. Based on the PMM comments, the individual's weight at transition was 220 pounds, but 280 pounds at the 45-day PMM visit.

visit. At the time of the 45-day PMM visit, the provider nurse noted that she suspected the weight at transition must have been closer to 280 because she didn't think he had gained that much weight. The PMM also documented he noted individual's clothes still fit him and it didn't look like he had gained that much weight. As a result, the PMM marked the support as in place and did not take this back to IDT as an area of concern, but should have. Based on the nutrition transition assessment, dated 8/31/21, the individual's weight that month was 241.1 pounds. The PMM should have completed due diligence to confirm the individual's actual pre-transition weight and not relied on the provider's opinion or his own visual assessment. At the time of the 90-day PMM visit, the individual's weight was recorded as 288 pounds. The PMM documented that the provider nurse stated she would speak to the host home provider, but did not document any other follow-up after the 90-day PMM visit. The PMM marked this support as in place for the 45-day and 90-day monitoring periods.

- It was positive to see that the IDT developed some pre and post-move supports that addressed the stringent requirements of Clozaril administration for the individual, but the PMM did not document sufficient follow-up for either set of supports. As described further with regard to Indicator 19 below, the PMM did not complete adequate follow-up to ensure completion of two pre-move supports for community provider registration in the REMS system. In addition, the CLDP included three post-move supports to ensure needed ongoing procedures were in place for the Clozapine monitoring (i.e., monthly CBCs, including the first no later than the first week of November 2021, and to be seen by a psychiatrist within 30 days transition). The evidence of post-move implementation was limited and did not clearly show these supports were completed on a timely basis:
    - At the time of the seven-day PMM visit, the PMM commented that a video intake with the psychiatrist (i.e., the first step in the process of being accepted as a patient) was scheduled for 10/22/21, but obtained no scheduling documentation. The PMM marked this as nonapplicable because it was not due yet, however, this was incorrect. Per the support, the primary care provider or the psychiatrist needed to be registered with the Clozapine registry and the PMM did not obtain this documentation to show this occurred. In addition, the PMM did not document a review of the medication administration record (MAR).
    - At the time of the 45-day PMM visit, the PMM documented reviewing labs from 11/1/21, but still did not obtain confirmation the provider was enrolled in REMS. The documentation further indicated the host home provider reported the psychiatry clinic "was satisfied" with the lab results and gave the individual a three month supply on 11/12/21. Per the REMS protocol, an individual can only receive 30 days of Clozaril at one time and it cannot be refilled until a new CBC is obtained and reviewed. The PMM did not document follow-up to resolve this discrepancy.
    - At the time of the 90-day PMM visit, the PMM documented review of the "most recent labs," but did not document the date. In addition, due to the timing of the PMM visit, the PMM should have documented a review of two sets of lab results, but did not.
    - Over the course of the 90 days, the PMM never documented reviewing a consult from a REMS- enrolled provider.

9-10. PMM did not occur during the remote review. 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: There were no occurrences of negative PDCT events. This indicator will remain in active monitoring. | Individuals: |

| # | Indicator | Overall Score | 285 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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%<br>1/1 | 1/1 | | | | | | | | |
| Comments:<br>11. Individual #285 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. | | | | | | | | | | | |
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| Summary: These indicators will remain in active monitoring. | | | Individuals: | | | | | | | | |
| # | Indicator | Overall Score | 285 | | | | | | | | |
| 12 | Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. | 0%<br>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%<br>0/1 | 0/1 | | | | | | | | |
| 15 | When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual. | 0%<br>0/1 | 0/1 | | | | | | | | |
| 16 | SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs. | 0%<br>0/1 | 0/1 | | | | | | | | |

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| 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%<br>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%<br>0/1 | 0/1 | | | | | | | | |

Comments:

12. Assessments did not consistently meet criterion for this indicator, and this remained an area of need. The APC reported that transition staff were set to begin training with the individual disciplines to assist them in crafting needed and community-specific supports. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: The BHA was dated 8/27/20, which was more than one year prior to transition. The dental assessment was dated 8/13/21, which was approximately two months prior to transition.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. For example, the nursing assessment, with an update on 9/17/21, indicated he had a hemoglobin A1c level of 6.0 on 10/21/20 and that it would be redrawn in April. The assessment did not provide any updated information, but should have.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Many assessments did not yet thoroughly provide specific and measurable recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. As described with regard to Indicator 2 above, there were missed opportunities to make recommendations for community-specific skill acquisition and meaningful employment and community integration.

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: As described with regard to Indicator 1 above, training did not yet meet criterion for this CLDP. The Monitoring Team requested and reviewed the rosters and competency testing for all training provided related to this transition, however, the Center did not make the training materials available for review. The CLDP pre-move training supports did not yet consistently identify the expected provider staff knowledge or competencies that would need to be demonstrated. In addition, competency testing did not clearly document provider staff had knowledge of all essential supports. The tests provided did not include questions for many supports, as also described with regard to Indicator 1 above.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed and, if any completed, summarize findings and outcomes. Overall, this CLDP met criterion. The IDT developed a related pre-move support, and the Center

nurse completed the collaboration. Based on the nursing discussion in the CLDP, it covered Individual #285's diagnosis, medication administration, medication regimen, Clozapine monitoring, and included any medication interactions and side effects to monitor.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. The CLDP noted that there were no issues in the front yard or porch and backyard or patio for safety concerns. This did not describe the IDT's consideration of any need for a settings assessment or state how, and by whom, it was completed.

17. The CLDP should include a specific statement of the IDT considerations of activities Center 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 CLDP did not meet criterion. The CLDP noted only that Individual #285 spent time with his mother and family every weekend and he was anxious to go home. This did not provide a discussion of any need related to this indicator. The IDT should document a specific discussion and determination with regard to whether a collaborative opportunity between provider and Center direct support staff would help to facilitate the individual's transition and adjustment.

19. The pre-move site review (PMSR) was completed prior to the transition date. However, it is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, and the PMSR did not accomplish this. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent for either individual, as described under Indicator 1 and Indicator 2. In addition, at the time of the PMSR, Center staff did not obtain evidence of REMS enrollment of the community psychiatrist and pharmacy as required. The PMM comments indicated only that the "enrollment process had begun." The PMM did alert the Center nurse and psychiatrist, but documented no additional follow-up to confirm the community providers were enrolled in REMS as needed.

| Outcome 5 – Individuals have timely transition planning and implementation. | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | |