United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report –** The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to

move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

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

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

Executive Summary

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

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

Status of Compliance with the Settlement Agreement

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

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Twelve of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included two outcomes: Outcomes 6, and 9 related to abuse, neglect, and incident management.

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

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

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

<u>Restraint</u>
Three indicators moved to the category of requiring less oversight (no use of prone restraint, psychiatry documentation was completed when needed, and multiple medications were not used during crisis intervention chemical restraints). Overall, however, the use of crisis intervention restraint at Brenham SSLC had steadily increased over this review period and across the two previous review periods, too. The restraint reduction committee was active, but needed to delve deeper into the possible causes of increased restraint and actions that could be taken to reduce the need for crisis intervention restraint. Similarly, A considerable (more than usual) number of documentation errors and omissions were identified. This might indicate less quality assurance review of restraint documentation than we have seen in our past reviews.

In addition to improving the timeliness of restraint monitoring, some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and documenting details and follow-up for restraint-related injuries.

Abuse, Neglect, and Incident Management
Nine indicators moved to the category of requiring less oversight. There were a number of positives in the incident management system at Brenham SSLC. For instance, investigations were complete and content was appropriate. Investigations commenced within 24 hours. Reviews of serious injuries and non-serious injuries were done correctly to assess if possible abuse or neglect had occurred. Recommendations related to findings, and both disciplinary and programmatic recommended actions, were taken in a timely manner.

On the other hand, only two DFPS investigations were completed within the required 10 days (or had acceptable extensions approved). This is of serious concern for individuals' protection from harm. In addition, more focus needs to be paid to proper reporting protocols, including timelines; some incidents were not reported correctly. Similarly, many staff incorrectly answered reporting questions posed by the Monitoring Team. Supervisory reviews need to identify problems in late reporting, completion of investigations, and so forth.

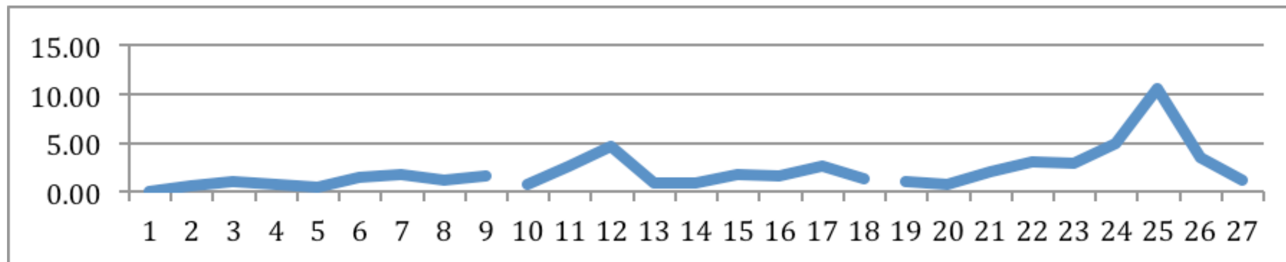
Other
It was good to see that pretreatment chemical restraint was addressed by all IDTs. Some, however, did not cover all of the detail required to meet criteria. Plans were developed and put into place for some individuals, but there were no data or reports indicating progress, problems, or revisions needed.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Crisis intervention restraint usage at Brenham SSLC had increased over this period as well as compared with the past two review periods, too. The restraint reduction committee was active and had identified some reasonable variables, but had not delved deeper into these potential causes nor put in place specific actions. The committee did, however, closely monitor restraint implementation and documentation. Five of the seven individuals had decreasing or very low occurrences of crisis intervention restraint. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
Comments:											

1. Twelve sets of monthly data provided by the facility for the past nine months (February 2016 through October 2016) were reviewed. Due to the changeover to the electronic record (IRIS), state office was unable to provide these data and graphs. Instead, the facility provided the graphs for the nine-month period. The Monitoring Team calculated the 1000-bed-day number using the facility-provided average daily census.

The frequency of crisis intervention restraint usage at Brenham SSLC was on a steady increase throughout the first seven months of the nine-month period, with a decrease in the last two months. A look back at the previous two nine-month periods also shows a steady increase in application of crisis intervention restraint. Below is a graph, prepared by the Monitoring Team, that shows this trend.



The facility's restraint reduction committee was active and met once or twice each month. The most recent minutes presented to the Monitoring Team were for 11/17/16. The committee correctly identified the increasing trend, though they only looked at a 10-month period. The committee identified school aged children as accounting for the most restraints. This was a good finding, but further analysis/exploration of why that was the case was needed. Similarly, the committee identified problems with IDTs holding ISPAs after crisis intervention restraint. The committee looked at data they collected regarding proper implementation and documentation of restraint. This was good to see. Their indicators lined up somewhat with the indicators reviewed by the Monitoring Teams.

The frequency of crisis intervention physical restraint paralleled the overall usage of crisis intervention restraint. The average duration remained low, at less than three minutes, about the same as at the last review. Crisis intervention chemical restraint was rarely used, and crisis intervention mechanical restraint was never used.

The number of injuries due to or during crisis intervention restraint showed a stable, low trend. All injuries were deemed non-serious. About seven individuals per month received crisis intervention restraint. The trend was stable and was about the same as last review, too.

No individuals were reported to have received protective mechanical restraint for self-injurious behavior (PMR-SIB). However, mittens were being used for Individual #34. In the past, he had a medical restraint plan for healing for use of the mittens. After further exploration, the Monitoring Team learned that he no longer needed the mittens, but often preferred to put them on. He could take them off by himself. Even so, a plan was being put into place to try to reduce his use of the mittens because they were heavy and also restricted him from engaging in other activities.

Overall, the usage of non-chemical restraint for medical or dental procedures, healing, or long-term usage was very low or at zero, respectively. The usage of chemical restraint for medical procedures was low, too. The facility data for usage of chemical restraints for dental procedures was zero, however, there was a lot of usage of TIVA at Brenham SSLC, therefore, these data were not correct.

Thus, facility data showed low/zero usage and/or decreases in eight of these 12 facility-wide measures (i.e., duration of crisis intervention physical restraint, use of crisis intervention chemical and mechanical restraints, injuries during restraint, number of individuals who received crisis intervention restraint, the use of non-chemical restraint for medical and dental procedures, and the use of chemical restraint for medical procedures.

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. Six received crisis intervention physical restraints (Individual #245, Individual #155, Individual #268, Individual #292, Individual #107, Individual #159), and one received crisis intervention chemical restraint (Individual #259). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for five of the seven (Individual #268, Individual #292, Individual #107, Individual #159, Individual #259).

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

Summary: A considerable (more than usual) number of documentation errors and omissions were identified. This may indicate less quality assurance review of restraint documentation than we've seen in our past reviews. All but one indicator will remain in active monitoring. Prone restraint was not used during this review period and the previous review periods. Therefore, indicator 3 will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	245	155	268	292	107	159	259		
3	There was no evidence of prone restraint used.	100% 10/10	2/2	2/2	1/1	1/1	2/2	1/1	1/1		
4	The restraint was a method approved in facility policy.	90% 9/10	2/2	2/2	1/1	1/1	2/2	0/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	80% 8/10	2/2	1/2	1/1	1/1	2/2	0/1	1/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	2/2	1/1	1/1	1/1	2/2	N/A	N/A		
7	There was no injury to the individual as a result of implementation of the restraint.	78% 7/9	1/2	1/2	1/1	1/1	2/2	N/A	1/1		
8	There was no evidence that the restraint was used for punishment or	90%	2/2	2/2	1/1	1/1	2/2	0/1	1/1		

	for the convenience of staff.	9/10									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/10	0/2	0/2	0/1	0/1	0/2	0/1	0/1		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	80% 8/10	2/2	2/2	1/1	1/1	2/2	0/1	0/1		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	60% 6/10	0/2	2/2	1/1	0/1	2/2	0/1	1/1		

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #245, Individual #155, Individual #268, Individual #292, Individual #107, Individual #159, Individual #259). Of these, nine were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

3. Prone restraints were not used at Brenham SSLC. Two crisis intervention restraints in the Tier 1 document request, however, were labeled as being prone. The Monitoring Team explored this further while onsite and learned that, in both cases, the individuals had themselves turned to a prone position during a crisis intervention physical restraint. In both cases, the staff appropriately released the restraint or re-established the correct position. Thus, both were not prone restraints. The Monitoring Team confirmed this interpretation with state office. Furthermore, the Brenham SSLC behavioral health services department reviewed video for both instances at the time of their occurrence. It was good to see this conservative approach to ensuring safe administration of crisis intervention restraint. Note, however, that many staff did not correctly report prone restraint as a prohibited restraint (see indicator 12 below).

4. For Individual #159 9/8/16, during video review of an unrelated incident, the video reviewers observed that staff restricted Individual #159's movement multiple times in a three minute period. Facility acknowledged this was not an approved restraint. The facility's history of, and continued use of, restraint video review is commendable.

5. For Individual #155 9/22/16, documentation only said that he was aggressive to staff and peers. Not enough detail was provided to meet criteria with this indicator. The information provided did not show that Individual #159 posed an immediate and serious risk of harm to himself or others.

7. For Individual #245 8/4/16, the face to face assessment form noted, in item 2.4, an injury to Individual #245, but item 3.7 showed "NA" to "injury report started?" But an injury report related to the incident was initiated at 3:44 am, well after the restraint and injury occurred. For Individual #155 9/22/16, the face to face assessment stated no injury, but also had no nursing assessment documented. A nursing assessment is required to determine if an injury occurred.

9. For this indicator, the Monitoring Team looks at a variety of treatment components that, if relevant for the individual, should be in

place to reduce the likelihood of restraint being needed. The various criteria for this indicator were met except that problems with consistent PBSP implementation were evident. 10. For Individual #155 9/22/16, insufficient data were reported on the restraint checklist and face-to-face assessment documents. For Individual #259 6/9/16, the pre-restraint consultation form showed that it was completed on 6/13/16 and was dated 6/10/16. 11. Three individuals' IRRFs did not reflect the required information

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Brenham SSLC scored low on this indicator for this review as well as during the last two reviews (25%, 0%, respectively). This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	155	268	292	107	159	259		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	14% 1/7	0/1	0/1	1/1	0/1	0/1	0/1	0/1		
Comments: 12. About half of the staff interviewed did not correctly identify prone restraint as a prohibited restraint and/or made other errors in describing prohibitions about restraint.											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Indicator 13 had low scoring for this review and last review, too. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	155	268	292	107	159	259		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	40% 4/10	0/2	1/2	1/1	1/1	0/2	0/1	1/1		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Comments: 13. Six restraints did not meet criteria for this indicator. Four of these six were because the entry for the date/time monitor arrived was blank. For Individual #245 8/4/16, there was conflicting injury data recorded on the face-to-face assessment form. Therefore, a											

determination of whether the restraint monitor correctly assessed the consequences of the restraint for could not be made. For Individual #245 10/28/16, the face to face assessment form showed that the restraint monitor arrived at 3:44 pm, but the restraint was at 2:41 pm.

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

Summary: In addition to improving the timeliness of restraint monitoring, some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring and documenting individuals' respirations, even when they refuse other vital signs; monitoring individuals for potential side effects of chemical restraints; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and documenting details and follow-up for restraint-related injuries. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 245	155	268	292	107	159	259		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	10% 1/10	0/2	1/2	0/1	0/1	0/2	0/1	0/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	50% 5/10	1/2	1/2	1/1	0/1	2/2	0/1	0/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	30% 3/10	0/2	1/2	1/1	0/1	1/2	0/1	0/1		

Comments: The crisis intervention restraints reviewed included those for: Individual #245 on 8/4/16 at 1:57 a.m., and 10/28/16 at 2:41 p.m. (at school); Individual #155 on 8/10/16 at 3:47 p.m., and 9/22/16 at 9:28 a.m. (at school); Individual #268 on 7/10/16 at 8:15 p.m.; Individual #292 on 9/17/16 at 10:02 p.m.; Individual #107 on 9/1/16 at 1:05 p.m. (at school), and 10/4/16 at 10:50 a.m. (at school); Individual #159 on 9/8/16 at 1:56 p.m.; and Individual #259 on 6/9/16 at 3:58 p.m. (chemical).

a. For three of the 10 restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. These included the restraints for Individual #155 on 8/10/16 at 3:47 p.m., Individual #268 on 7/10/16 at 8:15 p.m., and Individual #259 on 6/9/16 at 3:58 p.m. In four instances, restraints occurred at the public school, but the time the individual returned from school was not documented, which is necessary to determine the timeliness of the initiation of monitoring.

For three of the 10 restraints, nursing staff monitored and documented vital signs. These included the restraints for: Individual #245 on 10/28/16 at 2:41 p.m., Individual #155 on 8/10/16 at 3:47 p.m., and Individual #107 on 10/4/16 at 10:50 a.m. In some instances, nursing staff documented "refused" for vital signs. However, respirations do not require the individual's cooperation.

Nursing staff documented and monitored the mental status of the individuals for three of the 10 restraints, including those for

Individual #155 on 8/10/16 at 3:47 p.m., Individual #268 on 7/10/16 at 8:15 p.m., and Individual #107 on 10/4/16 at 10:50 a.m. In some instances, no mental status was documented, or the only reference to the individual's mental status was "alert," or "no change from baseline," which did not provide sufficient details, including specific comparisons to the individual's baseline.

On 6/9/16, nursing staff administered two chemical restraints to Individual #259, including Ativan 2 milligrams (mg) intramuscular (IM) in the right hip at 3:58 p.m. after two physical restraints, and then Zyprexa 10 mg IM in the right hip at 4:45 p.m. No explanation was provided regarding why both IM injections were given at the same site. In addition, the nurse noted that all vital signs except for respirations were "refused." However, there was no indication that the nurse subsequently reattempted to obtain vital signs, especially given that the individual received two chemical restraints. The IPN on 6/9/16 at 6:30 p.m. provided no objective assessment data to describe the individual's status.

b. and c. For Individual #259, who received two chemical restraints on 6/9/16, the IPN noted the individual fell twice during the behavioral episode, but did not document specifically if these falls were before or after the nurse administered the chemical restraints, or how the individual fell and where. Based on review of documentation, nursing staff conducted no assessment of gait, balance, sedation level, cognition, or activity level. The IPN noted: "continue to monitor closely," however, no further assessment was conducted. Overall, nursing staff did not conduct assessments consistent with accepted standards of care for this individual that had two chemical restraints.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: With more attention, higher performance could likely be shown. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	155	268	292	107	159	259		
15	Restraint was documented in compliance with Appendix A.	80% 8/10	2/2	1/2	1/1	1/1	2/2	0/1	1/1		

Comments:
15. For Individual #155 9/22/16, there was no comment regarding nursing assessment. For Individual #159 9/8/16, various aspects of the document were not in line with Appendix A.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Most restraints had a thorough review, but some did not. More attention should be paid to this (indicator 16). Recommendations for action, when provided, were implemented. This was an improvement from the last review and, with sustained high performance, this indicator (17) might move to the category of less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	155	268	292	107	159	259		

#	Indicator	Overall Score									
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	78% 7/9	2/2	2/2	1/1	1/1	0/2	N/A	1/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 9/9	2/2	2/2	N/A	1/1	2/2	1/1	1/1		

Comments:
16. For Individual #107 9/1/16, the IMRT review of the 9/1/16 restraint wasn't until the fourth business day 9/8/16. For Individual #107 10/4/16, the response involved ensuring that the public school knew how to properly apply a crisis intervention restraint (this was good to see), but didn't address helping the public school implement or know about ways to reduce the likelihood of behaviors occurring that can lead to restraint.

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)

Summary: When crisis intervention chemical restraint occurred, proper actions regarding its administration, consultation, and review. Multiple medications were not used as per criteria. This was the case at this review and the last two reviews, too. Therefore, indicators 47 and 48 will be moved to the category of requiring less oversight. Psychiatry follow-up after these incidents, however, was and continues to be something that needs attention from the facility and psychiatry department. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	259								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								

Comments:
47-49. These indicators applied to a chemical restraint for Individual #259. The review was performed within the 10-day time frame. There was no documentation of psychiatric follow-up following the restraint episode.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.												
Summary: Brenham SSLC maintained performance since the last review. Of note was that both investigations that had trends of prior occurrences did not have adequate implementation of PBSPs. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	75% 9/12	2/2	0/1	1/2	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

The Monitoring Team reviewed 12 investigations that occurred for 10 individuals. Of these 12 investigations, nine were DFPS investigations of abuse-neglect allegations (three confirmed, six unconfirmed). The other three were for facility investigations of a discovered eyebrow laceration, suicide threat, and encounter with law enforcement. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #382, UIR 17-064, DFPS 44953417, unconfirmed allegation of physical abuse, 11/8/16
- Individual #382, UIR 16-224, discovered left eyebrow cut laceration, 8/10/16
- Individual #245, UIR 16-196, DFPS 44522874, unconfirmed allegation of verbal abuse, 7/13/16
- Individual #268, UIR 16-180, DFPS 44447070, unconfirmed allegation of verbal abuse, 6/22/16
- Individual #268, UIR -241, suicide threat, 8/17/16
- Individual #107, UIR 17-021, DFPS 44786364, unconfirmed allegation of physical abuse, 9/20/16
- Individual #159, UIR 17-009, DFPS 44753965, unconfirmed allegation of physical abuse, 9/8/16
- Individual #259, UIR 16-170, DFPS 44375923, unconfirmed allegation of neglect, 6/2/16
- Individual #255, UIR 17-022, DFPS 44802975, confirmed allegation of physical abuse, 9/23/16
- Individual #25, UIR 16-148, DFPS 44331773, confirmed allegation of neglect and serious injury, 5/2/16
- Individual #546, UIR 16-197, DFPS 44527826, confirmed allegation of physical abuse, 7/13/16
- Individual #292, UIR 17-014, law enforcement encounter, 9/17/16

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

Nine of the 12 investigations met criteria. These were investigations of allegations of staff behavior/actions that were not related to any

trend in any staff, facility, or individual variables or characteristics. Of the three investigations that did not meet criteria, one was due to a missing 1020 duty to report form. The other two were due to problems with implementation and revision of PBSPs; required monthly integrity checks were only done intermittently.

In addition, no individuals were on the chronic caller list and, therefore, there were no streamlined investigations.

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

Summary: The facility scored 82% for the last two reviews. Additional focus needs to be paid to proper reporting protocols, including timelines. This is also reflected in outcome 3 below. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	245	268	107	159	259	255	25	546	292
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	58% 7/12	2/2	0/1	2/2	1/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments:
2. The Monitoring Team rated seven of the investigations as being reported correctly. The others were rated as being reported late. All were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them. A good incident management system needs to analyze whether or not reporting occurred within facility/state policy (and Settlement Agreement) requirements and document this analysis (and conclusions) in the body of the UIR.

- Individual #245 UIR 16-196: The incident occurred at 10:36, facility director designee was notified at 11:11, but the DFPS showed intake at 11:39 (63 minutes). Per discussion with the IMC, this was likely a phone wait time delay at DFPS. This could be an acceptable explanation, but it needs to have been included in the UIR documentation. From UIR, this incident was reported late.
- Individual #159 UIR 17-009: More thorough investigating could have figured out more about the circumstances of reporting and could have led to a determination that this was not a late report. Based on the UIR and DFPS report content, the incident occurred on 9/8/16, was reported to the Incident Management office on 9/12/16, and was reported to the director designee on 9/23/16.
- Individual #255 UIR 17-022: Per the DFPS report, the incident occurred at 4:15 am and was reported to them at 5:25 am. The UIR confirmed these times and noted facility director designee notification at 5:30 am. The reporter was unknown, but from the DFPS report, it looks like there were at least two staff on duty (in addition to the alleged perpetrators) who could have been the reporter, and who should have reported earlier.
- Individual #25 UIR 16-148: Per the DFPS report, the incident occurred at 6:30 am and reported to them at 8:53am. Per the UIR, the facility director was notified at 9:19 am, presumably after DFPS notified facility of the allegation. Also per the UIR,

blood was discovered at 6:50 am and "when staff began to look into the cause of the injury it was found that Individual #25 had fallen earlier in the morning and an identified alleged perpetrator failed to report the fall." There was no indication as to the time this determination was made, which would start the one-hour period for reporting purposes, but presumably it was earlier than 6:50 am.

- Individual #546 UIR 16-197: The DFPS report showed that the incident occurred at 6:29 pm and was reported to them at 9:05 pm. The incident occurred in the dining room and whoever reported it presumably saw what happened and didn't immediately report. There is nothing in either the DFPS or UIR report to suggest that Individual #546 self-reported.

Even though five of the 12 investigations did not meet criteria for proper reporting, two investigations, both for Individual #382 (UIRs 17-064 and 16-224) showed excellent responsiveness and reporting. For UIR 17-064, real time video observation of possible inappropriate interaction between staff and Individual #382 led to the allegation being reported immediately. For UIR 16-224, after receiving report of the discovered injury, the facility investigator conducted a preliminary investigation, which caused her to suspect abuse and to make an immediate report.

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

Summary: Brenham SSLC maintained good performance across this review and the last two reviews for indicators 4 and 5, which therefore will move to the category of requiring less oversight. Indicator 3 will remain in active oversight due to the many staff who incorrectly answered reporting questions as detailed in the comments below.

#	Indicator	Overall Score	Individuals: 382	245	268	107	159	259	255	25	546	292
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/3	Not rated	0/1	0/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	0/1
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
3. Because indicator #1 was met for seven of the individuals, this indicator was not scored for them. The indicator was scored for the other three individuals. Twelve staff were interviewed. About half of the staff said reporting needed to occur with 24 hours, and many staff did not properly indicate to whom the report should be made, nor differentiate between reports of possible abuse versus reports of serious injury. One effect of this may be what was found in indicator 2, that is, that many incidents were not correctly reported.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.												
Summary: The facility scored 100% at the last two reviews and met criteria for all but one incident during this review. With sustained high performance, this indicator is likely to move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	0/1
Comments: 6. For Individual #292 UIR 17-014, there was no immediate action information included in the report.												

Outcome 5– Staff cooperate with investigations.												
Summary: Brenham SSLC scored 100% on this review, but scored slightly lower on the previous review. With sustained performance, this indicator will likely move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
7	Facility staff cooperated with the investigation.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:												

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Brenham SSLC maintained 100% performance for these three indicators for this review and the past two reviews, too. Therefore, these three indicators will move to the category of requiring less oversight. Brenham SSLC's investigations were complete based upon the various criteria.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1

10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	Comments:											

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: Investigations commenced within 24 hours for all investigations and this had been the case for the past two reviews, too. Therefore, indicator 11 will be moved to the category of requiring less oversight. Indicators 12 showed a large decrease in performance. DFPS investigations were rarely completed within the allotted time or with valid extraordinary circumstances. This is of serious concern for individuals' protection from harm. The Monitor noted this is as a chronic problem during the exit presentation, however, upon further review of previous data, this was not near as large a problem in the past as it was at the time of this review. Indicator 13 also showed a decrease in performance. Supervisory reviews need to identify problems in late reporting, completion of investigations, and so forth. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
11	Commenced within 24 hours of being reported.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	17% 2/12	0/2	0/1	0/2	0/1	0/1	1/1	0/1	1/1	0/1	0/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	42% 5/12	0/2	0/1	0/2	0/1	0/1	1/1	1/1	1/1	1/1	1/1
	Comments: 12. There were major issues with DFPS timeframes associated with investigation completion. In one case, the first staff interview did not occur until day 15 and in another, day 16. Only two of the DFPS investigations were completed within the policy-required timeframe (within the number of days or with acceptable extension rationale; the other extraordinary circumstances rationale requires more detail). This is of serious concern for a number of reasons. First, delays in investigative activity seriously compromise the validity of the investigation findings. Staff and individuals' recollections/ memory of the events can deteriorate over time, even over a few days. Opportunities for collusion between alleged perpetrators have more time to occur. Timely completion of investigations is an extremely											

important aspect of protection from harm. Second, without improvement in this area, substantial compliance with this part of Domain 1 (abuse/neglect and incident management) will be impossible. The facility-only investigations also did not meet criteria because they were completed late or in some cases there was no recording of the completion date.

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

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: Serious injury audits were done correctly and showed nice improvement from 0% performance at the last two reviews. Thus, indicator 14 will remain in active monitoring. Non-serious injury investigations were done regularly and correctly for this and the prior two reviews. This was good to see, but the miss of conducting the non-serious injury investigation for some discovered injuries for one individual will keep this in active monitoring. With sustained high performance, however, indicator 15 may move to the category of requiring less oversight after the next review.

Individuals:

#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 12/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	92% 11/12	2/2	1/1	2/2	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:
14. Serious injury audits were done correctly. This was a nice improvement from last review when there was no process in place and a 0% score was given.

15. Non-serious injury investigations were done regularly and correctly. However, for Individual #25, some discovered injuries of undetermined cause should have been subject to a non-serious injury investigation.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.												
Summary: Recommendations related to findings, and both disciplinary and programmatic recommended actions were taken and in a timely manner. This is reflected in all three of these indicators scoring at 100%, as they did during the last two reviews, too. Therefore, all three indicators will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	382	245	268	107	159	259	255	25	546	292
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 11/11	2/2	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 9/9	2/2	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 6/6	1/1	1/1	N/A	N/A	N/A	1/1	1/1	N/A	1/1	1/1
Comments: 17. There were four investigations in which a confirmation of physical abuse level two was made. In all four investigations, staff employment was not maintained.												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. Criteria were met for some, but not for all five indicators. Details are provided in the comments below. These five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was	No									

	modified.										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-20. The facility reported that because of the new electronic data system, data availability was variable for incident management. This made data analysis across all criteria difficult to accomplish over the past few months. That being said, data were presented and reviewed at the QAQI Council meeting observed by the Monitoring Team and it included data going back to July 2016. Thus, these two indicators were scored as meeting criteria.

21-23. At the QAQI Council meeting noted above, some steps were taken (e.g., setting up work groups) to address what were identified as problematic areas. Presumably these groups will develop action plans that will (1) use data to define the problem, (2) show action steps to be taken, (3) assign responsibility to specific staff for each action step, (4) establish planned completion dates for each action step, and (5) identify specific data to be collected to compare to initial data so that progress (or lack of it) can be determined.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/1	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As noted in the Round 10 report, the Center's policy regarding criteria for the selection of individuals for TIVA required revision. This remained a concern.

In addition, as also noted in the Round 10 report, the Center did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical clearance by the PCP or specialists as indicated. Because of the lack of criteria for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA.

For these three instances of use of TIVA:

- Informed consent for the TIVA was present for Individual #133 and Individual #597, but not for Individual #159;
- Nothing-by-mouth status was confirmed for Individual #133 and Individual #597, but no information was provided for Individual #159;
- An operative note defined procedures and assessments completed for all three; and

- Post-operative vital sign flow sheets were submitted for Individual #159 and Individual #133, but not for Individual #257.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
	Comments: Based on documentation the Center submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.										

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: It was good to see that PTCR was addressed by all four IDTs. Two, however, did not cover all of the detail required to meet criteria. Plans were developed and put into place for two individuals. This was good to see, but there were no data or reports indicating progress, problems, or revisions needed. These six indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	268	259					
1	IDT identifies the need for PTCR 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 PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	100% 2/2	1/1	N/A	N/A	1/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 2/2	1/1	N/A	N/A	1/1					
4	Action plans were implemented.	100%	1/1	N/A	N/A	1/1					

		2/2									
5	If implemented, progress was monitored.	0% 0/2	0/1	N/A	N/A	0/1					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/2	0/1	N/A	N/A	0/1					

Comments:

1. There was evidence that two individuals, Individual #382 and Individual #259, received PTCR in the past year for routine dental procedures. The use of PTCR had been reviewed in their Integrated Risk Rating Form and both had ISPAs that noted when PTCR would be used. Also noted were the behaviors that were exhibited when dental treatment was attempted without PTCR. Both had service objectives related to toothbrushing.

The IDT had discussed and approved the use of PTCR at Individual #259's annual ISP meeting. Individual #382's ISP that was reviewed for this onsite visit did not include approval for the use of PTCR. Further, when this was discussed at his ISP meeting held the week of the visit, the team determined that PTCR was a support rather than a restriction. There was evidence of guardian consent for the use of PTCR with Individual #382, but the document provided for Individual #259 identified the facility director's consent was dated in September 2016, while the procedure took place in February 2016.

Two other individuals, Individual #133 and Individual #268, received PTCR for more intrusive procedures, dental extraction and colonoscopy respectively. Written consent was documented for Individual #133's dental work, and verbal consent was indicated in the nurse's notes for Individual #268's procedure.

2. As noted above, Individual #382 and Individual #259 both had service objectives for staff to assist them with toothbrushing. It was concerning that Individual #382 had had a SAP for learning to brush his teeth, but this had been discontinued due to his lack of interest.

Because Individual #382 is only 14-years-old, staff are advised to reconsider teaching him this essential skill. Perhaps with a revised teaching plan, using preferred materials and highly reinforcing consequences, and implemented with fidelity and consistency, he would be more successful.

3-5. Although both Individual #382 and Individual #259 had service objectives for staff to assist them with toothbrushing, there were no data provided in their most recent monthly reviews. Therefore, progress was not evident.

6. Because no data were presented, it was not possible to determine whether progress had been made.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.												
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:									
#	Indicator	Overall Score	190	456	165	112						
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.	50% 2/4	0/1	1/1	1/1	0/1						
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1						
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1						

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

- Individual #187 at the age of 62, with causes of death listed as anoxic brain injury, myocardial infarction, and coronary artery disease;
- Individual #484 at the age of 45, with cause of death listed as health care associated pneumonia;
- Individual #190 at the age of 45, with causes of death listed as aspiration pneumonia, cerebral palsy, and chronic hypoxemia respiratory failure;
- Individual #456 at the age of 65 with causes of death listed as cardiac arrest, acute respiratory failure, aspiration pneumonia, and acute gastrointestinal hemorrhage;
- Individual #165 at the age of 46, with causes of death listed as acute respiratory failure with hypoxia, aspiration pneumonia, and septic shock;
- Individual #112 at the age of 50, with cause of death listed as cardiac tamponade, and aortic dissection with rupture;
- Individual #131 at the age of 55, with cause of death listed as subarachnoid hemorrhage; and
- Individual #390 at the age of 60, with cause of death listed as unknown natural causes.

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Center conducted thorough reviews of nursing care to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- There were a number of recommendations made as part of the clinical death reviews and the nursing QI reports, but the administrative death reviews did not include them as recommendations with the expectation for follow-up.
- Individual #112's death was sudden and unexpected. An opportunity was missed by not developing a recommendation to provide an in-service on this rare and fatal event.

e. In addition to a lack of documentation to show recommendations from the various reviews were completed, the recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "Direct support staff and Nursing should receive education on the appropriate documentation of seizure activity" might result in an in-service session on seizure documentation. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not direct support professionals and nursing staff were properly documenting individuals' seizures.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Ten of these indicators, in psychiatry, psychology/behavioral health, medical, and dental had sustained high performance scores and will be moved the category of requiring less oversight. No entire outcomes were moved to less oversight.

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

Assessments

IDTs did not thoroughly consider what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. In part, as a result, IDTs did not always arrange for and obtain needed, relevant assessments prior to the annual meeting.

Psychiatry CPEs and annual updates were completed, and were in the proper format, but some components were missing from almost all of them. Psychiatrists attended about half of the ISP meetings.

Behavioral health assessments were done and were complete. About half of the functional assessments were current and about half were complete. Likewise, PBSPs were current, but were missing some components.

Skill related assessments were completed for most, though many did not contain specific recommendations for skill acquisition.

For the Integrated Risk Rating Forms (IRRFs) for individuals reviewed, few of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, for a number of individuals reviewed, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

For this review and the previous two reviews, Medical Department staff generally completed the medical assessments in a timely manner. As a result, the related indicators will be placed in the category of requiring less oversight.

Although some additional work was needed, the Center made progress with regard to the quality of medical assessments. For two of the nine individuals reviewed, the Medical Department assessed individuals' medical needs in accordance with generally accepted standards of care. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, include pre-natal histories, family history, childhood illnesses, past medical histories, updated active problem lists, and plans of care for each active medical problem, when appropriate.

During this review and the last two, dental summaries for individuals reviewed generally had been timely, so the related indicator will move to less oversight. Improvement was noted with the timeliness of exams. During this review, good improvement was noted with regard to the quality and completeness of the dental summaries. Eight of the nine dental summaries reviewed included all of the required information to assist the IDTs in understanding the individual's dental status, and planning for the upcoming year.

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

It is important that the Center put systems in place for IDTs to make referrals when individuals meet criteria for PNMT referral, and for the PNMT to self-refer should IDTs fail to do so. When the PNMT completes comprehensive assessments, it is essential that the PNMT review current supports thoroughly; identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem(s); and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem.

The Center needs to focus on the quality as well as timeliness of OT/PT as well as communication assessments.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but progress was evident. Four ISPs, for instance, included goals that met criteria (for a total of 10 goals). But, that being said, some of these were questionable regarding whether the IDT's approach to them was largely superficial. Further, of these 10 personal goals, three met criterion for measurability and one had reliable and valid data. IDTs (and the facility's QA and QIDP departments) also need to attend to the 11 indicators in outcome 3 (as evidenced by the scores for these indicators).

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

QIDPs were completing monthly reviews on a timely basis, which was positive to see. Some QIDPs were observed by the Monitoring Team to be active on the homes, interacting with individuals and staff.

Overall, implementation and monitoring of ISP goals and action steps continued to be of significant concern. The Center did not have a process in place to monitor the work of the QIDPs in this regard and implement corrective action as needed. The QIDP Coordinator indicated a plan would be developed to address these issues.

There were not yet individualized psychiatric goals. Individuals had behavioral health goals and they were based on assessments, but they were not measurable and reliable data were not obtained.

All individuals had skill acquisition plans, though many individuals had less than three. Moreover, the number of SAPs needs to be expanded for the school-age children.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. Four ISPs, for instance, included goals that met criteria, which was progress since the last review. Focus now needs to occur so that the IDT can determine if the goals are progressing/met (measurability), and that regular data and information are collected so that the determination can be made. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	5/6	3/6	1/6	1/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	2/6	1/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #382, Individual #133, Individual #292, Individual #159, Individual #297, Individual #273). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Brenham SSLC campus.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. None of the six individuals reviewed had individualized goals in all areas; therefore, none had a comprehensive set of goals that met criterion.

1. For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 10 personal goals met criterion for this indicator. These included Individual #133's goals for leisure/relationships, employment, independence, and living options; Individual #292's goals for leisure, relationships, and living options; Individual #159's goal for living options; and Individual #297's goal for leisure. Still, even some of these were questionable regarding whether the IDT's approach to them was largely superficial. For example:

- Individual #133's goals appeared to hold promise in that they reflected his personal preferences in an aspirational manner, a level of community participation and integration, and creativity on the part of the IDT. These goals included, for example, to become an active member of a garden club, to have a part time job working in a flower shop, to independently navigate through his environment at home and at stores in town, and to live in a group home near his family. While these met criterion for individualized personal goals based on the his preferences and strengths, and input from the individual on what is important to him, the Monitoring Team was concerned that the IDT had continued some of these goals from the previous year without any progress having been made, and that current action plans did not support achievement of the goals to any significant extent (see outcome 3).
- On first reading, Individual #297 had a personal goal for employment that also seemed to hold promise for its individuality. Individual #297 worked at Brenham Production Services (BPS), but had an employment goal to work at Camp for All. There was, however, no indication given in the ISP or ISP Preparation meeting as to why this goal would be personally meaningful to her, nor did her vocational assessment address it in any substantive way. The QIDP was also unable to articulate this rationale when interviewed.

2. Overall, personal goals for the set of ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Of the 10 personal goals that met criterion for indicator 1, three met criterion for measurability. These included the employment and living options goals for Individual #133 and the living options goal for Individual #292. Examples of those that did not meet criterion included:

- Individual #133's leisure goal was to be an active member of a garden club as evidenced by attending regular meetings. "Active" and "regular" do not provide an objective benchmark from which to measure achievement. The Monitoring Team also reviewed the action plans to determine if these were further defined, but this was not found to be the case. The action plans for this goal only addressed such membership through research of possible garden clubs by the QIDP. The timeline for completion was 11/30/16, but there were no additional actions specified to occur once that had been accomplished and none that stated any outcome for Individual #133 that involved membership in a garden club.
- Individual #297's leisure goal was to develop a relationship with an advocate/friend who could come spend time with her and read to her. On its own, this goal lacked measurability because the terminology was vague. It did not provide a clear way to measure whether a relationship was developed. How often, for example, would a friend/advocate spend time with her, such that one could say a relationship had been developed? The Monitoring Team again examined the related action plans to ascertain whether these provided any measurable criteria which could be applied to this indicator. The only action plan specific to this goal was to send a referral to the Human Rights Advocate by 7/29/16. There were no additional actions specified to occur once that had been accomplished or that stated any outcome for Individual #297 in this regard.

3. Most personal goals did not meet criterion above, therefore there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals. For the 10 personal goals that met criterion in indicator 1, one had reliable and valid data. This was Individual #292's living options goal. The others lacked action plans that clearly related to the achievement of the stated outcome and/or lacked implementation and consistent documentation.

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

Summary: When considering the full set of ISP action plans, the various criteria included in the set of 11 indicators in this outcome were not met. Zero percent scores on 10 indicators (and 17% on one indicator) clearly show that this is a focus area for the facility (and its QA and QIDP departments). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	292	159	297	273			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

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

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

8. A personal goal that meets criterion for outcomes 1 and 2 is a pre-requisite for evaluating whether progress has been made. One personal goal, related to living options for Individual #292, met criterion for each of those outcomes and was assessed as meeting criterion for this indicator as well. For the ISPs reviewed, the remaining personal goals did not meet criterion as described above in outcomes 1 and 2, therefore, action plans for those could not be evaluated in this context. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

9. While there was some progress in the integration of preferences and opportunities for choice in the identification of personal goals for the ISPs, these were often not well-integrated into the action plans. The sole exception was for Individual #292, who had action plans that integrated her preferences and opportunities for choice, particularly related to participating in sports and cheer club. Examples of concerns included:

- Action plans for Individual #133's goals related to his interest in flower arrangement, as described under indicator 1 above, did not describe an assertive plan to move toward achieving any meaningful outcomes. For example, for his goal to become an active member of a garden club was supported by an action plan for the QIDP to research possible clubs, with no expectation stated for participation to begin, or even for providing him with options to explore and choose among. His goal to have a part-time job working in a flower shop had been continued from the previous year, during which there had been no documented exploration of job opportunities. No such exploration was defined for the current ISP.

- The IDTs sometimes took very minimalistic approaches to addressing known preferences. For example, Individual #382 liked animals and preferred the company of two staff who no longer worked on his home. The action plans did not provide him with frequent opportunities to engage in these preferences, as they only called for making a quarterly outing that involved animals and visiting preferred staff at least monthly. Similarly for Individual #273, who liked sporting events, the IDT developed a related action plan that only called for this to occur quarterly.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. No action plans were identified that clearly supported decision-making skills.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Examples included:
    - The IDT did not assertively address Individual #382's independence needs. For example:
        - Per various documents and staff interview, Individual #382 could sign “no” and “more” and used a few words, but there were no action plans to enhance his communication skills.
        - SAPs for toileting and learning to brush his teeth were discontinued due to his "lack of interest" in learning these skills. But because these are essential skills for independence and dignity, they should not be abandoned for a 14 year old.
        - Individual #382 was restricted from entering the kitchen due to climbing on the appliances and taking food, which were concerns related to safety and his overweight status. The current ISP did not contain action plans to teach him kitchen and cooking skills that would both teach him to be in the kitchen with a productive purpose as well as teach him how to prepare healthy meals and snacks. For the ISP held onsite, the IDT did consider an action plan for using the microwave to make ramen noodles. This was a step toward the right direction, but was not an assertive or well integrated approach.
    - The IDT did not emphasize skill acquisition for Individual #292. She had only one SAP, for keeping a budget ledger. As a young teen who hoped to live independently one day, there were many other opportunities for learning necessary skills. Assessments revealed a number of other needs and preferences that should have been addressed. For example:
        - She had history of urinary tract infection (UTI) due to lack of appropriate toileting hygiene skills.
        - The FSA indicated she had needs in how to use public transportation, how to use a computer, and verbal cues for much laundry/clothing care.
        - She had expressed a desire to learn to drive.
    - Individual #133 was verbal, but difficult to understand, even to familiar staff at times, but there were no communication goal or action plans to support his goals for interaction with others while working at a flower store and joining a garden club. His communication assessment stated that he was able to express himself and was intelligible using short phrases. Per multiple observations, the Monitoring Team did not agree that intelligibility was sufficient to not warrant a goal or therapy to address issues with communicating with unfamiliar listeners.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:
    - Individual #297 was at high risk for osteoporosis. She had eight falls in past year, up from five the previous year, and had a fracture of unknown origin to her right ankle that required ongoing intervention. She had previously experienced a fall off the stairs of a bus and the IDT postulated the ankle fracture may have occurred in the same manner. Multiple falls also occurred as a result of losing her balance. A comprehensive falls analysis had not been completed, nor had the IDT developed action plans

to work on improving balance and/or the descending of stairs.
- For both Individual #292 and Individual #382, the IDT did not develop assertive action plans to address significant weight gain, despite frequent ISPA meetings to discuss this concern.
- For Individual #159, the IDT lacked a clear process for environmental sweeps related to his pica diagnosis.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in #11 and #12 above, examples included:
- For Individual #159, it was positive to see that the action plan for his bathing SAP integrated communication using put 'em arounds. A concern that was not addressed was an identified decreased balance and safety awareness contributing to falls risk. This issue had no related goal or evidence of direct therapy.
- Individual #273's OT/PT assessment mentioned a decrease in conditioning and participation in his walking program, but offered no recommendations other than to decrease program frequency. There were no recommendations for trial therapy to see if the approach by direct support staff was perhaps not appropriate or if other strategies could increase participation. In addition, it was noted in his SLP assessment from 2014 that his vision was declining and this was impacting communication, but no therapy or other action plan to address this was developed
- Individual #297's ISP preparation document referenced a communication book SAP to be implemented for use at BPS and monitored by the SLP for three months for effectiveness, and then quarterly thereafter. The IDT did not explore potential use of higher tech devices that would allow greater opportunities for growth, but should have been. The IHCP was also vague and did not contain the necessary action steps to guide staff and mitigate risk, such as lacking mention of diet texture or factors increasing risk. Finally, the OT recommended participation in water activities at the aquatic center and the IDT agreed to send a referral with Habilitation Therapies (HT) to attend the assessment session. No evidence was provided that this had occurred. The action plan stated only that a referral would be sent to the Recreation Department for a water safety assessment and did not integrate the recommendation for HT staff to participate.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs. There were few specific, measurable action plans for community participation that promoted any meaningful integration for any individual.
- For Individual #292, the IDT identified some positive opportunities for community integration, including to join a sports team or club in the community. There was also an action plan for making a friend through community sports events. These were good to see, but they did not have any specific methodology or data collection plan, and there were no related SAPs or SSOs. The ISP identified no goal frequencies for any community participation.
- Individual #133's goals appeared to offer tremendous potential for community participation and integration through community employment and participation in a community garden club. Action plans, as described under indicator 9, did not focus on actual participation in either of these.
- None of the other four individuals had any action plans that provided for encouragement of community participation and integration.

15. None of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Vocational needs were minimally addressed in the ISPs. Examples included:

- Four of six individuals had no vocational assessment for the current ISP, but should have.
- For the two individuals who did have vocational assessments, the documents did not provide data or recommendations that the IDT would require to address their needs. For example, Individual #297's assessment did not address the proposed personal goal from the ISP preparation meeting to work at Camp for All in any specific or relevant way, other than to state the assessor felt with proper encouragement she would be able to attain this goal. There was no discussion of employment options at Camp for All or how Individual #297's preferences and skills could be integrated in that work setting, nor had any vocational exploration related to Camp for All been undertaken in the months between the ISP preparation meeting and the annual ISP.
- Individual #382 did not have a vocational goal for his 2016 ISP other than to graduate from high school. For the 2017 ISP meeting observed onsite, the IDT did make an effort to develop a work goal for his future, to have a part-time job washing windows or wiping tables at a restaurant. There was no evidence that this represented a personal goal. It was not based on a comprehensive assessment of his interests, aptitudes, and capabilities. In fact, no vocational assessment had been completed. This was especially concerning, given the IDT indicated it had become aware that when given the correct letters, he could lay them in the right order to spell his first and last name and could also put the numbers 1-50 in the correct order. It also learned that he regularly used an IPad at school and could independently navigate to sites about his favorite movie *Madagascar*. This would indicate a need for a thorough, independent assessment of his educational and communication needs to identify and assist him to reach his potential.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. In addition to the concerns about vocational activities described above, skill acquisition opportunities were particularly lacking overall.

17. The IDT did not consistently address barriers to achieving goals. The Monitoring Team was particularly concerned that some individuals had goals continued from one ISP to another without having made any progress, but the IDT did not address how to address the related barriers and how to resolve them.

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

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

Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are reconciliation of team member recommendations for referral, and the conduct of a thorough living options discussion. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	382	133	292	159	297	273			

19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two of six ISPs included a description of the individual's preference and how that was determined. Both Individual #133 and Individual #292 were able to clearly state their preferences for community living. Examples of ISPs that did not meet criterion for this indicator included:

- The IDT documented Individual #382 had no awareness of community settings. In response to where he wanted to live, the IDT indicated he enjoyed living at his residential home at the Center and seemed to thrive in the structured environment with preferred staff. These preferences were determined based on observation, per the ISP. Based on available information about frequent unauthorized departures, including attempting to climb out his window at night, and his continued and even escalating behaviors and regular refusals to engage in programming, it was difficult to understand what observations the IDT

relied upon to make these determinations.

- Individual #273's ISP indicated he said he "didn't want to go" to live in the community. There was no discussion documented about his response to community living exposure in the past two years, during which time he was on the referral list. This referral was rescinded by the LAR on 5/5/15, but there was no discussion as to why this occurred.

20. The Monitoring Team observed Individual #382's annual ISP meeting. The IDT determined the living options goal was to live in a group home, but did not explore the option of a foster family home. While this may or may not be feasible based on Individual #382's needs, a family setting should always, at least, be considered for a child.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP, but those that were present typically provided a statement of the opinion and recommendation of the respective team member. The IDT did not consistently make a statement and offer a recommendation regarding living options that was consistent. Examples included:

- Three of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision included the following:
  - All but two members of the IDT independently indicated Individual #382 could be served in the community and recommended transition. As a team, they concluded he could not be served in the community and did not recommend referral. The reasons given for this determination were behavioral issues and lack of safety skills. The Monitoring Team noted that the behavioral health assessment identified these behavioral issues, but indicated Individual #382 could be served in the community and made that recommendation. The IDT should have documented discussion as to the nature of this discrepancy.
  - All members of the IDT independently indicated Individual #292 could be served in the community and recommended transition. As a team, they concluded she could be served in the community, but did not recommend referral because she was psychiatrically not stable. The psychiatric assessment was still pending at the time of the ISP, but psychiatry was listed as indicating she could be served in the community and recommending transition. The IDT did not provide a justification as to why the entire team made a decision that was in conflict with all of the members' opinions.
  - For Individual #159, it was also unclear how the IDT came to consensus. The annual medical assessment indicated he could be served in the community and so recommended, but several others cited his medical needs as justification for why he could not be served in the community. The IDT should have examined this discrepancy, particularly as it would relate to developing strategies to address this perceived barrier.

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for all six individuals.

23. None of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Two of six ISPs, for Individual #382 and Individual #133, identified a thorough and comprehensive list of obstacles to referral in a manner that should allow for the development of relevant and measurable goals to address the obstacle. Examples of those that did not meet criterion included:

- For Individual #159, the IDT did not identify individual choice/awareness, yet the living options action plans were for individual exposure.
- Individual #297's IDT identified only individual choice/lack of understanding of community options, but the IDT determination indicated the obstacle was the desire of the pending guardian.

25. The Monitoring Team observed Individual #382's ISP annual meeting while onsite. The IDT did develop a comprehensive list of potential barriers.

26. One of six individuals (Individual #133) had individualized, measurable action plans to address obstacles to referral. This included the QIDP assisting him to develop a list of questions he wanted to explore with vendors at the provider fair. It was also positive that the QIDP had made an effort to speak with the guardians prior to the meeting, resulting in a willingness to participate in community living options tours. Action steps then included having the transition specialist contact the guardians to set up a tour. Examples of those that did not meet criterion included:

- Individual #382's ISP had had no specific action plans tied to the living options goal. The ISP narrative agreed that tours were not a good idea at the time due to problematic departures, but stated he would benefit from provider fairs on campus twice a year and continued community outings. The ISP did not include a provider fair action plan. The community outings SSO had no individualized, measurable methodology to address awareness of living options or specific instructions as to how to minimize problematic departures in community setting.
- For Individual #159, the ISP living options action plans were to go on two CLOIP tours in a year, and attend a provider fair, but these were not individualized and had no measurable learning or awareness outcome.
- Individual #273's ISP identified medical instability as a primary obstacle. The IDT did not identify criteria for medical stability that would be required to consider community living as a feasible option, so there was no way to assess how the IHCP goals might address this. The IHCP goals were not individualized and measurable, in any event.

27. The Monitoring Team observed Individual #382's annual ISP meeting. Action plans that addressed his awareness and learning needs regarding community living were not clearly spelled out.

28. Only one individual (Individual #133) had individualized and measurable plans for education. See indicator 26 above.

29. Six of six individuals had obstacles identified at the time of the ISP. The Monitoring Team noted that Individual #292's IDT had since made a referral. She had been on several visits to potential homes and was about to participate in an overnight visit.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			

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

Comments:
30-31. ISPs were developed on a timely basis.

32. ISPs were implemented on a timely basis for none of six individuals. Examples in which timeliness criteria were not met included:

- For Individual #382, whose ISP was in February 2016, service objectives for community outings, monthly visits with preferred staff, and toothbrushing were not provided for implementation until the end of April 2016. His IEP was received in March 2016, but the IDT did not meet to review it until July 2016.
- For Individual #133, whose ISP was at the end of August 2016, the SAP for flower identification was still not present in November 2016. The QIDP did not document follow-up until 12/2/16. The service objective for visiting flower shops was not noted for September 2016 through November 2016. SAPs for dialing the telephone, making shopping list, and use of an inhaler were not implemented through November 2016. There was no documentation his family has been contacted to set up tours as indicated, despite his eagerness to move to a group home.
- For Individual #297, whose ISP was held at the end of July 2016, leisure and relationship action plans were not implemented through September 2016.
- Individual #273's ISP was held toward the end of July 2016. He had goals for leisure and relationships that were carry-overs from the previous year, during which they had been minimally implemented, if at all. Per the documentation, these had not been implemented through November 2016.

33. Five of six individuals participated in their ISP meetings. In particular, the ISP for Individual #133 provided a very detailed description of how he participated in the ISP and related decision-making. This was good to see. On the other hand, it was concerning that Individual #292 did not attend her ISP meeting due to it being held during school hours. The IDT did make an attempt to schedule her meeting outside of school hours, but changed that time to accommodate her mother's request. While it was understandable the IDT was responsive to the mother, who then participated by telephone, it should have documented a greater effort to also ensure Individual #292's participation, given her ability to participate in decision-making about her life.

34. Criteria were not met for all four sub-indicators for any of the individuals, however, Individual #297 and Individual #273 participated in their ISP meetings and also had appropriately constituted IDTs that participated in the planning process, based on the strengths, needs, and preferences of these two individuals. Examples of those did not meet criteria included:

- The speech-language pathologist (SLP) did not attend ISPs for Individual #133 or Individual #382, but both had significant communication needs.
- No vocational or day program staff participated in ISP meetings for Individual #159, Individual #382, or Individual #292. As described further under indicator 15, this was a troubling trend.
- Individual #297 and Individual #273 did not meet criteria for the sub-indicators related to knowledgeable staff and knowledgeable QIDP.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Performance decreased for both indicators, both of which will remain in active monitoring. Assessments are needed as a foundation for planning.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for one of six individuals. Examples of those that did not meet criterion included:

- The IDT did not request vocational assessments for Individual #382, Individual #292, or Individual #159, but should have, based upon their needs.
- For Individual #133, the IDT did not request a communication assessment or update, despite his lack of intelligibility and his proposed goals for community involvement. The ISP preparation document indicated only that the SLP said an assessment was not needed, with no rationale provided. The entire IDT should participate in making a determination as to the need for assessments.
- Individual #273's ISP preparation meeting was held on 8/9/16, just six days prior to his ISP. This would have been too late to identify needed assessments and that section was not completed.
- Individual #297's FSA was from 2015.

36. IDTs did not always arrange for and obtain needed, relevant assessments prior to the IDT meeting. Examples for which this did not occur included:

- Vocational assessments for Individual #382, Individual #292, and Individual #159 were not completed, but should have been, based upon their needs.

- Individual #273's last communication assessment was in 2014. It was noted that his declining vision was impacting communication and he was having difficulty with schedules and sequencing. No screenings were provided and no further assessments had been provided to monitor and reassess since 2014. An updated PSI was not completed until May 2016.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Lack of implementation and monitoring of ISP action steps continued to be areas of significant concern. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. The Center did not have a process in place to consistently monitor the work of the QIDPs in this regard and implement corrective action as needed.

The Center had begun an Integrated Monthly Review process at the time of the last monitoring site visit that appeared promising as a means to address these issues, as well as improve overall IDT follow-up, but this pilot had not been pursued in a consistent fashion. The QIDP Coordinator stated in interview that she believed it would take 18 months to two years to effectively implement across the campus. This timeframe was concerning at this stage of the game.

The Monitoring Team encourages the Center to develop a more timely approach to ensuring services and supports are being delivered as needed. The QIDP Coordinator indicated a plan would be developed to address these issues. The Monitoring Team would be interested in reviewing this plan once it has been finalized.

37. IDTs met frequently in some instances, but this was not consistent, and follow-up actions specified in ISPAs were often not documented. IDTs sometimes met to respond to various events, behavioral incidents, and medical issues, but rarely to review progress toward action plans and make revisions to supports and services as needed. Reliable and valid data were seldom available to guide decision-making, in any event.

38. QIDPs were completing monthly reviews on a timely basis, which was positive to see. The Monitoring Team would like to acknowledge good work on the part of Individual #292's QIDP, who was very involved in the home, working directly with the young women living there as well as with the staff. She was also well informed about the needs of Individual #292 without finding it necessary to rely heavily upon her tablet.

Overall, though, many action plans were not implemented on a timely basis, if at all (as described elsewhere in this report), and QIDPs

did not consistently take follow-up action in this regard. The Monitoring Team was very concerned about the inability of some QIDPs to describe individuals' needs, goals, and current status, even in a broad sense, despite having served in that capacity for the individual for more than one year. Examples included:

- Individual #273's QIDP was not able to address his personal goals or identify the status of significant needs.
  - She was not able to identify a cogent justification for a SAP, now in its second ISP year, for counting blocks.
  - The same was true for a goal to attend quarterly sporting events, also in its second year. It had not been implemented at all in the preceding year, but the QIDP was unable to articulate how the barriers resulting in that non-implementation were identified and addressed.
  - The QIDP was not able to readily identify his current weight status even though this was a critical and ongoing need. It was concerning that he had lost six pounds between December 2016 and January 2017, but the QIDP was not aware.
- Individual #297's QIDP was likewise not able to describe her goals, the rationale behind them or the current status of their implementation.

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

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

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The individual's risk rating is accurate.	33% 6/18	0/2	0/2	0/2	2/2	0/2	0/2	1/2	2/2	1/2
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.	28% 5/18	0/2	0/2	1/2	0/2	1/2	0/2	2/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #159 – fractures, and dental; Individual #133 – other: pain, and cardiac disease; Individual #597 –urinary tract infections (UTIs), and constipation/bowel obstruction; Individual #257 – falls, and dental; Individual #297 – constipation/bowel obstruction, and falls; Individual #205 – constipation/bowel obstruction, and dental; Individual #390 – skin integrity, and constipation/bowel obstruction; Individual #273 – skin integrity, and Addison's disease; and Individual #267 – dental, and other: adrenal insufficiency and diabetes insipidus].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #257 – falls, and dental; Individual #390 – skin integrity; Individual #273 – skin integrity, and Addison's disease; and Individual #267 – dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually, or completed

one within 30 days for the newly admitted individual. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes in status in the specified risk areas(s) that would have required review of the IRRFs: Individual #597 – constipation/bowel obstruction; Individual #297 – constipation/bowel obstruction; Individual #390 – skin integrity, and constipation/bowel obstruction; and Individual #273 – skin integrity.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Brenham SSLC's psychiatric goals and move them towards meeting criteria with these indicators. The use of some standardized tools was good to see, but needed to be compared over time. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications. In other words, much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, those that focused upon the individual's psychiatric disorder and monitored progress via what have come to be called psychiatric indicators. Psychiatric providers attended some ISP meetings. This was good to see and sets the occasion for presentation and discussion, as needed, of psychiatric indicators and psychiatry-related personal goals.											

In addition to collecting data regarding problematic behaviors, some assessment instruments were being utilized, specifically the ADAMS (Anxiety, Depression and Mood Scale) and ADHD rating scales. While this scale provided information regarding symptom experience at the time of the administration of the scale, there was no cumulative or comparative review of the ADAMS results over time. Comparison of assessment results would make these data more useful in monitoring psychiatric symptoms. Psychiatric progress notes did not routinely document review of data. In the psychiatric clinical encounters observed during this monitoring visit, data were not always available for review. Per the psychiatric clinicians, issues with IRIS had further complicated their receipt of data.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were present and were formatted correctly. This was the case for the previous two reviews for all individuals and for this review for all but one individual. That individual's CPE was not completed due to psychiatrist leave status, but had since been completed. Even so, given the overall high and sustained performance, these two indicators (12, 13) will be moved to the category of requiring less oversight. The other three indicators require focus from the facility. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
12	The individual has a CPE.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/6	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	78% 7/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
Comments: 12-13. CPEs were completed for all individuals, except for Individual #107. Her CPE was started shortly after her admission, but incomplete at the time of this review. Therefore, criteria were not met for her for these two indicators. The center reported that her											

CPE was initiated on time, but due to psychiatrist employment leave and changes in return dates, its completion was delayed. After the onsite review, the center told the Monitoring Team that the CPE was now completed and the completed, signed, and entered report was provided.

14. The Monitoring Team looks for 14 components in the CPE. One evaluation, regarding Individual #155, was complete and addressed all of the required elements.

Six of the evaluations lacked a sufficient bio-psycho-social formulation. This was the most common deficiency. Four evaluations were lacking sufficient information in one element, one evaluation was lacking sufficient information in two elements, one evaluation was lacking sufficient information in four elements, and one evaluation was lacking sufficient information in five elements. One evaluation, regarding Individual #107, was incomplete and not available for review.

15. For the six individuals admitted since 1/1/14, three had psychiatric evaluations performed within 30 days of admission. These individuals, Individual #382, Individual #155, and Individual #268, were lacking a progress note from the primary care provider documenting the initial assessment.

16. There were two individuals whose documentation revealed inconsistent diagnoses: Individual #245 and Individual #292.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: For this set of indicators, performance was about the same as at the last review and lower than two reviews ago in June 2015. These should receive focused attention from the facility and psychiatry department over the next review period. All five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
17	Status and treatment document was updated within past 12 months.	83% 5/6	1/1	1/1	1/1	1/1	N/A	N/A	N/A	1/1	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	0/1	0/1	0/1	0/1	N/A	N/A	N/A	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	56% 5/9	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
17. Six individuals required annual evaluations. Five were done. Individual #297's, however, was last done in January 2015.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None met full criteria. The missing components in the majority of the evaluations was a description of the derivation of the identified target symptoms, the combined behavioral health review/formulation, a review of the individual's non-pharmacological treatment, and the risk versus benefit discussion regarding treatment with psychotropic medication. In addition, the evaluations did not state the evaluator's summary and opinion as to the diagnosis and treatment.

21. 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.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: The criteria for this indicator were met for the one individual to whom the indicators applied. This is the first time this indicator was utilized during the monitoring review at Brenham SSLC. After the next review, if high performance is maintained, it is likely that this indicator will move to the category of requiring less oversight. It will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. One individual, Individual #133, had a PSP in effect. The PSP included the required information.

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

Summary: Work on consents resulted in improved performance on these indicators. Three of the indicators (28, 29, 32) showed improvement that, if sustained at high performance, may result in those indicators moving to the category of requiring less oversight after the next review. The components of consent specified in indicators 30 and 31, however, will also require some focused attention in order to meet criteria. All five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259

28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. The facility had transitioned to a revised version of the consent form. These consent forms included adequate side effect information.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions were not included. Most examples indicated that there were no alternatives to the medication.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.

Summary: At Brenham SSLC, individuals who needed PBSPs had them, PBSPs had goals, and all goals were based upon assessments. This was the case at 100% for this review and for the past two reviews, too. Therefore, these three indicators (1, 2, 4) will be moved to the category of requiring less oversight. Goals were not written in measurable terms and multiple problems with data compromised their validity. These three objectives will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 12/12	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

3	The psychological/behavioral goals/objectives are measurable.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Eight of the nine individuals reviewed by the behavioral health monitoring team had PBSPs. The exception was Individual #133 who had a Psychiatric Support Plan. This appeared appropriate. Of the six individuals reviewed by the physical health monitoring team, four (Individual #267, Individual #257, Individual #205, Individual #297) had PBSPs. Thus, this indicator applied to 12 individuals.

The exceptions were Individual #273 and Individual #597. Even though Individual #273 had a Psychiatric Support Plan, staff are advised to complete an updated functional behavior assessment to determine whether a PBSP is needed. Staff reported that Individual #273 will yell, scream, and wave his fist when asked to engage in certain activities. His current behavioral health assessment also identified verbal aggression as an observed behavior.

2. Of the nine individuals, eight had goals/objectives related to behavioral health services.

3. Only one individual, Individual #159, had goals that were measurable. The PBSPs for Individual #292 and Individual #259 did not include measurable treatment objectives, and the PBSPs for Individual #382, Individual #245, and Individual #268 did not provide treatment objectives for all targeted problem behaviors or replacement behaviors. For those individuals who had counseling plans, the goals did not specify whether the skills would be performed independently or with prompts.

4. All of the identified goals were based upon the individual's assessments.

5. None of the plans had reliable data. Assessment of the recording of data within an eight-hour shift occurred, but this is an inadequate measure of data timeliness. Regular assessment of inter-observer agreement was not evident in any of the plans. Staff also reported their lack of confidence in the reliability of the data.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.	
Summary: Individuals had current and complete annual behavioral health updates. This was an improvement from the last review and with sustained high performance, this indicator might move to the category of requiring less oversight after the next review. At this point, the other two indicators should be at a much higher level. The facility should focus on these basic foundational components of behavioral health service care. These three indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
12	The functional assessment is complete.	44% 4/9	1/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1

Comments:
10. All individuals had current and complete behavioral health assessments.

11. For six of the individuals, there was evidence that their functional assessments were current. The exceptions were Individual #133, Individual #245, and Individual #159. Although indirect assessments had been completed, the dates of completion were not identified.

12. The functional assessment was determined to be complete for four individuals (Individual #382, Individual #155, Individual #268, Individual #159). Their assessments included a table that provided a summary regarding the antecedent and consequent conditions that affect the target behaviors. There were no clear summaries in the assessments for the other five individuals.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: PBSPs were all current within the past 12 months. This was an improvement from the previous review and with sustained high performance, this indicator may move to the category of requiring less oversight after the next review. PBSP implementation within 14 of attaining consent did not occur, but once. All PBSPs were missing components regarding content and quality. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	13% 1/8	0/1	N/A	0/1	0/1	0/1	0/1	1/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
13. The PBSP for Individual #107 was implemented within 14 days of obtaining all necessary consents. The PBSPs for Individual #382, Individual #155, Individual #268, and Individual #292 were implemented before guardian or facility director consent. The remaining

PBSPs, for Individual #245, Individual #159, and Individual #259, were implemented more than 14 days after all consents were obtained.

14. The PBSP was current for the eight individuals who had this support.

15. None of the PBSPs were determined to be complete. Absent from most plans were the use of reinforcement in a manner that was likely to be effective, antecedent strategies, sufficient opportunities for replacement behaviors to occur, baseline/comparison data, and complete treatment objectives.

There were concerns regarding some of the language included in Individual #259's plan. In the prevention section, staff were advised not to "yell or tease" her and not to "order" her to her room when she displayed challenging behavior. These are unacceptable responses at all times for all individuals and raise concerns regarding the respect and dignity afforded the individuals who resided at the facility.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: When IDTs determine that an individual needs counseling, Brenham SSLC provides that counseling. This has been the case for this review and the last two reviews, too. Therefore, indicator 24 will be moved to the category of requiring less oversight. That being said, much improvement is needed in the counseling process (and documentation) to meet the standard components that comprise indicator 25, which will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 6/6	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/6	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A

Comments:
24. Six of the individuals reviewed by the behavioral health monitoring team were receiving counseling services as per IDT determination. These individuals were Individual #133, Individual #245, Individual #155, Individual #268, Individual #292, and Individual #107.

25. Although all individuals had counseling plans, there were several sub-indicators that did not meet criteria. The objectives did not identify the conditions under which the behavior(s) would occur, and did not provide a date when the objective would be achieved.

While methods were identified, there were no identified sources to indicate these were evidence-based practices. Progress was reported in narrative format, but data were not presented in a format that allowed for an assessment of progress over time. There were not clear plans to help the individual generalize the skills learned to other situations outside of the counseling session.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 78%, Round 10 – 89%, and Round 11 -89%), Indicators a and b will move to the category requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	1/1	0/1	1/1	N/A	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	Not Rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Although some additional work was needed, the Center had made progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed had diagnoses justified by appropriate criteria (Round 9 – 100% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b will move to the category of requiring less oversight. Indicator c for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual receives quality AMA.	22%	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1

		2/9									
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive that two of the annual medical assessments included all of the necessary components, and overall, some progress was noted. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included pre-natal histories, family history, childhood illnesses, past medical histories, updated active problem lists, and plans of care for each active medical problem, when appropriate. In its comments on the draft report, the State questioned the Monitoring Team's finding that Individual #159's annual medical assessment did not contain all of the necessary components. However, Individual #159 made 27 attempts at pica from April 2015 through March 2016, but pica was not listed on the active problem list.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #159 – choking, and seizures; Individual #133 – cardiac disease, and other: spasticity, muscle wasting, and pain; Individual #597 – respiratory compromise, and infections; Individual #257 – weight, and seizures; Individual #297 – gastrointestinal (GI) problems, and constipation/bowel obstruction; Individual #205 – choking, and constipation/bowel obstruction; Individual #390 – GI

problems, and osteoporosis; Individual #273 – respiratory compromise, and other: adrenal insufficiency; and Individual #267 – other: diabetes insipidus, and other: adrenal insufficiency].

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

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

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental summaries (Round 9 – 100%, Round 10 – 100%, and Round 11 -88%), Indicator a.iii will move to the category of requiring less oversight. During this review and the Round 10 review, improvement was noted with regard to the timeliness of dental exams. If this progress continues, Indicators a.i and a.ii might move to the category requiring less oversight after the next review. It was positive to see the Center's continued efforts with regard to improving the quality of exams, and the improvements with regard to the quality of dental summaries were notable. The Center is encouraged to continue with these efforts.

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	88% 7/8	1/1	0/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	88% 7/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1
b.	Individual receives a comprehensive dental examination.	67% 6/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: b. It was positive that for six of the nine individuals, dental exam documentation included all of the necessary components. Examples of concerns included:

- For Individual #133 and Individual #205, periodontal charting had not occurred and/or was not documented in the last year,

and no explanation was provided;

- An odontogram was not submitted for Individual #133 or Individual #205; and
- A summary of the number of teeth present/missing was not provided for Individual #205, and the number was incorrect for Individual #297.

c. During this review, good improvement was noted with regard to the quality and completeness of the dental summaries. Eight of the nine dental summaries reviewed included all of the required information to assist the IDTs in understanding the individual's dental status, and planning for the upcoming year. Individual #133's dental summary included most of the necessary information. However, the dental exam indicated he had poor oral hygiene, but the annual dental summary recommended a low dental risk rating, and indicated he had good oral hygiene.

Nursing

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

Summary: An area requiring improvement was the completion of annual nursing reviews and physical assessments, and/or quarterly nursing record reviews and physical assessments. Given that during the past two reviews the Center had done well with these indicators, this is an unfortunate finding and appears to be related to IRIS implementation and related documentation. The remaining indicators also require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.

Individuals:

#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
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.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	38% 3/8	1/1	0/1	1/1	N/A	0/1	0/1	1/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	For the annual ISP, nursing assessments completed to address the	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0/18									
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/8	0/2	0/1	N/A	0/1	0/1	N/A	0/1	N/A	0/2

Comments: a. Components for many individuals' annual nursing reviews and physical assessments, and/or quarterly nursing record reviews and physical assessments were missing (e.g., physical assessments, Braden scales, weight graphs, etc.).

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #159 – fractures, and dental; Individual #133 – other: pain, and cardiac disease; Individual #597 – UTIs, and constipation/bowel obstruction; Individual #257 – falls, and dental; Individual #297 – constipation/bowel obstruction, and falls; Individual #205 – constipation/bowel obstruction, and dental; Individual #390 – skin integrity, and constipation/bowel obstruction; Individual #273 – skin integrity, and Addison's disease; and Individual #267 – dental, and other: adrenal insufficiency and diabetes insipidus).

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

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

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

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. through f. Overall, the IHCPs reviewed did not address the individuals' needs for nursing supports. A couple examples of the many concerns included:

- Individual #257 had fallen 17 times in the last year, but the IHCP included no regular proactive nursing assessments to assist the team in identifying ways to prevent falls.
- In November 2016, Individual #205 had a fecal impaction and positive hemoccult. However, his IHCP indicated nurses should evaluate him quarterly for abdominal distension, tenderness, and bowel motility. This intervention did not meet the needs of an individual with this level of risk. Nursing staff should have been completing assessments daily. In addition, the assessment criteria in the IHCP were not complete for constipation, and should have included fluid intake, activity level, fiber intake, appetite, and reports of loose bowel movement that could indicate impactions.
- Individual #267's IHCP included no nursing assessments to address symptoms of adrenal Insufficiency, such as chronic fatigue, muscle weakness, loss of appetite, weight loss, abdominal pain, nausea, vomiting, low blood pressure, depression, headache, low blood sugar, and/or irregular menses. It also did not include assessments to address diabetes insipidus, such as dehydration, intake and output, and individual-specific symptoms the individual experiences.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.

Summary: It is important that the Center have systems in place for IDTs to make referrals when individuals meet criteria for PNMT referral, and for the PNMT to self-refer should IDTs fail to do so. When the PNMT completes comprehensive assessments, it is essential that the PNMT review current supports thoroughly; identify, whenever possible, the potential cause(s) of the physical and/or nutritional problem(s); and offer clinically justified recommendations, including, but not limited to recommendations for goals/objectives, as well as strategies to address the problem. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team	67% 2/3	N/A	N/A	N/A	0/1	1/1	N/A	N/A	1/1	N/A

	or PNMT.										
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 2/3				0/1	1/1			1/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	67% 2/3				0/1	1/1			1/1	
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	67% 2/3				0/1	1/1			1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 1/1				N/A	N/A			1/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	67% 2/3				0/1	1/1			1/1	
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/1				0/1	N/A			N/A	
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2				N/A	0/1			0/1	

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

- No evidence of PNMT review was found for Individual #257's right lower lobe pneumonia on 9/14/16, which can be indicative of aspiration pneumonia. Given the individual's multiple issues, such as altered mental status, weight changes, and pneumonia, at least a review was warranted. Similarly, Individual #257 experienced a significant increase in falls and a change in gait along with these other changes, but no evidence of PNMT review of the falls was found.
- It was positive that for Individual #297, and Individual #273, their IDTs referred them to the PNMT timely, and the PNMT conducted timely reviews and assessments with the collaboration of the disciplines needed to address their issues. The quality of the assessments is discussed below.

h. The PNMT assessments reviewed both were insufficient to address the individuals' needs. The following provide some examples of problems noted:

- For Individual #297, the assessment included a number of the required components, but key information and analysis were missing. More specifically, the assessment lacked a clear review of existing supports (i.e., direct physical therapy), and a

determination of whether or not the therapy resulted in improvement. Potential causes of her ankle fracture, and comparison to the previous history of falls from the school bus were not included in the assessment.

- For Individual #273, the assessment lacked investigation into the potential linkage between gastroesophageal reflux disease (GERD) and pneumonia as well as weight loss. The assessment offered no review of head-of-bed elevation for potential mitigation of risk associated with aspiration and reflux. In addition, the assessment did not include recommendations for measurable, clinically relevant goals/objectives.

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

Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/12	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and falls for Individual #159; falls, and aspiration for Individual #133; aspiration, and falls for Individual #597; aspiration, and falls for Individual #257; aspiration, and falls for Individual #297; choking, and weight for Individual #205; choking, and aspiration for Individual #390; choking, and aspiration for Individual #273; and choking, and aspiration for Individual #267.

a., b., d., e., f., and g. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT

assessment/review or PNMP, define preventative measures, identify action steps necessary to meet the objective, set forth clinical indicators, specify triggers and actions steps to take should they occur, and/or define the frequency of monitoring PNMPs and/or the individual's progress.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #390 and Individual #267 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example:

- Some PNMPs did not fully identify individuals' triggers (i.e., Individual #159, Individual #597, and Individual #273).
- Photographs were not current (e.g., the picture on the first page of Individual #133), or individualized (e.g., gait belt pictures for a number of individuals just showed a gait belt, and given that individuals have different body types, pictures should be individualized).

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center continued to make progress with IDTs documenting clinical justification for enteral nutrition annually. The Center should focus on developing plans to assist individuals to move along the continuum, when clinically appropriate. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
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.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	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% 0/3		0/1	0/1						0/1

Comments: a. For the three individuals with enteral feeding tubes, it was good to see that IDTs provided clinical justification for total or supplemental enteral nutrition in the IRRF and Dysphagia Assessment.

b. However, plans were not found that addressed individuals' needs. For example,

- Individual #133's assessment showed he was at stage 4 and the next stage would require tolerance of intake. However, no therapy plan was developed to focus on potential improvement in oral issues impacting swallowing or potential improvement of laryngeal strength and function.
- Individual #597's assessment showed she was at stage 2, but no therapy had been provided or plan developed to determine if

progression to stage 3 would be appropriate or possible. • For Individual #267, who was currently served chopped food items, no plan was in place to reintroduce liquids to the dining experience. The introduction of liquids would help mitigate the risk of choking as well as aid in digestion.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center needs to focus on the timeliness as well as the quality of OT/PT assessments.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	67% 6/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement;	N/A									

	▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	17% 1/6	N/A	0/1	0/1	0/1	N/A	0/1	1/1	0/1	N/A

Comments: a. and b. Six of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- Although Individual #159 had a timely assessment for the ISP meeting, he had a change in status related to increased gagging and self-purging, but no consult/assessment was completed to address this issue.
- Individual #597 had an OT/PT assessment, dated 1/14/16, which stated she needed a wheelchair mold modification to increase support of her right arm and trunk. This would require a wheelchair clinic assessment, but the Center did not provide evidence of this in response to Document Request #90 (i.e., which requests any wheelchair assessment within the last 12 months).
- In June 2016, Individual #257 began having an increase in falls, but the PT did not conduct a gait assessment until 11/8/16.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for three individuals. The following summarizes some of the problems noted:

- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: This was not applicable to Individual #267, and the assessment for Individual #297 included a sufficient analysis. However, the assessment for Individual #159 provided current information, but included no analysis comparing this information with previous assessment information (e.g., for ambulation, or activities of daily living);
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: The assessments for Individual #297 and Individual #159 did not review or include monitoring findings related to the effectiveness of current supports;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: All three assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

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

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).

e. Individual #390's update sufficiently addressed his OT/PT strengths and needs, and incorporated his preferences. Unfortunately, significant issues were noted with regard to the quality of the remaining OT/PT updates. The following summaries some examples of concerns noted with regard to the required components of OT/PT updates:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: At times, updates did not discuss the impact that changes in the individual's health status had on his/her OT/PT needs (e.g., for Individual #133, and Individual #257);
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: For Individual #257, for whom there had been an increase in the frequency of her falls, fall risk was not included in the assessment;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For some individuals, the updates failed to identify whether or not the individual experienced potential side effects (e.g., Individual #205, and Individual #257);
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: For Individual #257, activities of daily living were not included in the update;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For Individual #257, the update provided no discussion of the recommendation for her to use a cart during laundry activities as a form of adaptive equipment, or recommendations from direct therapy to prevent falls;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: This component was not fully addressed, for example, with regard to ambulation for Individual #133 (i.e., he was walking in 2014, but this could not be discerned from the update), and Individual #257 (i.e., related to falls, and activities of daily living);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: This was problematic across all of the updates (with the exception of Individual #390), with examples of concerns including: lack of discussion of monitoring findings, no discussion of therapy progress, and/or lack of analysis of the cause(s) for supports being ineffective to assist in determining what next steps should be recommended;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: This was problematic across all of the updates (with the exception of Individual #390), with examples of concerns including: failure to provide clinical justification for not recommending supports and/or services to address identified needs, or lack of justification for recommending continued direct therapy; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: This was problematic across all of the updates (with the exception of Individual #390), with examples of concerns including: the updates reviewed did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs.

On a positive note, in all of the updates the Monitoring Team reviewed:

- The individual's preferences and strengths were used in the development of OT/PT supports and services.

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: It was good to see that IDTs were reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. If the Center sustains its performance in this area, Indicator b might move to the category requiring less oversight after the next review. The Center should focus on improving descriptions of individuals' OT/PT functioning in ISPs. In addition, IDTs should consistently discuss and document discussion regarding recommended OT/PT strategies, interventions, and programs, and integrate them into ISPs/ISPAs, as appropriate to meet individuals' needs.

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	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.	72% 8/11	0/1	1/1	0/1	3/3	1/1	0/1	1/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	80% 4/5	N/A	0/1	N/A	3/3	1/1	N/A	N/A	N/A	N/A

Comments: a. For the individuals reviewed, their ISPs included limited discussion of their ambulation/mobility skills as well as their skills with regard to activities of daily living.

b. For the individuals reviewed, it was positive that IDTs had reviewed and revised, as needed, PNMPs and/or Positioning Schedules.

c. and d. Examples of concerns noted included:

- ISPs reflected little to no discussion of therapy-related recommendations for Individual #159, Individual #597, and Individual #205.
- For Individual #133, the PT was consulted to complete an ankle-brachial index (ABI) test to rule out peripheral vascular disease. However, no ISPA meeting documentation was found to show the IDT met to discuss the results.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1				1/1					
	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.	75% 6/8	1/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

	▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	N/A	0/1	0/1	0/1	N/A	0/1	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1	0/1

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

- Individual #133's last communication assessment was completed in 2014. Based on the Monitoring Team's multiple observations, its description of his communication abilities was not accurate in terms of his intelligibility with unfamiliar people, as well as staff. This suggested that it was either inaccurate initially, or that Individual #133 experienced a change in status. In either case, an updated assessment was warranted.
- Individual #273's last communication assessment was completed in 2014. It noted that he had declining vision that was impacting his communication, and that he was having difficulty with schedules and sequencing. In the intervening years, the SLP did not conduct screenings or further assessment, which were warranted to monitor his status, and to determine the need for more in-depth assessment, as appropriate.
- On 11/29/16, Individual #267's communication screening identified multiple areas that could have been explored further, including AAC, use of sign language, and methods to improve receptive and expressive language. However, an update to her 2015 comprehensive assessment was not provided/recommended.

c. As noted above, for Individual #267's, although the 2016 communication screening identified multiple areas that could have been explored further, it did not recommend an update to her 2015 comprehensive assessment.

d. The following describes some of the concerns with the four assessments:

- The individual's preferences and strengths are used in the development of communication supports and services: Although preferences and strengths were incorporated for Individual #133 and Individual #597, strengths such as use of some sign language (e.g., Individual #257) and/or verbal skills (e.g., Individual #205) were not incorporated into recommendations for the remaining two individuals;
- 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: In some cases, assessments primarily focused on existing skills and did not provide an in-depth analysis of individuals' potential for expansion or development of skills (e.g., Individual #133, and Individual #257). For Individual #205, expressive and receptive language was not assessed from a functional perspective. The exception was the assessment for Individual #597;
- The effectiveness of current supports, including monitoring findings: Although the updates and comprehensive assessments

spoke to the effectiveness of the supports, these findings did not appear to be based on monitoring in multiple locations throughout the year;

- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: In some cases, it was unclear whether the assessor had considered AAC's potential impact on expressive language and particularly the ability to communicate with unfamiliar people (e.g., Individual #133), whether additional assessment was needed (e.g., Individual #257 for whom multiple areas should have been explored further), whether AAC device assessment with devices more appropriate for a person with visual impairment would have yielded different results (e.g., Individual #597); and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that complete assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, all four assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- 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; and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

e. As noted above, Individual #273 and Individual #267 should have had updates completed, at a minimum, but did not. The following summaries examples of concerns noted with regard to the required components of communication updates:

- The individual's preferences and strengths are used in the development of communication supports and services: The only communication support for Individual #390 focused on a communication book, despite the fact that he refused to use one;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: None of the updates discussed the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings: Effectiveness monitoring was not based on relevant data (e.g., data discussed implementation, but not level of skill acquired), or data was not reflected in the assessments (e.g., statements such as "making progress" without data to support the conclusion). The only exception was for Individual #390;
- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: In some cases, it was unclear whether AAC device assessment with other devices would have yielded different results (e.g., Individual #297); and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that complete assessments were not completed of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, the three updates completed did include: • Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and • Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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: It was good to see improvement with regard to IDTs' annual review of Communication Dictionaries to ensure they comprehensively address individuals' non-verbal communication.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	100% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	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.	79% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	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 three individuals, their ISPs did not provide functional descriptions of their communication skills, including examples.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.	
Summary: All individuals had skill acquisition plans, though three individuals had less than three. Moreover, the number of SAPs needs to be expanded for the school-age children; there was very little learning of new skills when they were at their	Individuals:

homes at Brenham SSLC. With sustained high performance, indicator 2 might move to the category of requiring less oversight after the next review. Indicators 3 and 4 showed some decrease compared to the last review and more attention needs to be paid to SAPs being based upon assessment and being practical, functional, and meaningful. Only two SAPs had reliable data. All five indicators will remain in active monitoring.											
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 23/23	2/2	3/3	3/3	3/3	3/3	1/1	3/3	2/2	3/3
3	The individual's SAPs were based on assessment results.	57% 13/23	2/2	2/3	1/3	2/3	1/3	0/1	2/3	2/2	1/3
4	SAPs are practical, functional, and meaningful.	52% 12/23	2/2	2/3	0/3	2/3	1/3	0/1	2/3	2/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	9% 2/23	1/2	0/3	0/3	0/3	0/3	1/1	0/3	0/2	0/3

Comments:

1. All nine individuals had skill acquisition plans. While the Monitoring Team's goal is to review three SAPs for each individual, this was not possible for Individual #382, Individual #292, and Individual #159 who had only either one or two SAPs each.

2. Of the 23 SAPs that were reviewed, all were measurable.

3. Thirteen of the 23 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skills assessment (e.g., Individual #245 – advocacy, and Individual #268 – shaving and vacuuming); skills, the component parts of which were identified as mastered in the functional skills assessment (e.g., Individual #292 – budgeting, and Individual #107 – washing clothes); skills that the person was able to perform, but which they refused to do (e.g., Individual #245 – contacting people, and Individual #259 – washing arms, soaping a washcloth); or skills that were not applicable (e.g., Individual #133 – brushing teeth).

4. Twelve of the 23 SAPs were considered practical, functional, and meaningful. In addition to those skills that were mastered, exceptions included the following: Individual #245 was learning to identify her medication by reading its name off a card (she was able to read); and Individual #155 was learning to read a thermometer, but it was unclear how he was to use this information. While neither of these SAPs were reviewed, it was concerning that the SAP for learning to brush his teeth and use the toilet had been discontinued, due in part to Individual #382's lack of interest in learning these skills. Because these are essential skills for independence and dignity, these should not be abandoned for a 14-year-old.

5. Of the 23 SAPs reviewed, there was evidence that four had been monitored for data reliability. However, data reliability and validity were rated as current for only two of these four (Individual #382 – pay for purchase and Individual #292 – budgeting) due to problems with data collection noted elsewhere.

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: Criteria were met for all three indicators for four individuals, thus, demonstrating that the facility can meet these requirements. With some additional focus, all three indicators might improve to the point where higher scores are regularly occurring. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1

Comments:

10. Assessments were current for eight of the nine individuals. The exception was Individual #259, whose PSI was from 2014. Although five of the individuals were school-aged, a vocational assessment is recommended when an individual reaches the age of 14, because this is when transition planning should begin. This can serve as a baseline assessment and will allow staff to begin to explore the individual's interest in different areas of work. While an assessment had been completed for Individual #245, Individual #155, and Individual #107, this is recommended for Individual #382 and Individual #292.

11. For five of the nine individuals (Individual #382, Individual #133, Individual #155, Individual #268, Individual #159), their assessments were available to the IDT at least 10 days prior to the ISP meeting.

12. For six of the nine individuals, the assessments included SAP recommendations. The exceptions were Individual #245, whose vocational assessment included a recommendation that staff help her to get involved with a job, and Individual #159 and Individual #259, whose vocational assessments did not include any recommendations for skill acquisition.

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Thirteen of these, in psychiatry, psychology/behavioral health, medical, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This did not include any entire Outcomes.

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

Goals/Objectives and Review of Progress
Regarding management of frequent restraints (i.e., more than three in any rolling 30-day period), most of the indicators met criteria for two individuals. This was good to see and demonstrated that the facility can meet these requirements. Moreover, eight indicators showed improvement from the last review.

In psychiatry, without measurable goals, progress could not be determined. Reiss screens were conducted as required and referrals to psychiatry were made. Collaborative work between psychiatry and neurology was occurring. Polypharmacy practices were good. Better documentation regarding psychiatric clinics, side effect monitoring, and neurology consultation was needed.

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

Acute Illnesses/Occurrences
When an individual was experiencing increases in psychiatric symptoms, actions were taken for all applicable individuals.

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; the development of acute care plans for all relevant acute care needs; and development of acute care plans that are consistent with the current generally accepted standards.

It was positive that for the individuals reviewed who required Emergency Department (ED) visits, or hospitalizations, staff provided treatment and/or interventions for the acute illness. This was a consistent finding over the past few reviews, so this indicator will move to the category of less oversight. The Center should focus on providers' assessments of individuals whose acute illnesses are treated at the Center; for individuals transferred out, as appropriate, documentation of quality assessments in the IPNs; and communication of necessary clinical information to hospital staff.

Implementation of Plans

Brenham SSLC recently began a monthly clinic for all individuals with a high risk rating in behavioral health. This was good to see and should, in part, contribute to better performance on making sure quarterly clinics occur.

The Monitoring Team observed many instances of behavioral health services staff present and interacting with individuals and staff. This was very good to see. Problems in data collection and data summarization for PBSPs, however, led to poor performance on many indicators (this also affected psychiatry reviews). Behavioral health progress notes commented on the progress of the individual. Data collection, graphic and visual analysis, and peer review, however, should be showing a higher level of performance.

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. On a positive note, documentation often was found to show implementation of those action steps that IDTs did assign to the PCPs in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

For the two individuals reviewed with Do Not Resuscitate Orders in place that the Center indicated it would execute, sufficient clinical justification was not presented to the Monitoring Team. For example, for one individual, the qualifying diagnosis was spastic quadriplegia. The Center should review both of these DNRs, as well as those for other individuals on the list, and consult with State Office, including legal counsel to determine whether or not they are DNRs that the Center can execute.

With regard to the non-Facility consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, writing an IPN that includes the necessary components, and referring consultation recommendations to IDTs, as appropriate.

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

It was positive that individuals reviewed generally had regular prophylactic dental care, the Dental Department provided tooth-brushing instruction to staff and/or individuals, and individuals had x-rays in accordance with applicable standards. It was also good to see that individuals reviewed who needed restorative work had it completed timely, and individuals requiring extractions had them only when restorative options were exhausted. As a result, four indicators will move to the category requiring less oversight.

However, it was concerning that individuals reviewed did not have integrated treatment plans to address their periodontal disease. Five individuals reviewed had periodontal disease Type III or Type IV with no improvement noted.

Adaptive equipment was generally clean and in good working order. The indicator related to working order will be moved to the category requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (65% of 40 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, resources, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Most of the indicators met criteria for two individuals. This was good to see and demonstrated that the facility can meet these requirements. Moreover, eight indicators showed improvement from the last review. Focused attention should lead to improved performance for the next review. All of the indicators of this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	245	155	107	159	259				

18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	80% 4/5	1/1	1/1	0/1	1/1	1/1				
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	80% 4/5	1/1	1/1	0/1	1/1	1/1				
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	40% 2/5	1/1	1/1	0/1	0/1	0/1				
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	40% 2/5	1/1	1/1	0/1	0/1	0/1				
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	80% 4/5	1/1	1/1	0/1	1/1	1/1				
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	75% 3/4	1/1	1/1	0/1	N/A	1/1				
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1	N/A	N/A				
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A	N/A				
27	The crisis intervention plan was complete.	25% 1/4	0/1	0/1	0/1	N/A	1/1				
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least	40% 2/5	0/1	0/1	1/1	1/1	0/1				

	80% treatment integrity.											
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	80% 4/5	1/1	1/1	0/1	1/1	1/1					

Comments:
18-19. Five (Individual #245, Individual #155, Individual #107, Individual #159, and Individual #259) had experienced more than three crisis intervention restraints in a rolling 30-day period. For four of these individuals, there was evidence that their IDTs had met within the required time frame. There were also a sufficient number of meetings of each individual's team. The exception was Individual #107. A note was provided that indicated that a review was not necessary for the restraints that occurred between 9/26/16 and 10/14/16 because she had a Crisis Intervention Plan in place. This does not satisfy the requirements of the Settlement Agreement.

20-21. As reflected in the ISPA minutes, the IDTs for Individual #245 and Individual #155 had discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues. Their teams also discussed environmental variables. There was also evidence that the team had pursued counseling for Individual #245 and initiated a change in medication dosage for Individual #155. Further, the BCBA for Individual #155 was going to conduct an observation at school because this was where most of his restraints occurred.

Neither Individual #107's nor Individual #159's team reviewed these potential contributing variables. Individual #259's team had noted that she did not have any contact with her family and that many unfamiliar staff were working with her, but there were no actions identified to address either issue.

22. The IDTs for four individuals discussed potential antecedents that may have contributed to the use of restraint. The exception was Individual #107.

24. All five individuals had a current PBSP.

25. Three of the five individuals (Individual #245, Individual #155, Individual #107) had Crisis Intervention Plans at the time of the repeated restraints that were reviewed. In Individual #159's case, the IDT determined a plan was not needed because the restraints occurred on one day when staff were preventing him from leaving the couch or floor. These were the only restraints that had occurred over a 12-month period. In Individual #259's case, a Crisis Intervention Plan was developed shortly after these repeated restraints.

26. Review of the individual's PBSPs can be found elsewhere in this report (Psychology/Behavioral Health, Outcome 4, Indicator 5).

27. Individual #259's Crisis Intervention Plan was complete. The plans for Individual #245, Individual #155, and Individual #107 did not specify the type of approved restraint. Rather, staff were referred to PMAB approved or trained restraints.

28. Although treatment integrity had not been assessed regularly over a six-month period for any of the five individuals, there was documentation that an assessment had been collected either in the month prior to and/or in the same month as the repeated restraints for Individual #107 and Individual #159. In all assessments, treatment integrity was at 100%.

29. There was evidence that the IDT had reviewed the PBSPs for Individual #245, Individual #155, Individual #159, and Individual #259. In each case, the plan was either revised or was in the process of revision, or there were plans to retrain staff.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
Summary: Reiss screens were conducted as required and referrals to psychiatry were made as also required. This showed improvement from the last two reviews and with sustained high performance, these indicators are likely to move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	267	597	297							
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	1/1	1/1	1/1							
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	100% 1/1	N/A	N/A	1/1							
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A							
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, three individuals were not receiving psychiatric services. Two of these individuals, Individual #267 and Individual #597 were assessed utilizing the Reiss screen. Both of these assessments were in initial screenings. 2. One individual, Individual #297, was screened due to a team referral, apparently due to a change in status. In all three of these events, Reiss screen scores indicated that no additional evaluation was necessary.												

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.												
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
8	The individual is making progress and/or maintaining stability.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Performance on these two indicators was low at this review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health, for example, physical aggression, verbal aggression, unauthorized departure, and self-injury. It was not clear how these target behaviors related to the individual's diagnosis. In addition, while the functional assessment included information regarding the individual's psychiatric diagnosis, there was no discussion of the effects of said diagnosis on the target behaviors.

24. There was no documentation or indication that the psychiatric providers participated in the development of the PBSP. Individual #133 did not have a PBSP (he had a PSP), thus, this indicator did not apply to him.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
Summary: Collaborative work between psychiatry and neurology was occurring and it was occurring annually for all individuals for this review and the last review. Therefore, this indicator (26) will be moved to the category of requiring less oversight. Better documentation of this collaboration will likely lead to better performance on indicators 25 and 27. Both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	33% 1/3	0/1	N/A	1/1	N/A	N/A	N/A	N/A	0/1	N/A
26	Frequency was at least annual.	100% 3/3	1/1	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 1/3	0/1	N/A	1/1	N/A	N/A	N/A	N/A	0/1	N/A
Comments: 25 and 27. These indicators applied to three of the individuals. In one case, Individual #245, there was documentation of consultation/collaboration between psychiatry and neurology. During the monitoring visit, a neuro-psychiatry clinic was observed. During this clinic, collaboration between the providers was apparent. This was very good to see. However, documentation did not reflect this making it impossible to know what occurred at these other collaborative clinics. 26. This indicator applied to three individuals and met the annual criterion.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Brenham SSLC recently began a monthly clinic for all individuals with a high risk rating in behavioral health. This was good to see and should, in part, contribute to better performance on indicator 33, which had slipped since the last two reviews, both of which were at 100%. Indicators 34 and 35, regarding content of documentation and observed clinics, needs focused attention. All three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
33	Quarterly reviews were completed quarterly.	56% 5/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/4	0/1	N/A	N/A	0/1	0/1	N/A	N/A	0/1	N/A

Comments:
33. There were delays in the completion of quarterly evaluations for Individual #268, Individual #107, Individual #159, and Individual #259.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two to seven components; most commonly, a review of the implementation of non-pharmacological interventions, the description of symptoms that support the psychiatric diagnosis, and the results of the most recent MOSES/DISCUS evaluation. While MOSES and DISCUS results were included, the date of the assessment was not documented, therefore, it was not possible to determine what assessment was being reviewed.

35. Psychiatry clinic was observed for four individuals. Data used by psychiatry staff did not meet acceptable standards in a variety of ways, competing with the psychiatrists' ability to make data based decisions and instead having to rely on bad data or anecdotal information.

Data at some clinics were only provided through the previous month, that is, weeks prior to the clinic. Data were not being collected on the specific psychiatric indicators for each psychiatric disorder (i.e., psychiatry indicators 4-7).

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

Summary: This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:
36. Assessments and prescriber review of assessments were not routinely occurring in a timely manner. There also was a transition from the DISCUS to the AIMS. These reviews for Individual #159 met all of the criteria.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary: Brenham SSLC makes emergency/interim clinics available and properly documents those when they do occur. This has been the case for this review and the last two reviews, too. Therefore, indicators 37 and 39 will be moved to the category of requiring less oversight. A long-standing problem, however, has been making sure that these clinics, when requested, do occur as requested. Therefore, indicator 38 will remain in active monitoring.

#	Indicator	Overall	Individuals: 382	133	245	155	268	292	107	159	259

		Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	25% 2/8	0/1	N/A	1/1	1/1	0/1	0/1	0/1	0/1	0/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	N/A

Comments:
37-38. These emergency/interim clinics were available to all individuals and there was documentation of emergency/interim clinics being requested for all eight. When follow-up clinics were specifically requested, such as plans to follow-up in clinic in four weeks, there was documentation that these occurred as requested for two of the eight. The others had some documentation, but not for all that were requested.

A positive development at this Center was their relatively new monthly psychiatry clinic visits, for all individuals who had a high-risk rating for behavioral health. This is labor intensive, but an interesting development in the management of high-risk individuals. It will be interesting to see what benefits accrue to individuals, staff, and the psychiatrists with this frequent contact. While this was very good to see, it caused some difficulties with consistency of follow-up clinics. It appears that this frequency of service was difficult for the facility to maintain.

39. When clinics did occur, documentation was appropriate.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These indicators met criteria during this review and the previous two reviews, too. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
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: Protections related to polypharmacy were in place at Brenham SSLC. For all individuals a tapering plan was in place and polypharmacy committee activities met criteria. This was the case for this review and the previous review with but one exception for indicator 45. Therefore, indicators 45 and 46 will be moved to the category of requiring less oversight. With improved, high, and sustained performance, and based upon high performance on the last two reviews, indicator 44 may move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	67% 4/6	0/1	N/A	0/1	1/1	1/1	N/A	1/1	N/A	1/1
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 6/6	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A	1/1

Comments:

44. These indicators applied to six individuals. Polypharmacy justification was appropriately documented for four individuals.

45. There was documentation for all six individuals showing a plan to taper various psychotropic medications. In addition, two other individuals in the review group had medication reductions, though their medications did not meet the definition of polypharmacy.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for all individuals selected by the Monitoring Team meeting criteria for polypharmacy. The polypharmacy committee meeting was observed during the visit and was a facility level review of regimens. This was very good to see.

Psychology/behavioral health

#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Problems in data collection and data summarization for PBSPs led to poor performance on all of these indicators. Moreover, performance had deteriorated on indicators 8 and 9. These two indicators are scored based upon the facility's own reports. Improvement in data collection, summarization, and response to status of progress are areas for focus that, if addressed, will likely lead to improved scores for this outcome's indicators. All four indicators will remain in active monitoring.			Individuals:								
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	33% 1/3	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments:

6. Although information included in the progress notes for six of the nine individuals suggested progress, this indicator was rated as zero due to the identified problems with data timeliness and inter-observer agreement. That is, progress could not be determined.

7. Based upon the data provided, none of the individuals had met their goals/objectives.

8-9. There was no evidence that corrective actions had been suggested to address Individual #382's lack of progress. Even though a behavior therapy plan was developed for Individual #259 to address her refusal to participate in active treatment, there was no data based review of her progress in either her QIDP Monthly Review or her Behavioral Health Progress Note. Therefore, the frequency and fidelity of plan implementation could not be determined. It should be noted that this plan was implemented on 8/22/16, but discontinued on 10/27/16.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.												
Summary: The Monitoring Team observed many instances of behavioral health services staff present and interacting with individuals and staff. This was very good to see. More attention, however, needs to be paid to ensuring that staff are properly trained in PBSPs. The additional support of having supervision of PBSPs by a BCBA should also be ensured. There were, and had been for the quite some time, appropriate PBSP summaries for float staff. Therefore, indicator 17 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	38% 3/8	1/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1	1/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	56% 5/9	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1

Comments:

16. The facility provided rosters of staff assigned to the individual's home and training sign-in sheets. A comparison of these two documents revealed that 80% or more of the staff currently working with three individuals (Individual #382, Individual #155, Individual #259) had been trained. Only the home staff were reviewed for Individual #382 and Individual #155 because the school staff developed their own behavior support plans. Only home staff were reviewed for Individual #259 because she was not regularly attending a day program. It should be noted that training consisted of a review of the PBSP, completion of a short quiz, and in some instances, presentation of different scenarios. In no case, was on-the-job competency based training provided.

17. There were plans of one to three pages in length that were provided to float staff.

18. Based upon the documentation provided, there was evidence that the assessments and PBSPs for five individuals had been written by a BCBA. The author of the functional behavior assessment for Individual #382, Individual #155, Individual #268, and Individual #159 was not identified. The author of Individual #159's PBSP also was not identified.

The Monitoring Team observed many instances of behavioral health services staff presence and direct involvement with individuals. This is one of the most important foundational aspects of behavioral health services and ABA and was very good to see.

- The BCBA for school-aged students had an office in the home. He was often observed in the home interacting with individuals.
- Another BCBA had her office on the home. She was observed visiting with individuals.
- Another BCBA reported that she and one of two other behavioral health services staff rotated each week to spend time on the

unit during the 10-6 shift.
- The behavioral health services staff spent time with Individual #259 after the internal peer review committee meeting, at which members suggested additional observations be conducted by staff.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Progress notes commented on the progress of the individual for all individuals (with one exception in this submission) for this review and the past two reviews. Therefore, indicator 19 will be moved to the category of requiring less oversight. The other four indicators will remain in active monitoring. They require some focused attention from the facility and, at this point, should be showing a higher level of performance.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
19	The individual's progress note comments on the progress of the individual.	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1
20	The graphs are useful for making data based treatment decisions.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/4	0/1	N/A	N/A	0/1	0/1	N/A	N/A	N/A	0/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	25% 2/8	0/1	N/A	0/1	1/1	0/1	1/1	0/1	0/1	0/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. The most recent progress note for seven of the individuals included comments on the individual's progress. The exception was Individual #259. Her progress note referenced an addendum that provided a review of her progress, but no addendum was attached.

20. The progress notes did not include graphs. These documents were requested, and submitted, separately. None of the graphs were useful for reviewing the individual's progress. In some cases (Individual #382, Individual #245, Individual #292), data for four to six target behaviors were presented on one graph. These were very difficult to read. In other cases (Individual #382, Individual #245, Individual #155), the narrative indicated frequency measures were recorded, yet the graph was labeled number of intervals. Individual #159's graph suggested that SIB was recorded using an interval measure, however, the narrative indicated that the frequency and duration of this behavior was recorded. Individual #259's graph was labeled both frequency and 30-minute partial interval. For Individual #382 and Individual #268, their replacement behavior data were presented in pie charts, however, this allowed for a review

of progress across two months' time only. Other graphs lacked phase change lines to identify significant events, including new PBSPs (e.g., Individual #107).

21. The psychiatry clinics for three individuals were observed. Although the BCBA for Individual #382 and Individual #155 reported on data for the month of December 2016, no data for January 2017were presented. Further, as no graphs were displayed, it was not possible to review the individual's progress over time. While graphs were provided by the BCBA for review at Individual #268's psychiatric clinic, the data from January 2017 were not presented until these were requested by the Monitoring Team. During the onsite visit, Individual #259 was presented at the internal peer review meeting. Her BCBA presented a good amount of information, but data were not available for review by the participants.

22. There was evidence that the eight individuals who had PBSPs had been reviewed by the Positive Behavior Support Committee, Internal Peer Review Committee, and/or the External Peer Review Committee over the six-month period that preceded the Monitoring Team's visit.

After a referral was made, Individual #155 had begun participating in counseling. Individual #292's assessment had been revised in accordance with the recommendations made by the PBS Committee. For the other six individual's, committee recommendations were not addressed in their assessments and/or plans.

23. Over the past six months, internal peer review meetings occurred between one and four times per month. External peer review occurred monthly over the past six months.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Brenham SSLC was struggling with meeting criteria with these indicators. As a result, performance decreased since the last review. Much focused attention needs to be paid so that data can be collected and used to assess individuals' status, make changes in treatment, and overall improve services and supports. All five indicators of this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	0/1

30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. There remained problems with the electronic record system that was introduced in July 2016. As a result, the data collection system did not adequately measure the individual's target or replacement behaviors across all treatment sites. Furthermore, data on target and replacement behaviors were not recorded when the school-aged individuals are at school.

28. Although there were acceptable measures of inter-observer agreement and treatment integrity, the method for determining data timeliness was inadequate. At the time of the visit, data were considered timely as long as they were recorded within an eight-hour shift. This did not allow for a valid assessment of staff recording data in a timely manner.

29. For seven of the eight individuals who had PBSPs, there were established goal frequencies for data collection timeliness, inter-observer agreement, and treatment integrity. The exception was Individual #259, whose PBSP did not address these measures.

30. Although the goal frequencies and levels were achieved for data timeliness for seven of the eight individuals who had PBSPs, this was not an acceptable measure. None of the individuals had acceptable goal frequencies of inter-observer agreement or treatment integrity.

As reported by one of the behavioral health specialists, when inter-observer agreement of data was conducted, it was done by and between two behavioral health services department staff rather than by including a direct support professional. The validity of this reliability assessment is questionable without DSP participation because they are the ones who record the data day in and day out.

Medical

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

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

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #159 – choking, and seizures; Individual #133 – cardiac disease, and other: spasticity, muscle wasting, and pain; Individual #597 – respiratory compromise, and infections; Individual #257 – weight, and seizures; Individual #297 – GI problems, and constipation/bowel obstruction; Individual #205 – choking, and constipation/bowel obstruction; Individual #390 – GI problems, and osteoporosis; Individual #273 – respiratory compromise, and other: adrenal insufficiency; and Individual #267 – other: diabetes insipidus, and other: adrenal insufficiency).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #257 – weight, and Individual #273 – respiratory compromise.

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

Outcome 4 – Individuals receive preventative care.

Summary: Three of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Individuals:

#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual receives timely preventative care:										
	i. Immunizations	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
	ii. Colorectal cancer screening	100% 4/4	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1	N/A
	iii. Breast cancer screening	100%	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A

		3/3									
	iv. Vision screen	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	N/A
	vii. Cervical cancer screening	100% 3/3	N/A	N/A	1/1	1/1	1/1	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- Documentation was not present to show that Individual #159 received the Tdap. The last vision screening for him was completed on 9/17/15.
- Documentation was not present to show that Individual #133 received the Prevnar vaccine.
- No evidence was found of the Tdap vaccine for Individual #205.
- On 6/20/16, the zostavax vaccine was ordered for Individual #390, but had not yet been given because the Center had not yet obtained guardian approval.
- The last Vitamin D level for Individual #273 was not submitted and could not be determined. Records from 2/23/16 forward did not indicate a level had been obtained. The last level submitted was in the QDRR from 7/20/15, despite the fact the individual was prescribed Vitamin D supplementation for a diagnosis of osteoporosis.
- For Individual #267, the pneumovax and HPV vaccines had not been administered.

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: The Center is encouraged to review all individuals that have DNR Orders in place to ensure there is clinical justification for the orders. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267

#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
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.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A
	Comments: According to the annual medical assessment, since 4/30/09, Individual #597 has had an out-of-hospital (OOH) DNR Order in place. The qualifying condition listed was spastic quadraparesis. This did not appear consistent with State Office guidance, and applicable regulations. Similarly, the annual medical assessment for Individual #273 indicated that on 3/29/08, a "qualified relative" signed an OOH DNR. The Center should review both of these DNRs and consult with State Office, including legal counsel to determine whether or not they are DNRs that the Center can execute.										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, prior to the transfer to the hospital or ED, individuals reviewed received timely treatment and/or interventions for the acute illness requiring out-of-home care (Round 9 – 92% for Indicator 4.e, Round 10 – 100% for Indicator 4.e, and Round 11 - 92% for Indicator 6.e), Indicator e will move to the category requiring less oversight. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	44% 8/18	0/2	1/2	0/2	2/2	1/2	2/2	0/2	1/2	1/2
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.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	92% 11/12	2/2	N/A	1/1	2/2	1/1	2/2	N/A	2/2	1/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	78% 7/9	0/1		1/1	N/A	1/1	2/2		2/2	1/2
e.	Prior to the transfer to the hospital or ED, the individual receives	92%	2/2		1/1	1/2	1/1	2/2		2/2	2/2

	timely treatment and/or interventions for the acute illness requiring out-of-home care.	11/12									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	67% 8/12	1/2		1/1	2/2	0/1	2/2		1/2	1/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 3/3	N/A		1/1	N/A	N/A	1/1		1/1	N/A
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.	91% 10/11	1/2		1/1	2/2	1/1	2/2		2/2	1/1

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 18 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #159 (fracture of foot on 11/10/16, and bruise on 9/26/16), Individual #133 (back lesion on 12/1/16, and possible cardiovascular accident on 11/10/16), Individual #597 (conjunctivitis on 9/13/16, and abrasion to right lower back on 10/12/16), Individual #257 (congestion and laceration on 10/28/16, and left foot swelling on 11/16/16), Individual #297 (blister on 10/31/16, and wet cast on 10/27/16), Individual #205 (constipation on 12/9/16, and cough on 11/29/16), Individual #390 (respiratory infection on 11/4/16, and upper respiratory infection on 10/28/16), Individual #273 (anorexia on 10/18/16, and hypoxia on 9/19/16), and Individual #267 (acute rhinitis on 11/7/16, and upper respiratory infection on 11/4/16) .

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #133 (possible cardiovascular accident on 11/10/16), Individual #257 (congestion and laceration on 10/28/16, and left foot swelling on 11/16/16), Individual #297 (wet cast on 10/27/16), Individual #205 (constipation on 12/9/16, and cough on 11/29/16), Individual #273 (hypoxia on 9/19/16), and Individual #267 (acute rhinitis on 11/7/16) .

The acute illness/occurrence reviewed for which follow-up was needed, but documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included was for Individual #159 (fracture of foot on 11/10/16).

For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #159 (ED for altered mental status on 11/12/16, and ED for prolonged seizure on 10/14/16), Individual #597 (hospitalization for hypothermia on 7/5/16), Individual #257 (ED for altered mental status on 10/16/16, and ED for upper respiratory infection on 9/13/16), Individual #297 (ED for ankle fracture on 9/14/16), Individual #205 (ED for gastrointestinal bleed on 11/22/16, and hospitalization for pyelonephritis on 10/31/16), Individual #273 (ED for bradycardia, and hospitalization for pneumonia on 11/8/16), and Individual #267 (ED visit for hypernatremia and diabetes insipidus on 8/25/16, and hospitalization on 12/8/16).

c. For Individual #267 (ED visit for hypernatremia and diabetes insipidus on 8/25/16), although the PCP wrote a lengthy IPN the day following the individual's transfer to the ED, the PCP did not include the events leading up to the decision to transfer the individual.

d. Three of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For Individual #159 (ED for prolonged 22-minute 30 second seizure on 10/14/16), and Individual #267 (ED visit for hypernatremia and diabetes insipidus on 8/25/16), the PCPs or another provider did not write IPNs documenting the completion of assessments prior to transport to the ED.

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exception was Individual #257's ED visit for an upper respiratory infection for which no nursing IPN was available for the after-hours event. Therefore, information was not found regarding the series of events, including any treatment that occurred on the evening of 9/13/16. The individual returned from the ED with diagnoses of strep pharyngitis, nausea and vomiting, and right lower lobe pneumonia.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff were Individual #159 (ED for prolonged on 10/14/16), Individual #297 (ED for ankle fracture on 9/14/16), Individual #273 (hospitalization for pneumonia on 11/8/16), and Individual #267 (hospitalization on 12/8/16).

g. It was positive to see that the IDTs for Individual #597, Individual #205, and Individual #273 held ISPA meetings to addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. Each of these teams revised the IHCPs to add action steps related to necessary medical tests and treatments.

h. For the individuals reviewed, upon their return to the Center, there was generally 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. The exception was:

- On 10/14/16, Individual #159 had four seizures, and nursing staff administered Diastat per MD orders at 9:40 a.m. for a seizure longer than three minutes. Although it was a weekday, no PCP evaluated him. The seizure continued, and according to nursing notes, the PCP was called again, and gave orders to transport Individual #159 to the ED. The seizure lasted 22 minutes and 30 seconds. Emergency Medical Services was notified at 10:00 a.m. According to a PCP IPN, dated 10/14/16 at 3:23 p.m., Individual #159 had a few short seizures and then a prolonged seizure. The individual's Valproic Acid (VPA) levels were low. The plan was to recheck the level on 10/17/16. This was done (the submitted screenshots were not clear enough to identify results with certainty), and ED personnel recommended follow-up on the Keppra level drawn in the ED 10/14/16, but no additional information was found.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Given that over the last two review periods and during this review, for a number of the consultations reviewed, problems were noted with regard to the PCPs reviewing consultations and indicating agreement or disagreement, writing an IPN that includes the necessary components, and referring consultation recommendations to IDTs, when appropriate, all of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	60% 9/15	0/1	0/1	2/2	2/2	2/2	1/1	2/2	0/2	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	80% 12/15	1/1	1/1	2/2	2/2	2/2	1/1	1/2	2/2	0/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the	53% 8/15	1/1	0/1	2/2	2/2	2/2	1/1	0/2	0/2	0/2

	recommendation(s), and whether or not there is a need for referral to the IDT.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	77% 10/13	1/1	1/1	1/1	0/1	2/2	1/1	2/2	2/2	0/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	33% 2/6	N/A	N/A	N/A	N/A	2/2	N/A	N/A	0/2	0/2

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #159 for neurology on 9/20/16; Individual #133 for podiatry on 9/29/16; Individual #597 for neurology on 9/14/16, and podiatry on 9/29/16; Individual #257 for endocrinology on 11/1/16, and gastroenterology on 10/14/16; Individual #297 for orthopedics on 10/27/16, and orthopedics on 9/15/16; Individual #205 for podiatry on 8/4/16; Individual #390 for podiatry on 10/27/16, and podiatry on 7/21/16; Individual #273 for pulmonary on 11/3/16, and pulmonary on 8/31/16; and Individual #267 for endocrinology on 10/24/16, and endocrinology on 7/19/16.

a. The PCPs that did not review and/or initial the consultation reports, and indicate agreement or disagreement with the recommendations were those for Individual #159 for neurology on 9/20/16; Individual #133 for podiatry on 9/29/16; Individual #273 for pulmonary on 11/3/16, and pulmonary on 8/31/16; and Individual #267 for endocrinology on 10/24/16, and endocrinology on 7/19/16.

b. Those that were not reviewed timely were for Individual #390 for podiatry on 7/21/16; and Individual #267 for endocrinology on 10/24/16, and endocrinology on 7/19/16.

c. For a number of consultations, PCP IPNs were not found.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #257 for endocrinology on 11/1/16 (i.e., lab testing), and Individual #267 for endocrinology on 10/24/16, and endocrinology on 7/19/16.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations,	33% 6/18	0/2	0/2	2/2	2/2	2/2	0/2	0/2	0/2	0/2

	consistent with current standards of care.										

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #159 – choking, and seizures; Individual #133 – cardiac disease, and other: spasticity, muscle wasting, and pain; Individual #597 – respiratory compromise, and infections; Individual #257 – weight, and seizures; Individual #297 – GI problems, and constipation/bowel obstruction; Individual #205 – choking, and constipation/bowel obstruction; Individual #390 – GI problems, and osteoporosis; Individual #273 – respiratory compromise, and other: adrenal insufficiency; and Individual #267 – other: diabetes insipidus, and other: adrenal insufficiency).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #597 – respiratory compromise, and infections; Individual #257 – weight, and seizures; and Individual #297 – GI problems, and constipation/bowel obstruction. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- Individual #133 had a long history of chronic pain, and underwent two cervical spine surgeries in the past. He also had a history of major depressive disorder with psychotic features. The annual medical assessment listed potential causes for his chronic pain (i.e., sequelae of his cervical stenosis and subsequent surgery, depression, peripheral vascular disease, diabetic peripheral neuropathy, and spasticity). However, no information was submitted that provided evidence the PCP had evaluated the etiology of his chronic pain from this broad list of potential causes, which would then lead to specific treatment. Physiatry consultation had not been considered. The role of electromyography in assisting in determining a cause for his spasticity and hypertonicity of specific muscle groups had either not been considered or results were not submitted as part of the annual medical assessment or other report. Habilitation therapy services continued to work with the individual, but the PCP was unable to articulate specifically what was done during habilitation therapy sessions. There was concern that Individual #133 no longer ambulated, but had the capacity to undertake this activity, suggesting the possible need for a behavioral component to therapy to improve motivation. His pain reportedly was well controlled with Neurontin, Baclofen, Tramadol and Valium. However, without a definitive diagnosis for the cause of the chronic pain, the optimal treatment cannot be determined.

- Individual #159 had a diagnosis of Lennox-Gastaut syndrome, associated with generalized tonic clonic seizures, complex partial seizures, and absence seizures. On 2/29/12, he had a vagal nerve stimulator placed, but it currently was nonfunctional and the epileptologist recommended against replacement. He was on a combination of five anti-epileptic seizure medications to control his seizures. An epileptologist followed him. On 10/3/16, his Depakote level was 51 (i.e., therapeutic 50-100). On 10/14/16, he had a prolonged seizure (22 minutes), which did not respond to Diastat and he was transported to the ED. A Depakote level was completed and was low at 24. The PCP post-ED IPN noted: "unclear why his level would be half the value today of the value noted 10/3/16 as no dosing changes have been made..." Subsequently, the PCP learned that Individual #159 was not compliant with taking his medication (e.g., spitting out meds, etc.), but it did not appear the PCP was notified of repeated failed attempts at medication administration, especially for this individual's seizure medication. Reportedly, he was more compliant with familiar staff. Clinically, the number of seizures per month decreased over the past year, indicating treatment prescribed was likely appropriate. However, tracking and evaluation of medication compliance is needed, and the cause for refusals identified, and then interventions should be implemented as needed to increase medication compliance to reduce risk of prolonged seizures.

- Individual #205 had a long history of constipation with associated megacolon. On 12/23/16, findings from a colonoscopy were considered normal. He was currently prescribed Miralax several days per week, as well as Colace. He has had a positive guaiac stool, the source of which remained elusive, and recently required three units of blood for a hemoglobin level of 5.2. The PCP provided no information regarding a next step for resolution of the source of GI bleeding. The presence of chronic megacolon remained a therapeutic challenge. No colon motility studies had been competed to determine whether a section of bowel had hypomotility and whether a surgical intervention would be indicated or beneficial in reducing future risk of complications due to this finding.

- Individual #267 had adrenal insufficiency, a challenge in an individual who also had diabetes insipidus. Options for increased monitoring to determine any early signs of infection or blood pressure instability did not appear to be addressed. This window of time might be the only opportunity to provide additional steroids to prevent adrenal crisis, as well as treat the underlying cause at an early stage.

  Additionally, the endocrinologist provided treatment recommendations for emergency visits. Individual #267 had frequent hospitalizations in recent months, with hypernatremia as severe as 172 at Brenham SSLC, and by the time the individual was transported to Texas Children's Hospital, her sodium level had increased to 180. A protocol for early treatment might assist in preventing severe hypernatremia in this individual. For example, the Center should consider coordinating treatment at the local ED or providing IV therapy in an Infirmary setting at the Center until transport is obtained.

  Also, the endocrinologist made several recommendations, but it was unclear if the direct support professionals and IDT were trained on these recommendations. For instance, the endocrinologist recommended a daily count of wet diapers as one way to monitor urinary output as a measure of adequacy of treatment of the diabetes insipidus, but results were not reported at a follow-up visit to the endocrinologist. Despite the many hospitalizations and severity of illness, the IHCP was not updated throughout the year to reflect the endocrinologist's additional recommendations.

- Individual #273 developed adrenal insufficiency and had a difficult clinical course in recent months, including three acute events in November 2016. No plan was found to attempt to minimize the adrenal crises and/or to monitor closely to catch illness at an early stage. The IDT did not appear to have discussed development of an intense monitoring program (such as blood pressure monitoring every four hours while awake) to recognize early warning signs suggesting physiologic stress requiring additional steroid supplements. The current monitoring system was not sufficiently sensitive to catch early warning signs. Preventing adrenal crises and subsequent ED visits and hospitalizations will assist in optimizing health and improving quality of life. The PCP should guide the IDT to consider additional monitoring options in order to treat the earliest signs of physiologic stress and subsequent decompensation due to adrenal insufficiency.

  In addition to three hospitalizations associated with complications of hypoxia, respiratory failure, hypotension and sepsis, Individual #273's weight had fluctuated with a loss of 19.8 pounds in three months per an ISPA, dated 9/9/16, and a recent increase in weight of seven pounds. Although different causes of the weight loss were suspected (e.g., depression, tooth pain, specific food preferences), at the time of the review, the causes of his repeated pneumonias and history of weight loss

remained unknown. Individual #273 would benefit from communication between the PCP with the GI consultants to fast track the completion of endoscopic procedures as they had been delayed by repeated hospitalizations. In addition, no information was submitted reflecting that the IDT had met with the dietary department, psychology, psychiatry, and active treatment departments to develop a plan to assist in ensuring his dietary preferences were met based on the history of improved appetite when eating off campus. Overall, there is an urgent need for an aggressive approach to evaluation and management of his clinical condition. The most recent increase in weight needs to be verified and closely monitored for accuracy and consistency given that it represented a two-pound weight increase per week.

- Individual #390 had dysphagia, and a Speech Language Pathologist (SLP) worked with him with eventual upgrading of his diet. He had a diagnosis of GERD, and his bed was positioned to reduce reflux. The PCP indicated documentation was not clear whether GERD was present, and subsequently changed a proton pump inhibitor to an H2 blocker for treatment, with potential weaning from the H2 blocker. The individual also had a history of pica, as well as health care associated pneumonia. Although the diagnosis of GERD was identified as one without supportive documentation, no information was submitted indicating this had been evaluated further to determine the need for ongoing evaluation and treatment. Given the presence of dysphagia and history of pneumonia, it was unclear if gastric reflux was a potential contributing factor needing further medical or surgical treatment options. Given the significant comorbid conditions and complex history, the safest option would have been to rule out GERD prior to changing or reducing medication.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, documentation often was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	79% 11/14	2/2	1/2	1/1	2/2	2/2	N/A	0/2	2/2	1/1
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed often were implemented. The exceptions were for Individual #133 – other: spasticity, muscle wasting, and pain, and Individual #390 – GI problems, and osteoporosis.											

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
Comments: a. and b. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental. c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For the eight individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. A full review also was conducted for Individual #390 who was at low risk for dental (i.e., edentulous), but was part of the core group.											

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individuals have no diagnosed or untreated dental caries.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	Since the last exam:										

	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	86% 5/6	1/1	1/1	N/R	1/1	1/1	0/1	N/A	1/1	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Individual #390 was edentulous.

b. Between 7/14/15 and 7/24/16, Individual #205's periodontal disease worsened from Type II to Type III.

Also of concern, five individuals reviewed had periodontal disease Type III (i.e., Individual #159, Individual #133, and Individual #297) or Type IV (i.e., Individual #273 who had a full-mouth extraction, and Individual #257) with no improvement noted.

When individuals' exams identified them as having periodontal disease, but serial periodontal charting was not available, the Monitoring Team could not rate this indicator (e.g., Individual #597 who had Type III periodontal disease as of 1/8/16, but for whom no periodontal chart could be completed on 3/2/15). The Monitoring Team is applying the "N/R" score to this round of reviews to allow State Office to work with the Centers to improve practice. However, beginning in the next round of reviews, if an individual should have had periodontal charting, and it is not completed, or a justification is not provided for a lack of periodontal charting, then this indicator will be scored 0.

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

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had prophylactic care consistent with their oral hygiene needs (Round 9 – 88%, Round 10 – 100%, and Round 11, 88%), individuals generally had dental x-rays in accordance with applicable standards (Round 9 – 100%, Round 10 – 89%, and Round 11 - 100%), individuals' needs for restorative work was addressed (Round 9 – N/A, Round 10 – 100%, and Round 11 - 100%), and extractions were only done when restorative options were exhausted (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicators a, c, f, and g will move to the category of requiring less oversight. During this review and the last one, improvement was seen with regard to the provision of tooth-brushing instruction to	Individuals:

#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
individuals and staff. If this progress is sustained, Indicator b might move to the category requiring less oversight after the next review. Other indicators were new and/or required improvement.											
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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 4/4	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	N/A
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 4/4	1/1	N/A	N/A	1/1	N/A	1/1	N/A	N/A	1/1
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A

Comments: Individual #390 was edentulous, so these indicators were not applicable to him.

a. through d. It was positive that individuals reviewed generally had regular prophylactic care, Dental Department provided tooth-brushing instruction to staff and/or individuals, and individuals had x-rays in accordance with applicable standards.

e. It was concerning that individuals reviewed did not have integrated treatment plans to address their periodontal disease. One example of a resulting poor outcome was Individual #273 (admission date 8/8/74) who had a full-mouth extraction on 10/4/16. Prior to this, the plan was a three-month recall to the Dental Clinic and to "continue work" with staff in his home in order to achieve better oral hygiene and compliance in the Dental Clinic.

f. and g. It was positive that individuals reviewed who needed restorative work had it completed timely, and individuals requiring extractions had them only when restorative options were exhausted.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: Given that the Center attained 100% scores for Indicator a through c during this Round (i.e., these indicators were N/A in Round 9, and Round 10), with sustained performance during the next review, indicators a through c will likely move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 3/3	N/A	1/1	N/A	N/A	N/A	N/A	N/A	2/2	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1		1/1						N/A	
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1		1/1						N/A	
Comments: a. through c. For the individuals reviewed who needed it, complete emergency dental care was provided.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center should focus on improvement in this area.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	20% 1/5	N/A	1/1	0/1	N/A	N/A	N/A	0/1	0/1	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	20% 1/5		1/1	0/1				0/1	0/1	0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	40% 2/5		1/1	1/1				0/1	0/1	0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/5		0/1	0/1				0/1	0/1	0/1
Comments: a. through d. For individuals reviewed that required suction tooth brushing, their ISPs generally did not define measurable plans/strategies. The ISP/IHCP also should define the frequency of monitoring, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible.											

Outcome 9 – Individuals who need them have dentures.											
Summary: During this review and the last one, improvement was noted with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. If this progress is sustained, Indicator a might move to the category requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: For the individuals reviewed with missing teeth, the Dental Department provided recommendations regarding dentures. For Individual #257, the Dentist recently made a recommendation for partial upper and lower dentures. However, sufficient time had not elapsed to allow the fabrication, and fitting of dentures, so Indicator b was scored as N/A.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/13	0/2	0/2	0/1	0/2	0/1	0/2	0/1	0/1	0/1
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of	8% 1/13	0/2	0/2	1/1	0/2	0/1	0/2	0/1	0/1	0/1

	signs/symptoms that require medical interventions.										
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	8% 1/13	0/2	0/2	0/2	0/1	0/1	0/2	0/1	1/2	N/A
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	10% 1/10	0/2	N/A	0/1	0/1	0/1	0/2	N/A	1/2	0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/15	0/2	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/1
f.	The individual's acute care plan is implemented.	0% 0/15	0/2	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/1

Comments: The Monitoring Team reviewed 15 acute illnesses and/or acute occurrences for nine individuals, including Individual #159 – fractures on 11/15/16, and bilateral swollen hands on 7/14/16; Individual #133 – bilateral edema to lower extremities on 7/15/16, and skin breakdown on left upper thigh on 8/12/16; Individual #597 – hypothermia on 7/6/16, and urinary tract infection (UTI) on 7/25/16; Individual #257 – laceration on 9/26/16, and laceration post suture repair on 10/28/16; Individual #297 – fracture of left ankle on 9/14/16; Individual #205 – acute bronchitis on 10/23/16, and fever, tachycardia, and leg swelling on 10/31/16; Individual #390 – three small open areas on right buttock on 8/9/16; Individual #273 – pneumonia on 8/5/16, and pneumonia on 11/14/16; and Individual #267 – hypernatremia on 12/15/16.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual #597 – hypothermia on 7/6/16.

e. No acute care plans were provided for the following occurrences: Individual #159 – bilateral swollen hands on 7/14/16; Individual #133 – bilateral edema to lower extremities on 7/15/16, and skin breakdown on left upper thigh on 8/12/16; Individual #205 – acute bronchitis on 10/23/16, and fever, tachycardia, and leg swelling on 10/31/16; and Individual #390 – three small open areas on right buttock on 8/9/16.

On a positive note, the acute care plan for Individual #597's UTI included some good interventions. However, a major missing piece was monitoring of hygiene given that e coli was found on the urinalysis. Similarly, the acute care plan for Individual #267 included some good interventions, but did not include the frequency of assessments, where they would be documented, and who would review the data.

Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

The following provide some examples of concerns noted with regard to this outcome:

• On 11/8/16, an IPN noted Individual #159 was limping, but no nursing assessment was found, nor was there documentation to show the nurse notified the PCP. On 11/10/16, the PCP noted the individual had a fracture, but there was still no nursing assessment. Nursing staff did not initiate an acute care plan until 11/15/16, and did not include all of the basic elements of assessing a fracture and/or how frequently nursing staff should complete assessments. • On 7/5/16, Individual #597 was found unresponsive to sternal rub, although it was unclear who initially identified she was unresponsive. Although the nurse notified the PCP, documentation was not found to show a nursing assessment beyond vital signs. From 7/5/16 to 7/6/16, Individual #597 was hospitalized for altered mental status and hypothermia, but on 7/7/16, no nursing assessment was found (e.g., mental status, responsiveness). The acute care plan did not identify the frequency of nursing assessment for hypothermia, or assessment of mental status. The plan did not include preventive strategies. • On 9/14/16, a nursing IPN indicated that Individual #297 was sitting in a wheelchair and a direct support professional reported that her left ankle was bruised. The nursing note only indicated that the individual's ankle was discolored on the medial side with slight edema. Additional assessments were not included, such as the individual's ability to bear weight, pain, range of motion, temperature of skin, circulation, any other bruising, etc. The IPN indicated the individual was scheduled for sick call, but there was no indication the nurse notified the PCP about when the bruise was discovered. Once it was determined that the individual had an ankle fracture, there was much variability in the nursing assessments documented in the IPNs. For example, one nurse indicated that capillary refill could not be determined due to "dark nail polish on toes," while other IPNs reported capillary refill in less than three seconds. Assessments did not consistently contain the same assessment criteria for comparison, such as pedal pulse assessment, odor to cast, the appearance of visible skin on the fractured leg, pain, and/or activity level. Circulation checks are critical for a casted extremity, especially since the IPNs indicated that the cast was wet or had gotten wet (unclear of specifics from notes), which could easily impede circulation. • It was positive to see that for Individual #273's diagnosis of pneumonia for which an acute care plan was developed on 8/5/16, nursing staff conducted ongoing assessments consistent with standards of practice. The assessments documented in the IPNs were more complete and timely than what the acute care plan required. Unfortunately, when Individual #273 had another diagnosis of pneumonia a few months later in November 2016, the assessments nursing staff conducted often were not consistent with standards of care (e.g., lung sounds), and this was exacerbated by the lack of an acute care plan that defined the individualized assessments that nursing staff should have conducted.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #159 – fractures, and dental; Individual #133 – other: pain, and cardiac disease; Individual #597 – UTIs, and constipation/bowel obstruction; Individual #257 – falls, and dental; Individual #297 – constipation/bowel obstruction, and falls; Individual #205 – constipation/bowel obstruction, and dental; Individual #390 – skin integrity, and constipation/bowel obstruction; Individual #273 – skin integrity, and Addison's disease; and Individual #267 – dental, and other: adrenal insufficiency and diabetes insipidus).

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

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

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

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/13	0/2	0/2	0/1	0/2	0/1	0/2	N/A	0/1	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not

meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

The following provide a few examples of many risks that warranted IDTs taking immediate action:

- Individual #257 had nine teeth extracted using TIVA, but the IDT did not implement a program to increase cooperation with daily dental care.
- Nursing staff did not initiate regular assessments of gait, even after Individual #297 fractured her left ankle and continued to have additional falls, especially when exiting the bus.
- In May 2016, even after Individual #267 had two hospitalizations related to hypernatremia and dehydration, nursing staff did not initiate regular assessments related to adrenal insufficiency and/or diabetes insipidus.

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

Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following infection control procedures (g, and previously f). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 159	133	597	257	297	205	390	273	267
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R									
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	83% 5/6	1/1	0/1	N/A	1/1	1/1	1/1	N/A	N/A	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the	N/R									

	IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.										
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/R									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	25% 2/8	0/1	0/1	0/1	0/1	1/1	1/1	N/A	0/1	0/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of eight individuals, including Individual #159, Individual #133, Individual #597, Individual #257, Individual #297, Individual #205, Individual #273, and Individual #267. Individual #390 was deceased at the time of the review.

a. Of note, although Individual #597's medications could not be given due to a high residual, the nurse sprayed nasal spray into the individual's nostrils while the individual was sleeping in her chair. b. Of note, Individual #273 refused to take medications during two observations. Nursing staff did not document the attempts that resulted in refusals. Although the CNE indicated he took his medication within prescribed timeframes, the number of initial refusals is important information for the IDT to have on an ongoing basis. c. Individual #597's medications could not be administered due to residuals being too high. Individual #273 refused to take medications during two observations. For Individual #133, the nurse did not take the MAR to the individual's room to ensure that the individual received medications in accordance with the nine rights (i.e., right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation). d. This indicator was not assessed during this review, but will be during upcoming reviews. The Center had just recently obtained the curriculum State Office provided to assist the Centers in complying with these requirements. f. For six individuals, nurses did not check PNMPs, or PMNP pictures were not available during medication administration to ensure the individual was in the correct position. g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/14	0/2	0/2	0/2	N/A	0/1	0/2	0/2	0/1	0/2

	ii. Individual has a measurable goal/objective, including timeframes for completion;	71% 10/14	1/2	1/2	1/2		1/1	1/2	2/2	1/1	2/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14	0/2	0/2	0/2		0/1	0/2	0/2	0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14	0/2	0/2	0/2		0/1	0/2	0/2	0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14	0/2	0/2	0/2		0/1	0/2	0/2	0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	50% 2/4	N/A	N/A	N/A	0/2	1/1	N/A	N/A	1/1	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4				0/2	0/1			0/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/4				0/2	0/1			0/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4				0/2	0/1			0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/4				0/2	0/1			0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/4				0/2	0/1			0/1	

Comments: The Monitoring Team reviewed 14 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #159; falls, and aspiration for Individual #133; aspiration, and falls for Individual #597; aspiration for Individual #297; choking, and weight for Individual #205; choking, and aspiration for Individual #390; choking for Individual #273; and choking, and aspiration for Individual #267.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: choking for Individual #159; aspiration for Individual #133; aspiration for Individual #597; aspiration for Individual #297; choking for Individual #205; choking, and aspiration for Individual #390; choking for Individual #273; and choking, and aspiration for Individual #267.

b.i. The Monitoring Team reviewed four areas of need for three individuals that met criteria for PNMT involvement, as well as the

individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration, and falls for Individual #257; falls for Individual #297; and aspiration for Individual #273.

No evidence of PNMT review was found for Individual #257's right lower lobe pneumonia on 9/14/16. Given the individual's multiple issues, such as altered mental status, weight changes, and pneumonia, at least a review was warranted. Similarly, Individual #257 experienced a significant increase in falls along with these changes, but no evidence of PNMT review of the falls was found.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
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.	40% 2/5	0/1	N/A	N/A	0/2	1/1	N/A	N/A	1/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

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

b. No evidence was found to show Individual #159's IDT reviewed possible swallowing issues as a possible cause for his gagging when taking medication, which would have been especially important since he had a history of severe oropharyngel dysphagia.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, resources, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	35% 14/40
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.	0% 0/4
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during zero out of six observations (0%). Staff followed individuals' dining plans during 14 out of 34 mealtime observations (41%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: The Center had not made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/3	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	0/1
Comments: a. As noted above, plans had not been developed for individuals, and/or clinical justification was not provided for not developing plans to assist individuals to move along the continuum towards oral intake.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.	
Summary: For individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will	Individuals:

remain in active oversight.											
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	9% 1/11	0/1	0/1	0/1	0/3	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/11	0/1	0/1	0/1	0/3	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/11	0/1	0/1	0/1	0/3	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11	0/1	0/1	0/1	0/3	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11	0/1	0/1	0/1	0/3	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The goal/objective that was clinically relevant and achievable was for Individual #297 (i.e., ambulation). c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For the nine individuals, full reviews were conducted.											

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	9% 1/11	0/1	0/1	0/1	0/3	0/1	0/1	1/1	0/1	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.	N/A									
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that over the last two review periods and during this review, individuals observed generally had adaptive equipment that was in working order (Round 9 – 98%, Round 10 – 95%, and Round 11 - 100%), Indicator b will move to the category requiring less oversight. Given the importance of the cleanliness (Round 9 – 80%, Round 10 – 97%, and Round 11 - 100%), as well as proper fit of adaptive equipment (Round 9 – 85%, Round 10 – 84%, and Round 11 - 65%) to the health and safety of individuals and the Center's varying scores, these indicators will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	34	249	406	133	134	361	575	582	493
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 31/31	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 31/31	1/1	1/1	2/2	1/1	1/1	1/1	2/2	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	65% 20/31	0/1	0/1	0/2	0/1	1/1	1/1	2/2	1/1	1/1
		Individuals:									
#	Indicator		472	478	360	398	330	81	33	519	92
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		159	287	392	362	189	332	273	8	148

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
		Individuals:									
#	Indicator		492	297							
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1							
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1							
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1							

Comments: a. The Monitoring Team conducted observations of 31 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed was in working order.

c. Based on observation of Individual #249, Individual #406, Individual #133, Individual #81, Individual #287, Individual #189, Individual #273, Individual #8, and Individual #148 in their wheelchairs, the outcome was that they were not positioned correctly. In addition, the following individuals' gait belts were under their arms: Individual #34, and Individual #406. It is the Center's responsibility to determine whether or not these issues were due to the equipment, staff not positioning individuals or their equipment correctly, or other factors.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. None of the indicators had sustained high performance scores to be moved the category of requiring less oversight.

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

The 10 ISP personal goals that met criterion with ISP indicator 1 were not written in a way that progress could be determined or did not have data collected to determine progress (with but one exception). Staff knowledge regarding individuals' ISPs was insufficient. There were, however, some positives noted. For example, some QIDPs were able to provide a cogent and accurate description of individuals' behavioral needs and the strategies in PBSPs.

None of the SAPs were considered complete. Problems included schedules with limited opportunities for the individual to learn the identified skill. Four SAPs were observed with two of the four implemented as written. For the most part, SAP data did not reflect progress, data were not available to assess progress, or integrity had not been assessed. There were, however, some positive aspects of SAP management at Brenham SSLC. For instance, the teams were objectively assessing the individual's ability to perform the skill prior to SAP implementation, and all SAPs were reviewed prior to implementation.

Overall, engagement scores were low. State Office was now working with centers to enhance opportunities for engagement, and ways for DSPs to engage individuals in activities when they are available. It was good to see that engagement goals were established and that the center was collecting data, though the goals were not yet met. While all individuals should be provided a robust schedule of activities, this is particularly important for the school-aged population and extra attention should be paid here.

Brenham SSLC supported many individuals who were school-aged and received educational services from the local public school, the Brenham ISD. Much work needs to be done to establish a better working relationship, communication, shared information on skills and behavioral issues, and progress. Some plans were underway to address this.

It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. Moreover, according to documentation the Center provided, only 13% of the population (i.e., 35 individuals) had personal AAC devices. Many other individuals were listed as using general area communication devices. However, these either did not work, or were not easily accessible to individuals. The Center is encouraged to review the quality of individuals' assessments for AAC devices. Even for individuals identified as

being able to verbally communicate, review is necessary, due to the fact that although it appeared some individuals used verbal communication, their intelligibility frustrated their ability to communicate with staff as well as unfamiliar people.

IDTs did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: The 10 goals that met criterion with indicator 1 were not written in a way that progress could be determined or did not have data collected to determine progress, with but one exception for one individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/5	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/5	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	1/6	0/6	0/6	0/6			

Comments: Once Brenham SSLC develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Individual #292 had one personal goal, for living options, that met criterion for outcome 2. Otherwise, the remaining personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See outcome 7, indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	292	159	297	273			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.

But, there were some positives noted. For example, the QIDP III in Individual #382's home was able to provide a cogent and accurate description of his behavioral needs and the strategies in his PBSP. Otherwise, Monitoring Team observations included the following:

- For Individual #159, who had a diagnosis of pica, the Monitoring Team observed batteries on his dresser in his bedroom. At another time, the Monitoring Team observed a staff member trying to prevent him from leaving his room for medication pass using poor technique that placed him at higher risk for falls.
- For Individual #133, Individual #297, Individual #159, and Individual #273, knowledge of communication capabilities and styles was limited at best. When interviewed for knowledge of the PNMP, responses were limited to answers, such as "prevent aspiration, prevent choking," but were not specific to individual triggers and needs.
- Similarly, when interviewed about his risk areas, staff in Individual #133's day program indicated he should not have anything with sharp edges or anything he could ingest, but he had no history of ingesting non-edibles. This appeared to be a general response unrelated to his individual needs.

40. Action steps were not consistently implemented for any individuals, as documented above.

Skill Acquisition and Engagement

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

Summary: More attention needs to be paid to SAP implementation, determining whether SAPs are progressing, and taking actions to develop new SAPs or to modify existing SAPs. There was some progress in score improvement compared to the last review. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
6	The individual is progressing on his/her SAPS	4% 1/23	0/2	0/3	0/3	0/3	0/3	1/1	0/3	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	30% 3/10	1/1	N/A	N/A	1/3	1/3	N/A	N/A	N/A	0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	65% 15/23	1/2	3/3	3/3	1/3	1/3	1/1	0/3	2/2	3/3

Comments:

6. One SAP (Individual #292 – budgeting) had data that suggested she was making progress and had been assessed for integrity. For all other SAPs, either data did not reflect progress, data were not available to assess progress, or integrity had not been assessed.

7. None of the individuals had met the goal/objectives identified in his or her SAPs. Therefore, a new or updated goal/objective had not been introduced.

8. Three of the 10 SAPs, in which the individual was not making progress, resulted in action by the IDT. Individual #382's team had discontinued his pay for purchase SAP and replaced this with using a vending machine, Individual #155's team had purchased a new toothbrush, and Individual #268's team had discontinued his dialing his mother's number.

9. Data-based decisions were evident in 15 of the 23 SAPs. The exceptions were due to a lack of data (e.g., Individual #382 – use a vending machine; Individual #155 – read a thermometer and mail art to his family; Individual #268 – shaving and dialing his mother's phone number; and Individual #107 – washing clothes, make a pizza, and pay for purchase).

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: None of the 23 SAPs met all of the criteria that are part of this indicator. There was, however, some progress and some positive aspects of these SAPs. More work will be needed to bring them to criteria. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
13	The individual's SAPs are complete.	0% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/3	0/2	0/3

Comments:

13. None of the 23 SAPs were considered complete. Problems included schedules with limited opportunities for the individual to learn the identified skill. Twelve SAPs were scheduled to be trained one to two times each week, nine SAPs were to be trained five to seven days each week, and one SAP was to be trained only twice monthly. The only SAP that identified more than one trial per session was for Individual #159 to learn to use hand sanitizer.

Other problems included limited use of individual-specific reinforcers. Of the 23 SAPs, all but three identified praise as the sole consequence for correct responding. The exceptions were the following: Individual #133 was given the opportunity to talk with his mother after brushing his teeth, Individual #268 could talk with his mother after dialing her number, and Individual #159 could enjoy his bath after dispensing bubble bath.

None of the SAPs provided clear instructions as to how staff should document the individual's response.

All that being said, there were some very positive components of the SAPs. First, the teams are commended for objectively assessing the individual's ability to perform the skill prior to SAP implementation. Second, all SAPs are reviewed prior to implementation. Third,

behavioral objectives were complete for all of the SAPs. Fourth, relevant discriminative stimuli were identified in all of the SAPs.

Outcome 5- SAPs are implemented with integrity.											
Summary: Correct implementation of SAPs must be ensured. Both indicators showed progress compared with the last two reviews, which was good to see. That being said, much more work is needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
14	SAPs are implemented as written.	50% 2/4	N/A	0/1	N/A	1/1	1/1	N/A	0/1	N/A	N/A
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.	17% 4/23	1/2	0/3	0/3	1/3	0/3	1/1	1/3	0/2	0/3

Comments:

14. Four SAPs were observed with two implemented as written. Individual #155's SAP for reading a thermometer was implemented as written. Although he was on step two of the program, he completed all three steps independently. The discriminative stimulus and consequence for correct responding were delivered as identified in the SAP. Similarly, Individual #268 independently completed all the steps identified in his shaving SAP. In fact, he completed additional steps (e.g., plugging in the razor and applying after-shave) that were not identified in the SAP. In both cases, staff were advised to conduct probes of the terminal skill to determine whether the individual has achieved the skill and demonstrates competency consistently.

The other two SAPs were implemented slightly differently than written (Individual #133 – make flower arrangement, and Individual #107 – wash clothes). Staff are advised to re-assess the materials used and teaching methodology applied with Individual #133. Staff are also advised to conduct probes with Individual #107 on the terminal skill of washing her clothes.

15. The expectation is that SAP integrity measures will be collected on all SAPs at least once in a six-month period. A goal level of 80% is established, with re-training occurring if the measure is below this level. There was evidence of monitoring of four of 23 SAPs over the last six months. These were the following: Individual #382 – pay for purchase, Individual #155 – read thermometer, Individual #292 – budgeting, and Individual #107 – washing clothes.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Both indicators showed decreased performance since the last review and will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	382	133	245	155	268	292	107	159	259
16	There is evidence that SAPs are reviewed monthly.	57%	0/2	3/3	3/3	1/3	0/3	1/1	0/3	2/2	3/3

		13/23									
17	SAP outcomes are graphed.	0% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/3	0/2	0/3

Comments:

16. While there was evidence that all 23 SAPs were reviewed monthly, in only 13 SAPs was this review data-based. For the other 10 SAPs, there were notes in the monthly reviews indicating that no data were available. Individual #107's SAPs were an example in which monthly reviews from July 2016 through November 2016 noted that SAPs had not been entered into the electronic system, or, once entered, the data could not be reviewed.

17. Although there was a narrative regarding progress, none of the most recent monthly reviews included graphs depicting the individual's performance on their SAPs. It should be noted that at one psychiatric clinic (Individual #268), the BCBA presented pie charts depicting the SAP data from one month. While this provided interesting information, it did not allow for an assessment of progress over time.

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

Summary: Overall, engagement scores were low. State office was now working, supporting, brain storming with centers to enhance (1) opportunities for engagement, such as new types of activities, classes, materials, and (2) ways to support DSPs to engage individuals in activities when they are available. Brenham SSLC should seek out this support. It was good to see that engagement goals were established and that the center was collecting data. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
18	The individual is meaningfully engaged in residential and treatment sites.	13% 1/8	1/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	50% 4/8	1/1	0/1	N/A	1/1	0/1	1/1	1/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	50% 4/8	1/1	0/1	N/A	1/1	0/1	1/1	1/1	0/1	1/1

Comments:

18. Eight individuals were observed to assess for engagement. Individual #245 had recently moved from the facility by the time of the visit. One of these eight individuals, Individual #382, was determined to be actively engaged when observed. It is important to note, however, that he was engaged with puzzles or building blocks. His team had learned from his school program that he had skills that were significantly more advanced. Staff are encouraged to review the individual's PSI and other assessments to try to identify activities

that are meaningful to the individual. While all individuals should be provided a robust schedule of activities that address all domains of life (e.g., domestic, leisure, communication, self-care, academic, and community skills), this is particularly important in the case of the school-aged population. There are multiple opportunities for enhancing their skills and independence outside of the school day. For example, It was positive to observe the QIDP for the school-aged girls on the home helping the girls prepare for dinner. Two girls were helping prepare the meal and set the table.

19. Evidence presented by the facility indicated that engagement had been assessed in all home or residential environments. Assessments had occurred each month over the past six months in the homes for most individuals. The exception was the home in which Individual #292 and Individual #107 resided. Engagement had been assessed in five of the past six months. It should be noted, however, that the number of assessments each month ranged between one and 10 times. Therefore, adequate measures of engagement were found in all homes for all nine individuals. There was no evidence that engagement had been assessed in the day program sites for the four individuals who were not enrolled in public school.

20. Eighty percent is the expected level of engagement.

21. In the homes for six of the individuals, engagement averaged 80% or better over a six-month period. The homes in which Individual #133, Individual #268, and Individual #159 lived had engagement scores that averaged less than 80% over this same six month period.

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

Summary: Community outings occurred, but did not meet criteria for this indicator. With additional work, it is likely that the facility can make progress on these indicators. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 382	133	245	155	268	292	107	159	259
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/5	N/A	0/1	0/1	0/1	N/A	N/A	N/A	0/1	0/1

Comments:
22. Seven of the nine individuals (Individual #382, Individual #133, Individual #245, Individual #155, Individual #268, Individual #159, Individual #259) had goal frequencies for community recreational activities identified in the action plan section of their ISPs. These goals were achieved for Individual #382 and Individual #268. While there were no goal frequencies identified for Individual #292 and Individual #107, there was evidence of community-based activities over the previous six-month period.

23. None of the individuals had goal frequencies of community-based SAP training identified in their ISPs. 24. This indicator was rated for five individuals (Individual #133, Individual #245, Individual #155, Individual #159, Individual #259) who had community recreational goals that had not been met. For each of these five individuals, there was no evidence that the IDT had met to identify the barriers and develop action plans to correct the issues.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.												
Summary: Brenham SSLC supports many individuals who are school-aged and received educational services from the local public school, the Brenham ISD. Much work needs to be done to establish a better working relationship, communication, shared information on skills and behavioral issues, and progress. Some plans were underway to address this. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	382	245	155	292	107					
25	The student receives educational services that are integrated with the ISP.	0% 0/5	0/1	0/1	0/1	0/1	0/1					
Comments: 25. Five of the individuals (Individual #382, Individual #245, Individual #155, Individual #292, Individual #107) reviewed by the behavioral health Monitoring Team were attending school. There was evidence that their QIDPs participated in the IEP meeting and that inclusion and an extended school year were considered for each individual. This was good to see. Although the ISP noted the individuals' participation in the Brenham ISD public schools, only the ISP for Individual #155 listed IEP goals. None of the ISPs included action plans that supported the individual's IEP. Further, there was no evidence that the individual's IDT reviewed the report cards and/or progress notes from school. Data on PBSP goals were not collected while the children were at school. During the onsite visit, the administration explained that plans were in place to improve the relationship and collaboration between the local public schools and the SSLC. This is very positive step towards ensuring that there is an integration of services to best meet the needs of the children who reside at the facility.												

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: For the individuals reviewed, documentation did not show a history of one or more refusals to cooperate with dental care over the last 12 months.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The goal/objective that was clinically relevant, but not measurable was for Individual #297 (i.e., pointing to what she wants to eat). c. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals.											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	159	133	597	257	297	205	390	273	267
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	75% 3/4	1/1	N/A	N/A	0/1	1/1	N/A	N/A	N/A	1/1
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.	N/A									
Comments: a. Evidence was not present to show that the further diagnostics of AAC and sign language occurred for Individual #257.											

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: It was concerning that the Center had not made progress in this area. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	492	159	332	297	334	450	37		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	29% 2/7	0/1	0/1	0/1	1/1	0/1	1/1	0/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. Overall, the Monitoring Team observed limited personal AAC devices. According to documentation the Center provided, only 13% of the population (i.e., 35 individuals) had personal AAC devices. Many other individuals were listed as using general area communication devices. However, these either did not work (i.e., Childress B, where one of four worked), were not easily accessible to individuals (e.g., general picture boards were often too high for individuals using wheelchairs to utilize, such as on Bowie C, or were behind multiple chairs, such as in Childress C), or were inappropriate for the individuals living in the home (e.g., picture boards on Childress C, when one of the individuals had a vision impairment). The Center is encouraged to review the quality of individuals' assessments for AAC devices. Even for individuals identified as being able to verbally communicate, review is necessary, due to the fact that although it appeared											

some individuals used verbal communication, their intelligibility frustrated their ability to communicate with staff as well as unfamiliar people (e.g., Individual #133).

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

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier this year, the Center just had begun to take on additional post-move monitoring responsibilities, and was beginning to follow individuals in the community for a year as opposed to 90 days.

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

Although some supports in the CLDPs reviewed were measurable, more work was needed in this area. Numerous essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff.

It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, the PMM providing clear documentation to substantiate the findings, and the PMM as well as IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports.

Both individuals had experienced PDCT events. For both individuals, there were failures 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.

It was positive that IDT members actively participated in the transition process, and the CLDPs defined their roles. It was also good to see that the IDTs reviewed the CLDPs with the individuals and their guardians. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. The CLDPs did not define the training well. It also remained unclear whether or not IDTs had considered many of the necessary activities that can assist to make transitions successful.

It was positive that one individual transitioned within established timeframes, and the short delay for one individual was explained.

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: Although some supports in the CLDPs reviewed were measurable, more work was needed in this area. Numerous essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	580	269								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								

Comments: 1. The CLDPs reviewed did not consistently contain supports that were measurable. Examples included:

- The IDT developed 11 pre-move supports for Individual #580. Overall, these were not consistently measurable. Four of the 11 pre-move supports were for in-services to be provided prior to the transition. These supports did not include any descriptions of the training methodologies or competency demonstration criteria. The evidence required for all of the in-service supports called only for signed rosters, with no competency testing or demonstration, or even any staff interview. Other pre-move supports primarily focused on needed equipment such as a blender to process his chopped diet and a weight scale, items to be delivered by Brenham SSLC, and environmental modifications, including installation of items for bathroom safety and a dimmer switch for his bedroom. Some of these latter supports were measurable, requiring visual observation. Others were not, in that they only required a signed receipt for verification. These included a 30-day supply of medication, an updated communication dictionary, and various equipment/adaptive aids to be delivered by Brenham SSLC. These supports should call for observation of the presence of all required items.
- For Individual #580, many of the 23 post-move supports did not describe the specific intent or define measurable outcomes that the PMM could use to determine if the individual's needs were being addressed as required. For example, the CLDP included a support for a bowel log, but did not provide any detail as to where the bowel log should be kept or how the data were to be used. Although the support called for the provider to keep the log to assure that medications prescribed for constipation continued to be effective, it did not provide criteria to measure this effectiveness. It was also concerning that the bowel log was kept at the day habilitation and home, but not at school where he ostensibly spent much of each day during the school year.
- The IDT developed seven pre-move supports for Individual #269. Some supports were measurable, but this was not consistent. Three pre-move supports required training of provider staff, but did not indicate the specific staff to be trained or describe how training was to be conducted or competency determined. A fourth support called for 24-hour awake staff in the home, with additional staff available to the home through "on-call" during normal sleep hours. Per the CLDP narrative, Individual #269 required a manual lift with a sling for all transfers and two staff for bathing. The IDT also agreed that two staff would be available in the home during awake hours. The CLDP did not make this expectation clear in the supports, stating a second staff would "be available" to the home during high activity times such as baths, meals, and medication administration. It was not clear how this

would be different from the on-call availability during sleep hours and also did not address all awake hours as agreed.

- The IDT developed 18 post-move supports for Individual #269. Ten post-move supports called for community health care appointments and follow-up care to be completed. These were measurable. Supports that did not meet criterion included three post-move supports calling for staff to be able to demonstrate knowledge of Individual #269's preferences, medical needs, medication side effects, and physical and nutritional management needs. These required staff interview, observation and demonstration as evidence, but the IDT had not identified any competency or knowledge criteria from which the PMM could make this assessment. Similarly, a fourth post-move support required that Individual #269 continue to use a specific list of adaptive equipment, as evidenced by staff interview, observation and demonstration, but the IDT again did not identify any competency or knowledge criteria from which to make an assessment.

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 criterion to be met. Neither of these CLDPs comprehensively addressed support needs and did not meet criterion. Overall, the CLDP supports defined by the IDTs for these two Individuals were very broad and generic and lacked measurability, as described below:

a. Past history, and recent and current behavioral and psychiatric problems: Supports did not sufficiently reflect the individual's past history, and recent and current behavioral and psychiatric problems in a consistent manner.
   - For Individual #580, examples included:
     - Per his ISP, Individual #580 was to have weekly behavior therapy. This was not addressed in the CLDP. The CLDP did not include any post-move support for behavioral consultation, despite a significant history of aggression and self-injury.
     - A support called for establishing care with a psychiatrist within the first 30 days, but did not address the IDT's recommendation there be no changes in his psychiatric medications for the first six months following transition.
     - A pre-move support for in-service training of provider staff on Individual #580's behavioral assessment and intervention plan (BAIP) did not include training methodology, competency criteria, or competency testing.
     - There were no post-move supports related to his behavioral needs, including none for implementation of the BAIP, none for any data collection, and none to test staff knowledge.
   - According to documentation, Individual #269 had not displayed any behavioral issues since 2009-2010 and had no behavior support plan since that time. He did have a history of aggression during assistance with activities of daily living (ADLs) as well as a history of pulling out his g-tube. The IDT did not, but should have, developed a support related to his behavioral history, such that provider staff would be aware in the event it recurred.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the IDTs did not address significant health care needs with any specific supports.
   - For Individual #580, examples included:
     - He had a seizure disorder related to his diagnosis of tuberous sclerosis. The history was significant for intractable seizures, uncontrolled with medications, and multiple brain surgeries. He had an implanted vagus nerve stimulator (VNS). Although he had no reported seizure activity within the last year, he was at risk due to his tuberous sclerosis and receiving a seizure medication (Sabril) with potentially significant side effects. The CLDP included no training supports related to his seizure disorder or any diagnoses specified in the CLDP.
     - The IDT did not develop a support to monitor and track seizure activity. There was no training as to the

indications for or use of the VNS. There was a support for magnets to be available at home and day habilitation, but this did not include the school.

- At the Center, Individual #580 was on 1:1 supervision, with the exception of being provided routine supervision between the hours of 11:00 p.m. and 2:00 a.m. Per the Integrated Risk Rating Form (IRRF,) the 1:1 supervision addressed several needs. The IDT developed a post-move support for supervision to provide 1:1 supervision during awake hours at home and in community activities for the first 90 days, while Individual #580 was the only person residing in the home. Following this 90-day period, the home and community services (HCS) IDT was to meet and determine the needed level of supervision. There was no expectation defined for data that should be collected and analyzed by the HCS IDT in making the determination as to his supervision level after 90 days. The support did not address the various needs that had required 1:1 at the Center, including his tendency to run and the recommendation that staff hold his hand when in the community or outside in any unfenced area. The specified in-service training by the Brenham SSLC habilitation therapies staff did not include this issue.
- As a part of the CLDP, the IDT also modified his 2:1 supervision level for bathing to provide protection when he was exiting the tub, agreeing that 1:1 was sufficient with other supports in place, including a grab bar to be installed at the rear of the tub and a soft cover for the faucet. There was no evidence the appropriate IDT clinicians had trialed and/or observed these supports to ensure they were sufficient.
- There was no support related to the use, care and monitoring of the Mic-Key button, and no support related to knowledge of his history of meal refusals and/or the use of the Mic-Key for medication and supplemental feeding. There was no support related to keeping track of refused meals or medications. This would have been important data for making a future decision related to removing the Mic-Key button, which had been used on rare occasions in the previous six months. As it stood, his LAR wanted to wait at least six months for post-move stability in this regard, but without a support to collect data regarding stability, it would be impossible to accurately assess. There was also no support for revisiting his need for the Mic-Key, but should have been.
- There were no supports for access to OT/PT services or consultation for monitoring of his physical and nutritional management needs. He had been receiving sensory integration services at the Center. The CLDP narrative indicated the Speech-Language Pathologist (SLP) believed this to be beneficial and that this opportunity should be continued. There was no support for this.
- The CLDP included minimal communication supports for Individual #580. Pre-move supports for training on his communication strategies had no specific staff competencies or competency testing defined. The final PMM Checklist included a post-move support for the communication dictionary to be available to staff, but it did not include any competency criteria or otherwise define how the PMM would be able to accurately assess as to the presence of the support. The IDT did not develop any supports for ongoing communication consultation for this ten-year old nonverbal child with a severe or greater hearing loss.

- For Individual #269:
    - The IRRF indicated he received oxygen saturation checks on each shift and that oxygen was to be administered as needed to maintain his level at greater than 90%. He was also receiving inhalation therapy three times a day. Neither was referenced in the CLDP.

- Individual #269 had a history of small bowel obstruction. The IDT did not develop any specific support for monitoring or signs and symptoms for which staff should be aware.
- He had a history of urinary tract infection (UTI) and the nursing assessment indicated that it would be important to maintain proper hydration to avoid decrease in urine flow and increased risk of UTI. The IDT did not develop a specific support related to knowledge of this risk, monitoring, or prevention.
- The IDT did not develop supports for access to OT/PT for monitoring of his physical and nutritional management needs. The OT/PT assessment identified many needs that were not specifically addressed. Rather, the IDT identified broad and generalized supports to provide training for adaptive equipment, positioning, transfers, oral care, bathing, and handling techniques. Such broad supports lacked important details specifying what staff needed to know and what the PMM needed to review. Examples of specific supports and recommendations not addressed included the need for the provider to identify a Durable Medical Equipment (DME) provider with a certified Assistive Technology Professional (ATP) for future wheelchair needs; upright positioning at 45 degrees for all feeding and medication administration, as well as 30 minutes to one hour after; use of a bed elevation chain to identify other safe position ranges for check and change and sleeping; if he appeared to be having trouble breathing at higher levels, staff should lower the bed to 30 degrees and notify the nurse; Posey foot elevators to be worn while in bed, using buckwheat pillows for other specific positioning instructions in the recliner and bed; hands to be washed and dried thoroughly twice daily to reduce the risk of skin breakdown due to history of maceration; and wipe his mouth and gums with a damp washcloth as needed while in wheelchair or recliner as upright as possible. This list is not exhaustive.

c. What was important to the individual:
  - For Individual #580, the CLDP narrative identified a number of preferred items and activities, including, for example, his relationship with his family. Assessments recommended a weekly phone call with his mother and visits with his family. Only the phone calls were addressed in the supports. This was particularly concerning because one of .the primary goals of the transition was to facilitate family contact. There were otherwise no supports related to preferred activities and items. For example, the narrative also indicated he should have access to a fan, which he liked to have blow across his face, preference for a quiet environment with access to sensory items such as different textures, and access to country music, which helped him calm down. The IDT developed no supports for any of these.
  - The IDT was unable to identify many things that were important to Individual #269 in his ISP, but taking wheelchair strolls was one thing that he was noted to enjoy. There was no related support in the CLDP. The CLDP indicated he enjoyed quiet environments such as sitting on the patio or relaxing in his recliner, but there were no supports defining any expectation he would participate in either of these activities. The IDT identified staff being knowledgeable of his sensitivity to being touched as important, but this staff knowledge was not specifically addressed in the CLDP.

d. Need/desire for employment, and/or other meaningful day activities:
  - For Individual #580, the IDT did not define any supports related to school or to other meaningful day activities in the community that might take place outside of the school environment. It was possible to glean from PMM reports that he was attending school as well as attending a day habilitation program during school vacations, but neither was included as a support. The PMM documented no evidence of visiting the school during any of the post-move monitoring.
  - For Individual #269, the CLDP did not include a support related to attendance at day habilitation or any expectation as to what he might engage in at such a program. No supports were defined related to other meaningful day activities in

integrated community settings other than one post-move support that he would have opportunities to participate in preferred community activities at least monthly. No specific preferred activities were defined in the latter support.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success:
   - For Individual #580, a pre-move support for training staff on the BAIP did not provide any specific detail and did not address positive reinforcement, incentives, and/or other motivating components to his success. The IDT did not specify any related staff knowledge supports. The CLDP contained no environmental supports related to his sensory needs, with the exception of a dimmer switch in his bedroom. Assessments indicated he enjoyed water activities, but the only related support was to assure that if he went swimming, the pool should be chlorinated and a lifeguard should be on duty. The support did not define an expectation that he would go swimming or otherwise participate in water activities.
   - For Individual #269, the CLDP did not include any supports integrating positive reinforcement, incentives, and/or other motivating components. He did not like to be touched, but the IDT did not continue his program for tolerating touch.

f. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed few supports related to teaching, maintenance, participation, and acquisition of specific skills.
   - For Individual #580, the IDT continued a training program to learn to use utensils, but this was the only skill acquisition support in the CLDP. The IDT otherwise discontinued training programs for use of an adaptive switch to learn cause and effect, tooth brushing, and toileting. The latter two supports were revised to staff implementation rather than skill acquisition. The IDT did not provide a rationale that would justify its decisions to discontinue or downgrade skill acquisition in these areas, particularly given Individual #580's very young age. Early learning is critical for all children, and particularly so for children with learning disabilities. While the IDT noted his lack of progress in these areas as its rationale for de-emphasizing skill acquisition, it did not consider how a new and smaller community environment might provide new opportunities to learn these and other skills.
   - For Individual #269, the IDT provided minimal focus on skill acquisition.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Recommendations from assessments were not consistently addressed. Examples included:
   - For Individual #580, the IDT did not address the following:
     - Psychiatry recommendations to not change medications for six months and to be monitored for gynecomastia;
     - SLP recommendations that he would continue to benefit from sensory integration therapy and that he remain sitting or standing for one hour after oral intake, medication administration and g-tube flushes;
     - A recommendation for staff to observe for and report any changes in behavior that might relate to vision;
     - Per the annual medical assessment (AMA), the primary care physician (PCP) did not recommend "prolonged immersion with Mic-Key tube," and included a web link to a newsletter. The CLDP did not address this related to bathing and swimming. The Center pointed out the discussion of the water safety assessment that indicated the PCP recommended he swim only in a chlorinated pool with a certified lifeguard present, but this did not address the above recommendation.
   - For Individual #269, the OT/PT assessment included many detailed recommendations that were not specifically addressed in the CLDP supports, without justification. Details are described above under item 2b.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: It was positive that the Post-Move Monitor conducted timely monitoring for the individuals reviewed. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, the PMM providing clear documentation to substantiate the findings, and the PMM as well as IDTs following up in a timely and thorough manner when the PMM notes problems with the provision of supports. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	580	269								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1								
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	NA	NA	NA								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	NA	NA	NA								
Comments: 3. Post-move monitoring was completed at required intervals for both individuals, within the required timeframes, and in the proper format. For Individual #269, the PMM visited all locations, but no evidence was included the PMM ever visited Individual #580's school settings. Details and comments provided tended to be sparse, making it difficult to assess whether the PMM's assessment of the status of supports was correct. This was made even more difficult by the lack of detail in many of the supports as defined by the												

IDT and in the evidence required to substantiate their status.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports were not consistently available. This was due in part to supports that did not provide measurable indicators, as described under Indicator #1 above. In other instances this was due to insufficient documentation by the PMM. While comments were provided for every support, these were not consistently as detailed as needed to confirm whether supports were in place as required.

5. Based on information the Post Move Monitor collected, neither of the individuals had consistently received supports as listed and/or described in the CLDP, as detailed below:

- Individual #580 was not consistently receiving supports as listed and/or described in the CLDP. Examples included:
    - Supports not in place at time of seven-day PMM visit included: the provider did not keep the bowel log; provider had not installed the dimmer switch; and the Center did not deliver a full 30-day supply of critical seizure medication as required.
    - Supports not in place at time of 45-day PMM visit included:
        - The provider did not establish psychiatric care within 30 days, but this was not noted as an area of concern or unmet need.
        - The provider allowed Individual #580 to run out of seizure medication twice since transition.
    - Supports not in place at time of 90-day PMM visit included:
        - The provider did not establish psychiatric care within 30 days or ensure completion of the hearing evaluation appointment with the audiologist.
        - The succeeding provider had not installed the dimmer switch for the bedroom or the protective soft covering for the faucet in the new home. The documentation did not make clear if the grab bar for the bath was in place or not. The PMM documented staff indicated Individual #580 did not use the grab bar because he preferred to crawl into the tub and that this was easier for him and the staff assisting him. Per the checklist, it was determined the grab bar support was no longer necessary as a result. The documentation did not indicate how that determination took place or whether the IDT reviewed this plan for appropriateness and safety. The IDT did not hold an ISPA for this purpose.
    - Individual #269 was not consistently receiving supports as listed and/or described in the CLDP. The Monitoring Team could not always determine if some supports were in place due to lack of detail in both the description of the support as well as the PMM comments. This is further discussed with regard to Indicators #1, #3 and #4. As another example, the provider had not established care with an ophthalmologist prior to end of July as required. It was not completed at the time of the 45-day PMM visit in August, or at the time of the 90-day visit at the end of September.

6. The evidence did not always support the PMM's scoring, in particular because it did not provide a level of detail that allowed for such an analysis as detailed herein.

7. and 8. It could not be reliably determined the IDT/Facility consistently implemented corrective actions in a timely manner for the supports that were not being provided as needed and/or followed these through to resolution. Per the PMM Checklists reviewed, the PMM did not routinely follow up to ensure missing supports were in place until the next scheduled PMM visit. For example, for Individual #580, the PMM did not document confirming corrective action had been taken for the missing bowel log and dimmer switch

noted at the 7-day PMM visit until the 45-day PMM visit. At the time of the180-day visit, the PMM indicated follow up to psychiatric care not being in place would occur at the time of next monitoring visit, but this would not occur until 75-90 days later. The support was already 150 days late at that point and needed more assertive action. For Individual #269, the provider had not established care with the ophthalmologist prior to the end of July as required. As of 9/28/16, this care had not yet been completed.

9. and 10. Post move monitoring did not occur during the week of the onsite review. Therefore, these two indicators could not be scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: Both individuals had experienced PDCT events. For both individuals, there were failures 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.			Individuals:									
#	Indicator	Overall Score	580	269								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	0% 0/2	0/1	0/1								

Comments: 11. Both individuals experienced PDCT events following transition.

- Individual #580 experienced two PDCT events.
  - The first was an ER visit that occurred on 6/22/16, for what appeared to be a minor, unobserved injury that caused him to limp noticeably. There was no identified cause and he recovered quickly. On 6/24/16, the provider took Individual #580 to his PCP for a follow-up exam. It was agreed the provider should keep pathways and play areas free from obstructions and obstacles. The IDT correctly observed this event could not have been predicted.
  - On 6/30/16, a second PDCT meeting was held as a result of the LAR's decision to change providers. The PDCT ISPA listed the following concerns as cause:
    - On 5/23/16, Individual #580 was taken to the ER for a swollen ear. This had not been reported to the Center, but both the school and his mother were aware.
    - On 5/25/16, the provider ran out of his seizure medication, Sabril, and contacted the APC for assistance. On 6/11/16, the provider ran out of Sabril again and none had been re-ordered as of the time of the 45-day PMM visit on 6/13/16. The provider documented missed doses on 6/1, 6/2, 6/3 and five additional doses between 6/11 and 6/13. No PDCT or other IDT meeting was documented as being held at that time. When the IDT met on 6/30/16, it determined it had made efforts to address the medication issue prior to the event by providing information on how to order Sabril to the provider and encouraging the provider to contact the SSLC or LIDDA if there were any further problems. The IDT also concluded nothing could have been done differently. The

IDT should have reviewed the CLDP supports more carefully in making this assessment. For example:

- The IDT did not develop any specific supports related to staff knowledge related to Individual #580's seizures or specific supports related to how to obtain his medication from the Specialty Pharmacy. The latter process differed from standard procedure for filling medications. While the Center reported in interview it had shared this information prior to the transition, the provider clearly did not know or understand how to use the Specialty Pharmacy.
- The Monitoring Team also noted that the Center only provided a 23-day supply of this medication, rather than the full 30 days as indicated in the CLDP. The IDT should have documented this in the CLDP and put in place a specific follow-up plan. The PMM Checklist and Pre-Move Site Review (PMSR) indicated the 30-day supply of medication was in place, which was incorrect. The PMM should have indicated this was not in place and provided a detailed comment as to how it would be resolved.

- Individual #269 had extensive specific positioning needs and equipment that were not spelled out in any support; rather, there was a broad support that indicated provider staff would be trained in various areas including his PNMP. The IDT did not define any competency criteria or testing of staff knowledge. He transitioned on 6/30/16. By 9/21/16, he had developed a non-healing rash and was referred to the community PCP. The rash did not heal and he was referred to a wound care specialist on 10/4/16. On 10/16/16, a wound VAC (vacuum assisted closure) was ordered, which did not arrive until 11/21/16. On 12/12/16, the provider took Individual #269 to the ER after a foul odor was documented and he was admitted the same day. He was later admitted to a long-term care facility for continuing treatment, where he remained at the time of this monitoring visit. The IDT did acknowledge this event to be preventable based on his previous history and identified that training and monitoring his positioning needs might have made a difference. It was particularly concerning that the 90-day PMM Checklist for the visit that occurred on 9/28/16 did not identify this issue of the rash and bring it to the attention of the IDT to address. In response to a support calling for staff to demonstrate knowledge of his adaptive equipment, positioning, transfers, and handling techniques (among other needs), the PMM documented at that time only that all staff were able to verbalize or demonstrate their understanding of the listed items.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.	
Summary: It was positive that IDT members actively participated in the transition process, and the CLDPs defined their roles. It was also good to see that the IDTs reviewed the CLDPs with the individuals and their guardians. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of some components of transition assessments. The CLDPs did not define the training well. It also remained unclear whether or not IDTs had considered many of the necessary activities that can assist to make transitions successful. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	580	269							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. The monitoring team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 Days of transition: The Center did not review or update the IRRF for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The APC should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. Other examples of assessments that were not updated within 45 days included:
  - For Individual #580, the Center did not provide the Functional Skills Assessment (FSA), vocational/day, pharmacy, or

nursing assessments for review.

  - For Individual #269, the Center did not provide the FSA, pharmacy, vocational/day, or vision assessments for review.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: Overall, assessments available provided a summary of relevant facts of both individuals' stay at the facility, but the lack of needed updates described above negatively impacted compliance in this area.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: This sub-indicator did not meet criterion. In addition to the missing updates described above, assessments did not consistently provide a comprehensive set of recommendations.
- Assessments specifically address/focus on the new community home and day/work settings: This sub-indicator did not meet criterion. In addition to the missing updates described above, assessments did not consistently address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: 1) There was documentation to show IDT members actively participated in the transition planning process; 2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed; 3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting. The Center met criterion for this indicator.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: The CLDPs for these two individuals did not identify the specific staff to be trained other than to state provider staff. Supports did not include the training methodologies or identify expected competencies or how these would be measured. Evidence for the pre-move training supports required only a signed training roster and a copy of the materials used. Pre-move supports did not include staff knowledge requirements; this was also largely true for post-move supports. The PMM Checklists did include additional post-move supports for training any new staff, but these also did not include any competency criteria, training methodologies, or testing of staff knowledge. In interview, the APC indicated that competency-based provider training was not taking place at this time, but that she was trying to develop a policy to address this need. The Monitoring Team expressed concern regarding the quality of training being provided for transitions and to ensure health and safety of the individuals affected. It encouraged the Center to take steps to quickly address this need.

15. When necessary, Facility staff should collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual. The CLDPs should evidence the IDT's specific consideration as to the need for such collaboration as well as the results of any collaboration that may have taken place, but did not.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results. Neither of the CLDPs provided evidence the IDT made such a consideration.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center,

Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #580 and Individual #269 did not provide evidence of this consideration.

18. The APC and transition department staff collaborated with the Local Authority staff when necessary to meet these individuals' needs during the transition and following the transition. The LIDDA typically participated in meetings throughout the process and assisted in locating another community home for Individual #269.

19. According to the available evidence, pre-move supports were not consistently in place in the community settings on the day of the move. For example:

- For Individual #580, pre-move supports for bathroom safety needs (soft protective covering for bathtub nozzle) and dimmer switch were not completed. At time of transition, the room at the chosen home was not ready, so he transitioned to another home temporarily. Per the PMSR, the IDT agreed these two items could be installed in the chosen home, but would not be needed in the temporary residence. The Monitoring Team requested the ISPA documenting the IDT's consideration, but none had been held. The IDT did not meet to consider whether alternative supports, such as reverting to the 2:1 supervision for bathing were considered and/or implemented for purpose of ensuring his safety. The PMSR also provided no evidence that provider staff were knowledgeable of Individual #580's needs or competent to implement them.
- For Individual #269, the PMSR had all pre-move supports checked as present, but there was no evidence provided to substantiate this assessment. The PMSR included no comments for any of the supports. For example, the training supports required a staff roster to be reviewed and staff to be interviewed, but the PMSR did not provide any comments for these supports indicating what evidence was reviewed.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: It was positive that for the individuals reviewed documentation was present to show timely transitions or justifiable reasons for the delays in their transitions. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	580	269							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							

Comments: 20. Individual #580's transition slightly exceeded 180 days, but there was ample documentation of the ongoing provider search by the mother and Transition Specialist. Individual #269 transitioned within 180 days.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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