United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

Dates of Onsite Review: October 2nd to 6th, 2017

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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, and mortality review. At the time of the last review, 12 of these indicators, including two entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, three additional indicators in the areas of restraint, and abuse, neglect, and incident management will move to the category of less oversight, including the entirety of Outcomes #4 and #5 for abuse, neglect, and incident management. Two indicators in the area of abuse, neglect, and exploitation will return to active oversight.

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.

Restraint

The overall usage of crisis intervention restraint at Brenham SSLC remained about the same as at the last review. Compared with the other SSLCs, the census-adjusted rate was in the middle, that is, six Centers had a higher rate and six Centers had a lower rate. Occurrences of crisis intervention chemical restraint, in particular, were not descending. In fact, the most recent month had the highest number of occurrences ever in a single month (five). There were, however, no occurrences of crisis intervention mechanical restraint.

More individuals had received a crisis intervention restraint than during the last review. In August 2017, for instance, 33 individuals had crisis intervention restraint. One individual (i.e., Individual #34) was described as having protective mechanical restraint for self-injurious behavior (PMR-SIB). But, it may be that the mittens are not restraint at all (because the individual can put them on and take them off on his own, there is no requirement for him to wear them, and he is not asked to put them on), however, there are times when he is required to wear the mittens due to the need for injuries or wounds to heal. At those times, categorization as medical restraint may make more sense.

There was progress in the correct implementation of restraint. An area for improvement is regarding correctly implementing protocols when crisis intervention chemical restraint is used. This includes the proper consultations with other clinicians prior to the administration of the crisis intervention chemical restraint, and proper monitoring of the individual by nursing after administration of the crisis intervention chemical restraint.

Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: describing the circumstances surrounding the restraint in an Integrated Progress Note (IPN); providing detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and clearly documenting injuries, and when necessary providing enough information to clarify whether or not an injury occurred prior to, during, or after the restraint, or stating if this cannot reasonably be determined.

Restraints were being reviewed, for the most part, which was good to see. Follow-up to recommendations, however, was not occurring for more than half of the restraint occurrences.

Abuse, Neglect, and Incident Management

Brenham SSLC improved on ensuring that supports were in place to have reduced the likelihood of occurrence of the incidents. This included review of trends and putting plans in place (for all but one individual). For individuals designated for streamlined investigations, however, attention needs to be paid to ensure that all of the Department of Family and Protective Services (DFPS) and SSLC protocols are being followed. Allegations of abuse and neglect, injuries, and other incidents were reported appropriately in all cases in the review group.

Unusual Incident Reports (UIRs) continued to be well written. Investigations, however, did not collect or analyze all relevant evidence. This occurred for 25% of the investigations and, as a result, Indicators 9 and 10 will be returned to active monitoring. More detail was needed when extraordinary circumstances were cited by DFPS as the reason for investigation extensions past 10 days. The Monitoring Team attended three Incident Management Review Team (IMRT) meetings during the onsite week. There was good attendance, active participation, and substantive discussion.

Despite these areas for improvement, the work of the Incident Management Coordinator (IMC) and incident management staff was continuing to improve. A positive organizational change was that the IMC now reported directly to the Facility Director.

Other

Regarding pretreatment sedation, for the one case in the review group, there was no provision of other supports that could be provided in the future, review of this need in her ISP, or evidence of guardian/LAR consent.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: The usage of crisis intervention restraint at Brenham SSLC remained at about the same level as during the last review for most of the sub-indicators in indicator 1. More attention needs to be paid to crisis intervention restraint management. The restraint reduction committee was more active over the past few months and this may set the occasion for more progress to occur. A high number of individuals had crisis intervention restraints implemented during this review period. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	60% 6/10	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (January 2017 through September 2017) were reviewed. The overall usage of crisis intervention restraint at Brenham SSLC remained about the same as at the last review, with an average slightly higher than at the last review and no descending trend evident. Compared with the other SSLCs, the census-adjusted rate was in the middle, that is, six Centers had a higher rate and six Centers had a lower rate. The usage of crisis intervention physical restraint paralleled the overall usage because the majority of crisis intervention restraints were crisis intervention restraints. The average duration of a crisis intervention physical restraint was slightly lower than last time, though a descending trend was not evident. Occurrences of crisis intervention chemical restraint were also not descending. In fact, the most recent month had the highest number of occurrences ever in a single month (five). There were, however, no occurrences of crisis intervention mechanical restraint, and there were very few injuries that occurred during restraint and those that did occur were not serious.

More individuals had received a crisis intervention restraint than during the last review. In August 2017, 33 individuals had crisis intervention restraint. While onsite, the restraint managers said that this was an error, but when their data were re-submitted, that number remained.

One individual (Individual #34) was described as having protective mechanical restraint for self-injurious behavior (PMR-SIB). Based upon document review, observation, interview, and discussion while onsite, it was evident that there was confusion on how to categorize the use of mittens. The Monitoring Team suggests that the behavioral health services department get some guidance from the state's discipline coordinator for behavioral health services. It may be that the mittens are not restraint at all (because the individual can put them on and take them off on his own and there is no requirement for him to wear them and he is not asked to put them on), however, there are times when he is required to wear the mittens due to the need for injuries or wounds to heal. At those times, categorization as medical restraint may make more sense.

There was low usage of non-chemical medical restraints, low usage of pretreatment sedation for medical procedures, and low (and declining) usage of TIVA for dental procedures. The Monitoring Team could not determine the amount of usage of pretreatment sedation for dental procedures because the graph showed zero, but another document (tier 1 .17) listed seven individuals as having pretreatment sedation for annual dental exams.

The restraint reduction committee met at least once per month. Over the past few months, under the direction of the new behavioral health services director, more data and more facility-wide issues were being addressed. It looked like the committee was reviewing the same data sets that are reviewed by the Monitoring Team. This was good to see.

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

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #142, Individual #128, Individual #179, Individual #147, Individual #265), and two received crisis intervention chemical restraint (Individual #142, Individual #128). In addition, PMR-SIB was reviewed for one individual (Individual #34). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for two (Individual #142, Individual #179). Data were unavailable/not collected for Individual #34. The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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: There was progress in the correct implementation of restraint. Four of the eight indicators in this outcome had improved scores, two indicators remained the same, one indicator decreased slightly, and one indicator remained at 0%. A particular area of focus is regarding the consultations required prior to administration of crisis intervention chemical restraint (indicator 10). On the other hand, all restraints were terminated as per requirements for all restraints during this review, as well as all restraints for the past two reviews, too (with one exception in April 2016). Therefore, indicator 6 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	179	147	265	34			
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.	100%	2/2	2/2	1/1	1/1	2/2	1/1			

		9/9									
5	The individual posed an immediate and serious risk of harm to him/herself or others.	88% 7/8	2/2	2/2	0/1	1/1	2/2	N/A			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	1/1	1/1	N/A	1/1	2/2	N/A			
7	There was no injury to the individual as a result of implementation of the restraint.	78% 7/9	1/2	2/2	1/1	1/1	1/2	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	Not rated	0/1	Not rated	0/1	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.	78% 7/9	1/2	1/2	1/1	1/1	2/2	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	78% 7/9	2/2	2/2	0/1	1/1	2/2	0/1			

Comments:

The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #142, Individual #128, Individual #179, Individual #147, Individual #265, Individual #34). Of these, six were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was a protective mechanical restraint for self-injurious behavior. 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.

4. A modified restraint was used for Individual #142. All approvals were obtained and all protocols were followed.

5. For Individual #179 3/5/17, the restraint checklist/face to face form only reported aggression to staff with no description of what was occurring that posed imminent danger. While onsite, the Center described the incident as being due to severe self-injury. It turned out to be a misunderstanding of how to correctly enter this type of information into the IRIS system.

7. For Individual #142 7/7/17 and Individual #265 7/8/17, the restraint checklist item to indicate that the nurse checked for injury was blank.

9. Because criterion for indicator #2 was met for two of the individuals, this indicator was not scored for them. Criteria for this indicator were not met due to problems with all staff being trained in the PBSP (Individual #128), limited activities and engagement (Individual #128, Individual #147), absence of vocational assessments (Individual #265, Individual #34), and/or late psychiatric reviews or other medical assessments (Individual #265).

10. For the two crisis intervention chemical restraints (Individual #142 5/9/17, Individual #128 4/16/17), the required consultation with behavioral health services prior to administration was not done.

11. The ISP IRRF section was not properly completed for Individual #179 and Individual #34.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary: Performance improved greatly compared with the last two reviews. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	128	179	147	265	34			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	1/1	Not rated	1/1	1/1	Not rated	1/1			
Comments:												

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: Both indicators scored higher than during the last two reviews. Both will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	128	179	147	265	34			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	78% 7/9	1/2	2/2	1/1	1/1	2/2	0/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1			
Comments: 13. For Individual #142 7/7/17, the data/time of restraint monitor arrival was not recorded. Proper PMR-SIB documentation was not completed for Individual #34.												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: describing the circumstances surrounding the restraint in an IPN; providing detailed descriptions of individuals' mental status,	Individuals:

including specific comparisons to the individual's baseline; and clearly documenting injuries, and when necessary providing enough information to clarify whether or not the injury occurred prior to, during, or after the restraint, or stating if this cannot reasonably be determined. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	142	128	179	147	265				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	38% 3/8	0/2	1/2	1/1	0/1	1/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 2/8	0/2	1/2	0/1	0/1	1/2				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	38% 3/8	0/2	1/2	1/1	0/1	1/2				

Comments: The crisis intervention restraints reviewed included those for: Individual #142 on 5/9/17 at 5:25 p.m. (chemical), and 7/7/17 at 3:44 p.m.; Individual #128 on 4/16/17 at 7:19 p.m. (chemical), and 5/30/17 at 12:22 p.m.; Individual #179 on 3/5/17 at 12:42 p.m.; Individual #147 on 7/28/17 at 8:43 a.m.; and Individual #265 on 5/5/17 at 11:24 p.m., and 7/8/17 at 8:52 a.m.

a. through c. For the following restraint episodes, it was positive that nurses performed physical assessments, documented any restraint-related injuries or other negative health effects, and took action to meet the individual's needs: Individual #128 on 5/30/17 at 12:22 p.m., and Individual #265 on 7/8/17 at 8:52 a.m.

The following provide examples of problems noted for the other restraints:

- For Individual #142's chemical restraint on 5/9/17 at 5:25 p.m., no PCP order was submitted for the Ativan 2 milligrams (mg) intramuscular (IM). Also, there was no documentation addressing mental status for each of the nursing checks found in the IView documents provided. On a positive note, the nurse documented vital signs. The injury report provided was dated 5/7/17, which was two days prior to the restraint episode, for an injury that occurred during this episode. In addition, much of the IView documentation had information cut off of the pages. The IPN from the nurse on 5/9/17 at 8:20 p.m. provided a good description of the individual's behavior at the time of the physical restraint. However, the IPN indicated that the psychiatrist who was notified of the need for a chemical restraint would not accept the nurse's description of the individual's behaviors and asked to speak with the Behavioral Health Services (BHS) staff. The IPN indicated that the nurse informed the psychiatrist that the BHS staff was "currently performing the restraint and was currently being bit, hit, kicked, etc. so could not come to the phone." The note then indicated that the psychiatrist asked if the BHS requested a chemical restraint. The nurse noted she then sent another Registered Nurse (RN) to ask the BHS if she was requesting a chemical restraint. The IPN indicated that: "she [the BHS staff] again affirmed her request for a chemical restraint due to her difficulty in holding the individual and the fact that challenging behavior was NOT resolving. [The nurse] informed [the psychiatrist] of this, as well as the fact that 3 RNs also assessed the same need." It was unclear why the nurse who witnessed the behavior and would be the licensed professional responsible for accepting a verbal order from a physician as well as for administering the chemical restraint had to delay the emergency treatment to affirm the request from the BHS staff. In addition, the following response to the question "Way to

restrain safer/more effective" was of significant concern: "if there had been more staff to assist it could have helped." This called into question whether or not the staffing levels were sufficient. There was no documentation provided indicating that this statement regarding staffing was evaluated and addressed to determine if the restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.

- For Individual #142's physical restraint on 7/7/17 at 3:44 p.m., the documentation submitted did not include nursing IPNs, a PCP order, vital signs, mental status exams, or indication of injury. The documentation from IView provided had some of the information cut off of the pages.
- For Individual #128's chemical restraint on 4/16/17 at 7:19 p.m., the IPN, dated 4/16/17 at 9:45 p.m., did not indicate that the individual was off campus and was brought back to the Center in a police car due to behaviors while at a park. The nurse's IPN did not include information about the individual's time of return to the Center, the specific behaviors the individual exhibited, PCP notification for the chemical restraint, the specific time the chemical restraint of Ativan 2 mg IM was given, and/or the individual's level of cooperation while the nurse administered the IM injection. In addition, no mental status exams were documented for each check. On a positive note, the nurse did document vital signs. The nurse noted in the IPN a number of injuries (scratches), but did not indicate if these were a result of the restraint episode. The documentation from IView had much of the information cut off of the pages.
- The IPN for Individual #179's restraint on 3/5/17 at 12:42 p.m. provided a good description of injuries, but did not indicate if they were a result of the restraint episode. The documentation from IView had some of the information cut off of the pages.
- For Individual #147's physical restraint on 7/28/17 at 8:43 a.m., the IPN at 10:45 a.m. did not mention the restraint that occurred earlier that day or any injuries related to the restraint process. No mental status documentation was found. The documentation from IView showed monitoring of vital signs, but had some of the information cut off of the pages.
- For Individual #265 's physical restraint on 5/5/17 at 11:24 p.m., nursing checks were not initiated within 30 minutes. Although the nurse documented vital signs, no mental status was found. The IPN, dated 5/15/17 at 11:56 p.m., noted: "called to do a post restraint assessment." However, no specific information regarding the individual's behavior or the restraint was included. In addition, there was no indication if the blood that was noted at the individual's gum line with a loose tooth was a result of the restraint process.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Summary: One-third of the restraints were documented as required. Various errors in documenting nursing activities, supervision, and PMR-SIB were found in the other restraint documentation. Attention needs to be paid to this indicator. Perhaps an additional quality assurance check should be implemented. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	179	147	265	34			
15	Restraint was documented in compliance with Appendix A.	33% 3/9	0/2	1/2	1/1	1/1	0/2	0/1			

Comments:

15. Documentation requirements for six restraints were not complete as required by Appendix A.
    - Individual #142 5/9/17: The documentation did not name the nurse who administered the crisis intervention chemical restraint, observations were not conducted by the nurse as required, and the content of any observations was not as required.
    - Individual #142 7/7/17 and Individual #265 7/8/17: The restraint documentation did not indicate that the nurse checked for injury (though it was noted in the IPN for the incident).
    - Individual #128 4/16/17: Some, but not all, of the required nursing observation content was done.
    - Individual #265 5/15/17: An incorrect data entry was made regarding supervision during restraint application.
    - Individual #34 6/17/17 to 6/23/17: There were a number of errors and omissions in PMR-SIB documentation.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

Summary: Restraints were being reviewed, for the most part, which was good to see. Follow-up to recommendations, however, was not occurring for more than half of the restraint occurrences. Quality assurance regarding this aspect of the Center's restraint management program might be helpful. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	179	147	265	34			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	88% 7/8	2/2	2/2	1/1	0/1	2/2	N/A			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	57% 4/7	0/1	2/2	1/1	0/1	1/2	N/A			

Comments:

16. For Individual #147 7/28/17, post-restraint review should have detected that she did not have, but should have had, a PBSP and a CIP.

17. Recommendations made during restraint review were not implemented for one recommendation for Individual #142 5/9/17, development of a CIP for Individual #147 7/28/17, and dental issue for Individual #265 5/15/17.

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: Psychiatry follow-up after these incidents continues to be something that needs attention from the facility and psychiatry department. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	147							
47	The form Administration of Chemical Restraint: Consult and Review	Due to the Center's sustained performance, these indicators were moved to the									

	was scored for content and completion within 10 days post restraint.	category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.										
49	Psychiatry follow-up occurred following chemical restraint.	50% 1/2	0/1	1/1							

Comments:
49. There was clinical follow-up immediately following the chemical restraint in one of the two examples. Individual #128 was reviewed by psychiatry the day following the chemical restraint via an ISP meeting, thus, criteria were met. The psychiatrist, however, attended this meeting via telephone and that medication adjustments were made in the absence of a clinical assessment. In the case of Individual #142, she was seen in psychiatry clinic two days after receiving chemical restraints. Documentation from this clinical encounter did not mention the chemical 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 improved on ensuring that supports were in place to have reduced the likelihood of occurrence of the incidents. This was good to see and it included review of trends and putting plans in place for all but one individual. For individuals designated for streamlined investigations, attention needs to be paid to ensure that all of the DFPS and SSLC protocols are being followed.

Individuals:

#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	92% 11/12	2/2	3/3	1/1	1/1	2/2	1/1	0/1	1/1	

Comments:
The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, eight were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one unfounded, one administrative referral). Two of these were designated as a streamlined investigation. The other four were for facility investigations of serious injury, choking, law enforcement contact, and suicidal threat.

The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #142, UIR 17-172, DFPS 45211150, confirmed physical abuse allegation, 3/26/17
- Individual #142, UIR 17-282, DFPS 45355054, administrative referral of verbal abuse allegation, streamlined investigation, 7/2/17
- Individual #128, UIR 17-311, DFPS 45396852, unconfirmed verbal abuse allegation, 7/30/17

- Individual #128, UIR 17-141, DFPS 45172711, unconfirmed neglect allegation, 2/27/17
- Individual #128, UIR 17-192, encounter with law enforcement, 4/16/17
- Individual #146, UIR 17-322, DFPS 45405497, unfounded physical abuse allegation, streamlined investigation, 8/4/17
- Individual #179 (and Individual #146), UIR 17-224, DFPS 45273048, unconfirmed physical abuse allegation, 5/8/17
- Individual #147, UIR 17-232, DFPS 45292921, confirmed neglect allegation, 5/20/17
- Individual #147, UIR 17-269, suicide threat, 6/27/17
- Individual #265, UIR 17-173, DFPS 45214009, unconfirmed physical abuse allegation, 3/28/17
- Individual #34, UIR 17-245, discovered hip fracture, 6/7/17
- Individual #143, UIR 17-180, choking incident, 4/3/17

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

Eleven of the 12 investigations met criteria for the above four sub-indicators. Eight of the investigations were regarding allegations of staff conduct (i.e., abuse/neglect) and there were no related trends or prior occurrences, therefore, sub-indicators b, c, and d did not apply. The other four investigations were facility-only investigations and criteria were met for three of the four. In particular, trends were examined and protections were in place, such as PBSPs and PNMPs. Individual #34 UIR 17-245 did not meet criteria because the PNMP was not implemented as written at the time of the occurrence of the injury.

Individual #142, Individual #128, and Individual #146 were identified for streamlined investigations by DFPS. Some aspects of the SSLC protocol for IDT review and treatment/intervention planning, however, were not being conducted. One aspect that was being conducted was that, for each individual, the incident management department determined whether or not the alleged perpetrator should be placed on no contact status or, alternatively, 30-minute monitoring. Documentation regarding this decision-making was complete and documentation showing occurrence of 30-minute checks was provided.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
Summary: Performance improved to 100% from 58% at the last review. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	100% 12/12	2/2	3/3	1/1	1/1	2/2	1/1	1/1	1/1	
Comments:											

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: Continued attention is needed. Many staff could not correctly answer the Monitoring Team's questions about abuse, neglect, and incident reporting. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	0/1	Not rated	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.										
Comments: 3. Because indicator #1 was met for seven of the individuals, this indicator was not scored for them. The indicator was scored for the other individual and criteria were not met, that is, two staff members who worked with this individual were unable to correctly answer all of the Monitoring Team's relevant questions. Moreover, the Monitoring Team spoke with 15 various direct support professionals (DSP) staff during the onsite review week. Many of these staff did not correctly answer all of the Monitoring Team's questions about the reporting of allegations and incidents.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: Immediate actions were taken for all of the incidents in this set of investigations as well as for all of the three previous reviews, with one exception at the time of the last review. Therefore, this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12	2/2	3/3	1/1	1/1	2/2	1/1	1/1	1/1	
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: In all investigations for this review and the previous two reviews, too (with one exception in April 2016), staff cooperated with all investigations. Therefore, this indicator will be moved to the category of requiring less oversight			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
7	Facility staff cooperated with the investigation.	100% 12/12	2/2	3/3	1/1	1/1	2/2	1/1	1/1	1/1	
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: UIRs continued to be well written. Investigations, however, did not collect or analyze all relevant evident. This occurred for 25% of the investigations and, as a result, indicators 9 and 10 will be returned to active monitoring. Details are provided in the comments below.			Individuals:								
#	Indicator	Overall Score									
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. Due, however, to evidence collection and analysis not being collected or reviewed as per criteria, indicators 9 and 10 will be returned to active monitoring.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.										
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)										

Comments:

8. UIRS were, for the most part, organized logically and sequenced chronologically. They were comprehensive and contained the necessary and needed investigatory information.

9-10. Three investigations did not collect or analyze all relevant evidence (i.e., 25% of the investigations). Therefore, these two indicators will be returned to active monitoring.

- Individual #142 UIR 17-282: The alleged perpetrator was not interviewed by the facility.
- Individual #179 UIR 17-224: Video was not reviewed to confirm the individual's testimony.
- Individual #34 UIR 17-245: Staff involved in the transfer over the previous 24 hours should have been identified, interviewed, and asked to demonstrate how they typically implemented the transfer (evaluated by PNMP coordinators). This would contribute to making the determination that the injury (fracture) was more likely an accident rather than a lack of staff

competency.

Outcome 7– Investigations are conducted and reviewed as required.											
Summary: Both indicators showed improvement since the last review. That being said, more detail was needed when extraordinary circumstances were cited as the reason for investigation extensions. The Monitoring Team attended three IMRT meetings during the onsite week. There was good attendance, active participation, and substantive discussion. Attention to some of the missing aspects of the investigations selected for review by the Monitoring Team may result in improvement in performance and scoring. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	75% 9/12	1/2	2/3	1/1	1/1	1/2	1/1	1/1	1/1	
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.	50% 6/12	0/2	2/3	1/1	0/1	1/2	1/1	0/1	1/1	

Comments:

12. Three investigations did not meet criterion. One was Individual #128 UIR 17-311, which was completed on day 11. For the other two (Individual #142 UIR 17-172, Individual #147 UIR 17-232), the extension requests stated due to extraordinary circumstances, but a description of what the extraordinary circumstances were is necessary for the Monitoring Team to make a proper assessment.

13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late completion of investigations 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: The protections afforded by audits of injuries were not being done at Brenham SSLC as they had been done in the past. The Center said that this was due to changes in staffing and in the electronic record, but that it would be corrected and restarted immediately. Non-serious injury investigations, however, were being done as required and with sustained high performance, indicator 15 might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	146	179	147	265	34	143	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 5/5	1/1	N/A	N/A	1/1	N/A	1/1	1/1	1/1	
Comments: 14. Audits of injuries were not being conducted. The Center reported that this was due to staffing and electronic record changes. The Center staff stated that these would be started again immediately. 15. Non-serious injury investigations were conducted when they should have been conducted, and they were done correctly.											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary:			Individuals:								
#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										
Comments: 17. There were two investigations that included a confirmed physical abuse category 2. In both cases, the employment of the involved											

staff 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. There was no progress since the last review. A new QA director had recently been appointed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 19-23. There had been no progress in the collection of data, trends, and action plans as required by these indicators. A new QA director had recently been appointed and the Monitoring Team had the opportunity to review the criteria for these indicators with her during the onsite review week.											

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	0/1	N/A	N/A	0/1	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 two instances of the use of TIVA:

- Informed consent for the TIVA was present for Individual #142, but not for Individual #554;
- Nothing-by-mouth status was confirmed for Individual #142, but not for Individual #554;
- An operative note defined procedures and assessment completed for both individuals; and
- Post-operative vital sign flow sheets were submitted for both individuals, but for Individual #142, they were incomplete according to the requirements set forth in her ISPA.

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 this indicator.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
Comments: Informed consent was not provided for the pre-treatment medical sedation of Individual #473 on 7/26/17.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Performance remained about the same as at the last review. The actions required to meet criteria (and the intent) of this outcome and its indicators were not met. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142								
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/1	0/1								
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b)	100% 1/1	1/1								

	determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	100% 1/1	1/1								
4	Action plans were implemented.	0% 0/1	0/1								
5	If implemented, progress was monitored.	0% 0/1	0/1								
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1	0/1								
Comments: 1-5. According to the documentation provided, three of the nine individuals reviewed by the behavioral health Monitoring Team had received pretreatment sedation (PTS) over the previous 12-month period. Individual #146 and Individual #179 received sedation for emergency surgery, whereas Individual #142 was provided sedation prior to a dental exam and procedure. Therefore, only Individual #142 is reviewed for this indicator. In a QIDP monthly review, it was reported that PTS was required for dental work. There was no provision of other supports that could be provided in the future, review of this need in her ISP, nor was there evidence of guardian/LAR consent. Although a service objective had been identified in her IHCP, there was no evidence to indicate this had been implemented.										

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	120	186	61	403					
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	0/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across	0% 0/4	0/1	0/1	0/1	0/1					

	disciplines that require improvement.										
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 2/7/17, Individual #29 died at the age of 78 of unknown natural causes;
- On 4/7/17, Individual #120 died at the age of 44 of bleeding serosal erosions of the colon;
- On 4/24/17, Individual #186 died at the age of 60 of sudden cardiac death;
- On 5/1/17, Individual #61 died at the age of 54 of an acute cardiovascular accident;
- On 6/28/17, Individual #363 died at the age of 59 of probable pneumonia;
- On 7/5/17, Individual #184 died at the age of 51 of respiratory failure, pneumonia, and acute myeloid pneumonia;
- On 7/11/17, Individual #111 died at the age of 48 of cardiac arrest;
- On 7/17/17, Individual #403 died at the age of 66 of ischemic bowel disease, aspiration pneumonia, acute respiratory failure with hypoxia, and septic shock; and
- On 7/30/17, Individual #273 died at the age of 60 of aspiration pneumonia, and dysphagia.

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

- Overall, the nursing reviews of deaths were not sufficient to identify problems with nursing care that required remediation. For each death, the Center provided a Quality Improvement Death Review of Nursing that included the following areas: Place of Death; Manner of Death; Medical History/Chronic Diagnoses; Seizures; Hospitalizations/Emergency Room Visits/Consultations in the last six months; Acute Illness/Injury prior to death; Restraints prior to death; Medications; Review of Medical Record (at least six months prior to death) that consisted of boxes to be checked for areas such as Quarterly Medication Reviews and Acute Care Plans, Weights and Diet; a Narrative Section of events at least 72 hours prior to death and pertinent information from the medical record review, including observations notes, progress notes, physicians orders, vital signs, neuro checks; Autopsy; Conclusions; and Recommendations. The reports did not reflect comprehensive reviews of additional areas, such as risk areas, the quality and implementation of IHCPs, ISPs, ISPAs, implementation of Acute Care Plans, nursing assessments and documentation, and the IDT's response to issues.
- For Individual #120:
    - The last reported electrocardiogram (EKG) was completed on 7/26/13 (according to the submitted page of the annual medical assessment). The Death/Discharge summary indicated that EKGs were completed on 2/25/12, 7/26/13, and 2/15/17. The individual was prescribed an atypical antipsychotic, and it appeared that the frequency of monitoring was inconsistent (i.e., the Center policy should provide guidance consistent with current accepted standards regarding which monitoring tests and the frequency of those tests for individuals prescribed antipsychotics, etc.). However,

there was no information that there was discussion or review of the protocol for the frequency of EKGs in those prescribed antipsychotics, and/or guidance on how to proceed when an individual's behavior impeded his/her ability to cooperate with routine EKGs.
    - Additionally, the Pharmacy Department is supposed to play a key role in reviewing labs, such as EKGs, and alerting medical providers when they have not completed them. From the mortality information provided, it was not clear if the Committee reviewed this process, if alerts occurred, and how these alerts were interpreted.
    - The report of the nursing review of his death lacked a significant amount of specific information regarding Individual #120's health issues, including, for example, how many falls he had sustained over the past few weeks and how he had sustained "multiple subacute healing right lateral rib fractures" from x-rays obtained on 4/5/17 (died on 4/7/17), or reconcile this information with the autopsy results that did not show rib fractures.
- For Individual #186, a recommendation was included to complete an in-service for PCPs on those individuals to whom they should prescribe a statin according to national standards. This did not occur until a death occurred, at which time the Pharmacy Department generated a list of those that were eligible. The Pharmacy Department should be more proactive in reviewing national standards for medication use and determining individuals that meet criteria for specific medications for many chronic conditions for PCPs' consideration. However, the Committee did not further discuss or recommend that the Pharmacy focus on other medications beyond statins and their indications in prevention and treatment of specific conditions. In its comments on the draft report, the State disputed this finding, and stated: "The Clinical Pharmacist reviewed aspirin, ACE-inhibitors/ARBs, and statin use 5/23/17 (TX-BR-1710-WZ.06 pg. 364-368 of 921)." Individual #186 died on 4/24/17, and as the documentation showed the Pharmacy did not complete training until 5/23/17, which was after the death. The Monitoring Team's point was that the Medical and Pharmacy Departments should be more proactive in offering training to assist PCPs in keeping up with national standards on medication use. Additionally, the Pharmacy Department should conduct follow-up to determine if the information the Clinical Pharmacist shared had an impact on the PCPs' prescribing practices (e.g., labs ordered, individuals identified that would benefit from the medication and whether or not they were prescribed the medication, review of those on medications to determine appropriate dosage, etc.). As part of the mortality review follow-up, the Center did not submit any information regarding any follow-up to the DUE findings to ensure the PCPs had initiated treatment for other individuals that would benefit from statins. Evidence of an ongoing monitoring role by the Clinical Pharmacist was needed.
- For Individual #61:
    - A stroke is a diagnosis requiring rapid response, because there is a short window of a few hours for the administration of lifesaving interventions and prevention of neurological damage, requiring transfer to the Emergency Department (ED) as soon as this condition is suspected. Although the Committee recommended an in-service on stroke, it did not document discussion of a facility-wide and departmental-wide process to expedite individuals' transfer to the ED when a stroke is suspected.
    - The nursing review report noted that Individual #61 "has had several medical issues over the past few months." However, the report did not include any specific data addressing her medical issues or specific data regarding the 25 injuries she sustained in the past 12 months, three of which were serious injuries (two due to falls and one due to multiple fractured ribs as noted in the Center's investigation). The timing of these injuries should have been addressed in relation to signs/symptoms she experienced and if these injuries could have played a role in her CVA.
- Individual #403's causes of death were listed as ischemic bowel disease, aspiration pneumonia, acute respiratory failure, and septic shock.

- He had been receiving speech therapy and his diet had been upgraded. The Committee should have reviewed the process of upgrading his diet, including steps to ensure silent aspiration was not occurring, as well as to ensure that his behaviors of standing up while eating, and grabbing food did not impact the safety of the process.
- The nursing review did not address discrepancies between the number of times direct support professionals noted emesis (as noted in the Center's investigation) and nursing staff documented emesis in the IPNs.
- Although the report indicated that nursing staff implemented the Emesis guideline and documented "excellent assessments," there was no documentation included in the report to support this statement given that the IPNs that were included did not note nursing staff completed assessments prior to the individual's transfer to the ED.
- In addition, although the nursing report noted that the individual had been losing weight in the last year (from 158 pounds in August 2016 to 138 pounds in July 2017), there was no indication that that the IDT's response to this issue was assessed.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, the following recommendation resulted in in-service training: "The Nurses should receive education on the correct procedure to follow when the AED is removed from an individual. (The AED pads should be removed.) This training should be covered in the Nursing Competency Fair as well. All AEDs will be labeled with these instructions. This will be followed in the Emergency Response Committee meetings that are held after every CPR [cardiopulmonary resuscitation]." 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 all AEDs were labeled with instructions. In addition, no specific monitoring system was described to ensure that the Emergency Response Committee ensured the training was effective as demonstrated through emergency drills and actual emergencies.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 10 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, eight additional indicators in the areas of ISPs, psychiatry, behavioral health, dental, and OT/PT will move to the category of less oversight. One indicator in the area of behavioral health will return to active 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.

It was positive that the new QIDP Coordinator seemed to have a good handle on the priority needs of the QIDP Department.

Assessments

The IDTs did not consider what assessments the individuals needed and would be relevant to the development of individualized ISPs. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meetings. Lack of implementation and meaningful monitoring (i.e., analysis/discussion of status, actions taken, follow-up) of ISP action steps continued to be areas of significant concern.

Comprehensive Psychiatric Evaluations (CPEs) existed for all applicable individuals reviewed. Additional attention needs to be paid to the content requirements of CPEs and consistent diagnostics across the record. Performance continued to improve for psychiatry attendance at ISP meetings, however, there was steady decline in timely completion of annual updates.

Some individuals at Brenham SSLC needed, or likely needed, a PBSP, but did not have one. Functional assessment protocols and content needed improvement in quality in order to meet the generally accepted professional standard.

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

At the time of the last review, the indicator related to timely annual medical assessments was placed in the category requiring less oversight. However, some problems with timeliness were noted during this review. The Center should ensure this issue is corrected to prevent this indicator from returning to active oversight at the time of the next review.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Four of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate, as well as that all other required components of the assessments are consistently, accurately, and thoroughly completed.

A number of positives were noted with regard to dental exams and summaries. For all nine individuals, the Dental Department completed exams and summaries timely. As a result, two indicators will move to the category of less oversight. For seven of the nine individuals reviewed, dental exams included all of the necessary components. In addition, all nine individuals' dental summaries included the required elements.

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.

Referral to the Physical and Nutritional Management Team (PNMT) for one of three individuals was significantly delayed, and the falls that occurred in the intervening months placed her at significant risk. It is essential that referral to the PNMT occurs when individuals' increased risks warrant it. The Center also should focus on the involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments.

While maintaining the quality of the other elements of the Physical and Nutritional Management Plans (PNMPs), the Center is encouraged to correct the sections on risks and triggers. With this focus, the Center potentially could show significant improvement on the PNMP indicator at the time of the next review.

Timeliness of Occupational and Physical Therapy (OT/PT) assessments was sometimes still an issue. The quality of OT/PT assessments continues to be an area on which Center staff should focus.

Based on findings from this review and the last two, IDTs reviewed and made changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. The related indicator will move to less oversight.

A significant problem was individuals not receiving communication assessment updates when they had unmet communication needs. This negatively impacted the development of relevant communication goals/objectives. However, since the last review,

the communication assessments that were completed showed improvement. With some additional focus on specific areas, the Center could move forward in terms of the overall quality of the communication assessments.

Individualized Support Plans

Eight goal areas (out of 36 across the six individuals) had an individualized personal goal that met criteria. This was a slight decrease from the last review, when 10 met criteria. Brenham SSLC is the only Center, at this point, to have a decrease in performance across consecutive reviews. The handful of goals at Brenham SSLC that were individualized, were not written in a measurable manner and did not have sufficient implementation or data for progress to be determined.

Many personal goals were not aspirational, and instead might have been more appropriate as action plans toward a different, more aspirational, goal. The IDTs decided against establishing personal goals in some areas for two individuals without providing a sound rationale. For Outcome #3, performance remained as low as last time.

Brenham SSLC revised the ISP annually and developed ISPs for new admissions within the required timelines. On the other hand, implementation did not occur in a timely manner for any individuals.

In psychiatry, individualized diagnosis-specific personal goals need to be created that reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, and regarding positive pro-social behaviors. There was some progress along these lines in terms of discussions with the psychiatrists.

Positive Behavioral Support Plans (PBSPs) remained current for all individuals reviewed. Implementation within proper timelines and content of PBSPs remained at low performance. Several individuals had mental health needs that the IDTs and Behavioral Health Services Department staff were not equipped to fully assess and/or treat. Similarly, individuals did not have goals for their counseling programs.

Individuals did not have a sufficient number of skill acquisition programs, especially school-aged children. Many SAPs were not meaningful for the individual, and even fewer SAPs had reliable data, when compared to the last review.

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

ISPs

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

Summary: Establishing good individualized personal goals is the cornerstone of the ISP. Eight goal areas (out of 36 across the six individuals) had a personal goal that met criteria. This was a slight decrease from the last review, when 10 met criteria. Brenham SSLC is the only Center, at this point, to have a decrease in performance. That is, all other Centers have shown an increase in the number of areas that had a personal goal at criteria across subsequent monitoring reviews. Moreover, the handful of goals at Brenham SSLC that were individualized were not written in a measurable manner and did not have sufficient implementation or data for progress to be determined. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	179	146	522	167	25			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	1/6	0/6	2/6	2/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	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	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #142, Individual #146, Individual #179, Individual #522, Individual #167, Individual #25). 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. One of the individuals (Individual #142) had moved to another SSLC prior to the onsite monitoring visit; as a result, some indicators that rely on observation and personal interview are only scored for the other five individuals.

Since the previous review, the Center demonstrated some progress in timely completion of QIDP monthly reviews. Otherwise, the Monitoring Team did not identify significant progress during this visit regarding the development, implementation, monitoring, and revision of the ISPs.

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

1. During the last monitoring visit, the Monitoring Team found 10 personal goals met criterion. During the current site visit, eight

personal goals met criterion. Findings included:

- The eight personal goals that met criterion were leisure goals for Individual #142, Individual #179 and Individual #167; relationship goals for Individual #142, Individual #522, and Individual #167; and, living options goals for Individual #522 and Individual #25.
- Of the remaining personal goals, many were not aspirational, but may have been more appropriate as action plans toward a different, more aspirational, goal. For example, Individual #146 had an independence goal to make pancakes, but his self-described goal for the future was to live independently. Learning to independently prepare meals would require many skills, including planning nutritionally balanced meals, following recipes, shopping for ingredients, etc. Given Individual #146's abilities and desire for independent living, it would have been good to see the IDT define a more aspirational goal and then perhaps have the process of making pancakes as <u>one</u> action plan that integrated the skills described above. With this type of a more assertive approach, it would have been very likely that Individual #146 could have easily learned to prepare at least several meals over the course of a year.
- The IDTs also decided against establishing personal goals in some areas for two individuals without providing a sound rationale. For example:
    - For Individual #25, the IDT agreed goals were not needed for the areas of leisure/recreation and work/school/day program. In both instances, the IDT indicated that other areas needed to be worked on first, but did not provide a clear rationale for what those other areas might be. His other goals tended to be vague and did not demonstrate why they might preclude goals in these areas. For example, his relationship goal was to find a friend or form a relationship with someone in the community and his independence goal was to look nice and appropriate for the day.
    - For Individual #167, the IDT decided that a work/day program goal was not a priority. The rationale provided was that jobs she would enjoy were undetermined at the time.

2. Of the eight personal goals that met criterion for indicator 1, none met criterion for measurability. The Monitoring Team reviewed the personal goals and their underlying action plans in making this determination. Action plans typically did not lay out a path for achieving personal goals. For example, Individual #179 had a goal to obtain his driver's license, which was an aspirational goal, however, no action plans described steps for obtaining a driver's license, such as studying for a learner's permit or taking a driver's education course. The only related action plan was for him to continue a current budgeting skill acquisition plan (SAP) because, the IDT rationalized, he would someday need money to buy a car. The budgeting SAP did not address obtaining a license, and also did not really address buying a car.

3. For the eight personal goals that met criterion in indicator 1, none had reliable and valid data, due in part to lack of implementation.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: The 11 indicators of this outcome look at the entire set of action plans in the ISP. Performance remained as low as last time, with 0% scores for 10 of the 11	Individuals:

indicators (and 17% on the 11th). Details are provided in the comments below regarding each of these important aspects of the action plans (i.e., the specific supports the individual will receive). These indicators will remain in active monitoring.											
#	Indicator	Overall Score	142	179	146	522	167	25			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: As Brenham SSLC further develops more individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.											

8. This group of individuals did not have personal goals that met criterion in all areas, as described under indicator 1 above.
    - For the handful of areas that did have ISP personal goals (eight), the goals generally did not have a clear set of action plans that would serve as a road map for their ultimate achievement, as exampled by Individual #179 under indicator 2 above.
    - Some other goals did have a good set of action plans that had potential to lead to achievement, but had not been implemented or revised to help support those goals. For example, Individual #522 had a relationships goal to be an active member of his community church. The IDT did not specifically define active membership, but did have action plans that included monthly attendance, bible study with congregation monthly, and referral to chaplain to assist with organizing interactions. This set of action plans may have served to define what an active membership would look like. These action plans were essentially the same as those from last year, ones that had been largely ineffectual and they, too, had not been implemented regularly since his new ISP began.

9. None of six ISPs contained a set of action plans that clearly integrated preferences and opportunities for choice. Findings included:
    - The IDTs demonstrated some increased proficiency in developing action plans that integrated preferences. For example, for Individual #25, it was good to see that the IDT had developed action plans related to horseback riding, which he had enjoyed in his youth.
    - One good example of integrating opportunities for choice was a revision to Individual #25's SAP for putting on his shirt that included instruction for staff to offer him a choice of two shirts as a first step. Overall, though, action plans minimally integrated opportunities for day to day choice making. For example, for Individual #522 and Individual #25, the IDT did not focus attention on enhancing their ability to communicate and make choices.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making, even though both Individual #179 and Individual #146 possessed ample cognitive, reasoning, and language skills needed for higher-level decision-making skills.

11. None of six ISPs met criterion for this indicator.
    - There was a lack of emphasis on skill acquisition as a means toward enhanced independence. As one example, at least some IDTs seemed to have an understanding that because a widget had been added in CareTracker to document toothbrushing, SAPs in this area were no longer needed. Having a methodology to ensure toothbrushing is being accomplished does not obviate the need to provide individuals with formal training that increases their opportunities for greater independence. Other examples included:
        - Individual #167 had one SAP, to make mashed potatoes, and it had not been implemented.
        - For Individual #522, the IDT should have emphasized skill acquisition, particularly given his youth, but did not. He had two SAPs, for tying shoes and recognizing letters of his name. Both had been continued from his previous ISP, with little to no progress having been achieved. The IDT had not taken any assertive or creative actions to address the lack of progress. For example, they had not obtained an OT evaluation or consultation to assess why he might be having difficulty with tying his shoes. A self-administration of medication (SAMS) program would have been a good place to integrate name recognition on a daily basis, but he did not have one. His FSA identified additional needs in the areas of bathing and most personal care, street and warning signs, math, time-telling, and money management skills, which were not addressed.
        - Communication forms an important foundation for exercising independence, but the respective IDTs did not

assertively address communication needs for Individual #522, Individual #167, and Individual #25.

12. The IDTs did not assertively address risk areas in a consistent manner. Examples included:
- For Individual #522, the IDT rated his aspiration risk as low, but his Physical and Nutritional Management Plan (PNMP) included strategies related to what staff should do if he had food or liquid in his mouth at the time of a seizure. This would indicate that he did have an elevated risk in this area about which staff needed to be aware. This risk and related strategies were also not addressed in the Integrated Health Care Plan (IHCP).
- The IDT did not meet to update Individual #146's Integrated Risk Rating Form (IRRF) or IHCP in the area of skin integrity to address his ongoing risks related to basal cell carcinoma and skin graft.
- Individual #142's physical therapy (PT) assessment did not address what needed to be done about toe walking as it related to her elevated risk for falls.
- Individual #167 had experienced 32 falls since February 2017 and the IDT had not completed a thorough root cause analysis. She had irregular and fluctuating blood pressure that was possibly related to multiple medications and treatments. Neither the pharmacy nor medical staff were involved in the PNMT assessment of falls, despite the orthostatic hypertension as a potential cause for losing her balance. The most recent ISPA related to PNMT actions yielded three recommendations, none of which addressed possible medication issues.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated, also as described throughout this report. In addition to the examples provided in #11 and #12 above, other examples included:
- In the area of behavioral support needs, the Monitoring Team observed that some IDTs placed a greater emphasis on the use of restrictive approaches than on creating rich environments that offered substantial opportunities for ongoing positive reinforcement. For example:
    - Overall, Individual #146's IDT had failed to provide meaningful opportunities for leisure, work, or relationships. His IDT had also implemented a complete restriction for community outings and continued that restriction for more than a month without appropriately reviewing or obtaining ongoing Human Rights Committee (HRC) approval. When brought to attention by the Monitoring Team, the Lead QIDP indicated the IDT would begin to include this restriction in their monthly review. The IDT should have reviewed this restriction immediately, particularly because it had continued in place due to their own oversight.
    - Individual #146 was also receiving 24-hour 1:1 level of supervision, due to his self-injurious behavior. His IDT had defined a plan for reducing this restriction that required him to have zero incidents for 12 months before the team would begin to fade the supervision. It did not appear the IDT had carefully considered whether it was feasible to ask Individual #146 to forgo a behavior that may have been providing him with some form of reinforcement for a full year without receiving any contingent reinforcement as an alternative. This was particularly striking when compared to the fading plan Individual #179's team had in place for the same behavior, which was for the IDT to begin fading after two weeks without an incident.
- Also in the area of behavioral support needs, the Center had not identified the potential impact of post-traumatic stress disorder (PTSD) for Individual #167. Center staff reported she had sleep disturbance and often moved from her bedroom to the couch in the living area. This type of behavior can sometimes indicate that an individual lacks a sense of security and this

should at least be explored by the IDT. Individual #167's behavioral health assessment documented she engaged in inappropriate sexual behavior, which included stripping and then making statements that indicated she may have experienced sexual abuse prior to her admission. The likelihood that PTSD factored into her mental health diagnosis and behaviors needed to be examined and addressed.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these individuals, with few specific, measurable action plans for community participation that promoted any meaningful integration.

15. One of six ISPs (for Individual #179) considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Examples of those that did not meet criterion included:

- Individual #142 attended school, but the IDT never met to integrate her individualized education plan (IEP) with her ISP. When her educational services were curtailed to homebound programming for two partial days a week, the IDT did not complete any vocational or day program follow-up.
- Neither Individual #167 nor Individual #25 had vocational goals.

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. The IDTs did not place significant focus on skill acquisition and many action plans were not being implemented. Examples included:

- Individual #142 had one SAP, for logging money. Action plans for bike riding, sewing, and cooking had not been implemented or revised to ensure she had opportunities for functional engagement in the areas the IDT identified. Her ISP also did not identify opportunities to be engaged in vocational activity even though her school programming had been curtailed to Homebound services for 60 minutes twice a week.
- For Individual #167, no SAPs were being implemented, nor were action plans for joining a book club or cooking. She had been to the library once. When interviewed, day program staff indicated the goal was to keep her there as long as possible, which did not address any specific need.
- Individual #146 had a set of action plans for community art class, computer learning, resume development, library, cooking, and work that would have supported opportunities for functional engagement, but most of these plans had been unimplemented for a period of months without the IDT revising ensure functional engagement of sufficient frequency, duration, and intensity throughout the day to meet his personal goals and needs

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

- IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described in indicator 26. Both Individual #146 and Individual #179 needed, but did not have, individualized action plans to specifically address barriers to community living in a manner that would have allowed them to understand the nature of the barrier and the specific expectations/objectives they needed to meet.
- Individual #522 had been working on tying his shoes for more than a year and was still on step one. The IDT continued this goal at his annual ISP without considering what the barriers to progress might include.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often

missing key elements and data had not been demonstrated to be valid or reliable, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness.

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 just a small number of indicators and individuals. More work is needed to ensure that all of the activities occur 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	142	179	146	522	167	25			
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	0/1	0/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	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.	83% 5/6	0/1	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	0/1	0/1	1/1	0/1	1/1	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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two of six ISPs (Individual #179, Individual #167) included a description of the individual's preference for where to live and how that was determined.

20. None of the six individuals had an annual ISP meeting during this onsite visit, so this indicator was not scored.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members.
- Assessments that were present provided a statement of the opinion and recommendation of the respective team member. This was an indicator of progress, but current assessments by key staff members were sometimes not available at the time of the ISP. For example, the psychiatric assessments for Individual #142, Individual #146, and Individual #179 were not available at the time of their ISPs, but all had psychiatric barriers to community living.
- ISPs did not consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. The IRIS format often listed a series of identical statements stating a professional recommendation, but they were not attributed to any specific discipline. The Monitoring Team could not determine whether all disciplines had contributed or what specific recommendations they made.

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for five of six individuals. The only exception was for Individual #142, who's ISP identified an obstacle, but did not make a specific statement about the conclusion of the overall IDT.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. The ISPs did not reflect a robust discussion of available settings that might meet individuals' needs. For example:
- For Individual #25, all discipline assessments, except for nursing, indicated he could be served in the community and recommended it, but the IDT documented a determination that his needs could likely not be met in the community. The IDT stated this was due to his need for continuous use of the gait belt. The IDT did not document any discussion that evidenced they had explored community living options that might be able to meet this specific need.
- For Individual #522, the IDT did not document any discussion about alternative living options, even though the entire facility IDT recommended transition.

24. Two of six ISPs (Individual #146, Individual #167) 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. For the other four individuals, the IDTs did not include individual awareness as a formal barrier, even though the narrative made clear this was a need in each case.

25. None of the six individuals had an annual ISP meeting during this onsite visit, so this indicator was not scored.

26. None of six individuals had individualized, measurable action plans to address obstacles to referral. Examples included:
    - The action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes.
    - Individual #146 and Individual #179 both had behavioral/psychiatric obstacles listed. The IDTs did not quantify what behavioral/psychiatric thresholds would need to be met for community transition to be considered, information needed to develop a specific and measurable action plan.

27. None of the six individuals had an annual ISP meeting during this onsite visit, so this indicator was not scored.

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

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

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

Summary: Brenham SSLC revised the ISP annually and developed ISPs for new admissions within the required timelines. This was the case for all individuals for this review and the two previous reviews, too. Therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. On the other hand, implementation did not occur in a timely manner for any individuals and more attention needs to be paid to ensuring individual and IDT member participation. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	179	146	522	167	25			
30	The ISP was revised at least annually.	100% 4/4	N/A	N/A	1/1	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% 2/2	1/1	1/1	N/A	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).	20% 1/5	N/A	1/1	0/1	0/1	0/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/5	N/A	0/1	0/1	0/1	0/1	0/1			

Comments:
30. This indicator met criterion. Annual ISPs were developed on a timely basis.

31. Two of these individuals (Individual #142, Individual #146) had been newly admitted and the IDT held their ISPs on a timely basis. This indicator also met criterion.

32. ISPs were not consistently implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals. Many action plans in these ISPs were service objectives or simply statements that activities would occur, but the Center provided only a few service objective implementation plans other than those for enhanced level of supervision. The Center should evaluate whether the lack of formal plans with clearly stated and measurable methodologies contributed to the overall lack of implementation.

33. Individual #142 was not available to interview, so this indicator was not scored for her. Two of the other five individuals participated in their ISP meetings. Of those two, Individual #179 was knowledgeable of his ISP, but Individual #146 was not. The remaining three individuals did not attend their annual ISP meetings and were not able to participate in this kind of interview.

34. None of five individuals (excluding Individual #142) had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. This finding was based on attendance at the annual ISP meetings as well as interviews to evaluate staff knowledge.

- It was positive that four of the five individuals had appropriately constituted IDTs in attendance for their annual planning meetings. Only Individual #522 did not.
- Overall, QIDPs did not yet demonstrate knowledge of individuals' plans, particularly as it related to the current status of action plans as well as health and safety risks. It was positive that Individual #522 had a (relatively new) QIDP who was able to discuss his goals with some fluency. She was not yet consistently able to state the rationale for action plans, but when the Monitoring Team met with her the following day, she had already begun to strategize new approaches to personal goal development with a clear path of realistic and measurable action plans. This was encouraging and good to see.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Assessments are critically important for the development of the ISP, especially for the development of personal goals. Brenham SSLC's ISPs were missing many important assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	179	146	522	167	25			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	0% 0/4	N/A	N/A	0/1	0/1	0/1	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 none of four individuals. (The ISPs reviewed for Individual #142 and Individual #146 were initial plans, so ISP Preparation meeting were not held.) Examples of assessments the IDT should have asked for, based on the individuals' needs, included:

- The IDT did not request an OT/PT assessment for Individual #522, but should have. He had a PNMP as well as numerous learning needs in the area of activities of daily living per the Functional Skills Assessment (FSA). He had also been working on tying his shoes for more than one year with little progress, with no consult from OT or an annual OT/PT assessment.
- The IDT for Individual #167 did not ask for a communication assessment update or any clarification of a recommendation from the 2015 assessment that her overall potential to improve communication skills would be dependent on her willingness to participate in therapy. That previous assessment indicated she had high-level communication errors that would have benefited from intervention.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. In addition to the assessments not requested. Examples included:

- Several individuals had mental health needs the IDTs had not addressed as needed. For example, both Individual #146 and Individual #179 had expressed gender identity questions/desires, experienced depression, made suicidal statements and gestures, and engaged in frequent self-injury to their genitals. This constellation of issues and symptoms called for expert assessment, which had not been obtained.

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

Summary: Lack of implementation and meaningful monitoring (i.e., analysis/discussion of status, actions taken, follow-up) of ISP action steps continued to be of significant concern. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	179	146	522	167	25			
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, but it was a positive step that QIDPs had been completing monthly reviews regularly each month.

37-38. Even so, IDTs did not review and revise the ISPs as needed, which reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports. QIDP monthly reviews provided minimal analysis regarding progress or outstanding needs. Follow-up to identified concerns was generally haphazard or absent. Examples included:

- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. In some cases, these unimplemented plans had been continued from one ISP year to the next without identifying and addressing the barriers that prevented implementation. For example, for Individual #522, the IDT continued goals and action plans even though there had been no progress and minimal implementation.
- Individual #167 had frequent falls and these had not been assertively addressed by the IDT as detailed above.
- Individual #146's community restriction had been continued without the required review by the IDT.

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: 522	142	167	287	554	25	403	318	473
a.	The individual's risk rating is accurate.	17% 3/18	0/2	1/2	0/2	0/2	0/2	1/2	0/2	0/2	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.	44% 8/18	2/2	0/2	0/2	1/2	0/2	1/2	2/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #522 – infections, and cardiac disease; Individual #142 – weight, and infections; Individual #167 – falls, and urinary tract infections (UTIs); Individual #287 – seizures, and infections; Individual #554 – circulatory, and gastrointestinal (GI) problems; Individual #25 – choking, and falls; Individual #403 – cardiac disease, and skin integrity; Individual #318 – constipation/bowel obstruction, and infections; and Individual #473 – choking, and constipation/bowel obstruction].

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #142 – infections, Individual #25 – choking, and Individual #473 – choking.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #522 – infections, and cardiac disease; Individual #287 – infections; Individual #25 – choking, Individual #403 – cardiac disease, and skin integrity; Individual #318 – constipation/bowel obstruction; and Individual #473 – choking.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: This outcome requires that individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some progress along these lines. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
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 or to the absence of side effects related to psychotropic medications. 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 need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents, as well as be part of the QIDP's monthly review.

Discussions with psychiatric treatment providers at the facility and observation of psychiatry clinical encounters indicated that the psychiatrists were beginning to identify psychiatric target symptoms (i.e., indicators) for individuals. This was a start and good to see.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. These data consisted of lists of numbers of events that occurred in a particular month. There was no documentation of a discussion of what these data indicated.

There was documentation of the use of the ADAMS rating scale noted in some examples. Unfortunately, the ADAMS scores were not trended over time and, as such, could not be compared to prior scores. The use of the ADAMS was good to see, but trending the results over time would make these data useable. It was noted that the ADAMS was the primary psychiatric symptom indicator utilized at the facility. This instrument has limitations and may not be informative for all individuals. Other than the ADAMS data, most other data collected were not regarding psychiatric symptoms, but rather regarding specific behavioral challenges. These data were not useable for making decisions regarding the efficacy of the individual's psychotropic medication regimens.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs for newly admitted individuals were documented in the new electronic record, which did not follow the Appendix B format (indicator 13). This was the case for four of the nine individuals. This indicator will remain in less oversight, however, the formatting needs to meet the Appendix B requirement in order for this indicator to remain in active monitoring. Additional attention also needs to be paid to the IPN content requirements (indicator 15) and diagnostics across the record (indicator 16). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	1/1	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.	17% 1/6	1/1	0/1	N/A	0/1	0/1	0/1	N/A	N/A	0/1
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.	44% 4/9	0/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1

Comments:

13. Four evaluations were not in Appendix B format. These four evaluations, regarding Individual #142, Individual #128, Individual #146, and Individual #147, were completed in IRIS. These four evaluations differed from the other examples at this facility in that they did not include the same volume of information. This is an area where the psychiatrists may want to consult with other psychiatrists in the system to determine how others are managing to include the required information in the IRIS format.

14. The Monitoring Team looks for 14 components in the CPE. One of the evaluations, regarding Individual #179, addressed all of the required elements. The other eight evaluations were missing anywhere from one to three elements. The most common deficiency was

the bio-psycho-social formulation.

15. For the six individuals admitted since 1/1/14, five had a CPE completed within the first 30 days of admission. Individual #142 had a CPE completed within the first 30 days of admission. There was also an IPN from nursing and primary care written within the first business day after she was admitted to the facility. Individual #179 was admitted to the facility on 3/31/14, but the CPE was not completed until 10/22/14. While the remaining four individuals had a CPE completed within 30 days of admission, the IPN from nursing and/or primary care was not located for review in the records of Individual #128, Individual #146, Individual #147, and Individual #522. In all five examples, however, there was an IPN documenting an admission note from psychiatry on the date of admission. This was good to see.

16. There were five individuals whose documentation revealed inconsistent diagnoses, Individual #142, Individual #128, Individual #146, Individual #147, and Individual #522.

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

Summary: Performance continued to improve for psychiatry attendance at ISP meetings, however, there was steady decline in timely completion of annual updates (indicator 17). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
17	Status and treatment document was updated within past 12 months.	60% 3/5	N/A	N/A	0/1	N/A	1/1	N/A	1/1	0/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/5	N/A	N/A	0/1	N/A	0/1	N/A	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	56% 5/9	1/1	1/1	0/1	1/1	0/1	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. Five individuals required annual evaluations. Three were completed. The last annual assessment regarding Individual #265 was dated 10/5/16. The last annual assessment regarding Individual #205 was dated 8/25/16. Per a discussion with the psychiatrists, they scheduled the annual evaluations in conjunction with the annual ISP; as such, they were not always completed in a timely manner.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. None of the evaluations met full criteria. The most common deficiencies in the annual evaluations were regarding the combined behavioral health review/formulation, risk of medication, risk of illness, and the risk/benefit discussion. The facility psychiatrists were developing psychiatric medication treatment plans as a

separate document. Some of the risk/benefit information was included in these documents. Another common area of deficiency was the symptoms of diagnosis, that is, the symptoms that the individual was experiencing indicating that he or she met the diagnostic criteria were not clearly stated.

20. The psychiatric clinician attended the ISP meeting in five of the cases.

21. Review of the ISP documents indicated that there was a need for improvement with regard to the consistent 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: Two PSPs were reviewed. One indicated the need for a PBSP almost six months prior, and the other needed more detail regarding data/measures. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

Comments:
22. Two PSP examples were reviewed. Although Individual #147 had a PSP, the IDT recommended a PBSP in April 2017. Interestingly, the purpose section of her PSP indicated the need to transition to a PBSP. At the time of the monitoring visit, this had not occurred. The PSP regarding Individual #167 had some positive points. For example, baseline data were included and there were multiple interventions included for staff. The issue with this PSP was that the instructions for staff with regard to documenting data were lacking. Staff were instructed to utilize the ADAMS as the sole measure of her psychiatric status, which as discussed in other areas of this report, is limiting and may not be useful for all individuals.

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

Summary: Indicators 29 and 32 sustained high performance over this and the previous two reviews and, therefore, these two indicators will be moved to the category of requiring less oversight. With sustained high performance, indicator 28 might be moved to this category after the next review. On the other hand, the content of the consents showed no improvement since the last review, remaining at 0%. These three indicators (28, 30, 31) will remain in active monitoring.

#	Indicator	Overall	Individuals: 142	128	205	146	179	147	276	265	522

		Score									
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	1/1	1/1	0/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or 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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28. The consent forms for Individual #205 expired 8/26/17.

29. The facility consent forms generally contained adequate medication side effect information.

30-31. The risk versus benefit discussion was not included in the consent forms. For non-pharmacological alternatives, the consent forms did not include individualized alternatives.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Some individuals at Brenham SSLC needed, or likely needed, a PBSP, but did not have one. This is indicator 1 and was in less oversight. The Center needs to attend to this or this indicator may be moved back to active monitoring after the next review. Similarly, individuals did not have goals for their counseling programs. This is part of indicator 2 and also needs to show improvement or this indicator may also be moved back to active monitoring after the next review. Goals that did exist were not written in a way to make them measurable and, furthermore, reliable data were not being obtained. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
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	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

	PBSP.										
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
4	The goals/objectives were based upon the individual's assessments.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:

1. Eight of the nine individuals reviewed by the behavioral health Monitoring Team had a Positive Behavior Support Plan (PBSP). The exception was Individual #147 who had a Psychiatric Support Plan. This was concerning because her IDT had indicated since April 2017 that a PBSP should be developed due to observed behavioral difficulties. She had also experienced repeated restraint. Of the six individuals reviewed by the physical health Monitoring Team, one, Individual #25, had a PBSP. After meeting the other five individuals and talking with staff, the Monitoring Team recommends that the facility staff consider developing a PBSP for Individual #167 whose PSP noted that she exhibited pica behavior and whose recent behavioral health assessment noted she hit furniture/glass/objects, and hit and kicked staff. She also refused to attend work while the Monitoring Team visited her home.

Not every I-Book included a current PBSP: Individual #205's plan was dated 8/11/16; there was no PBSP in either Individual #146's or Individual #522's book; the plan in Individual #179's book was not dated; Individual #276's book contained a two page PBSP from 2017; and Individual #265's book included a two page PBSP that was not dated, along with a BAIP from 12/1/15.

While not identified for review, there were two individuals observed during the visit about whom the Monitoring Team would like to provide some comments.

- The first was Individual #76 who was observed in his day program. He was seated with his legs up in his wheelchair. He was not wearing either his shirt or shoes and socks. When a staff member was asked about this, she informed the Monitoring Team that he often disrobed and they're lucky when he kept his shorts on. A review of his PBSP indicated that he should be prompted to put on his clothing, but this was clearly not being done. Further, there appeared to be an acceptance of this condition.
- Later in the week, the Monitoring Team entered a home to find Individual #533 naked by the front door. Although a screen had been placed around him, he was visible to anyone who entered the home. There was no staff member present until the Monitoring Team walked further into the home. It did not appear that efforts were being made to help him redress because the staff member went back into another room after answering the Monitoring Team's questions. Again, this situation appeared to be accepted by staff in his environment. A review of his PBSP indicated that staff should seek assistance from the BHS department after repeated requests for him to get dressed, but it was unclear if this was pursued.

2. Of the eight individuals reviewed by the behavioral health Monitoring Team, five had goals related to their behavioral health needs.

The exceptions were Individual #146, Individual #265, and Individual #522, whose counseling plans did not include goals/objectives. Individual #179 was receiving community-based services, but the facility did not have a copy of his plan.

3. None of the objectives were considered measurable. In every case, the completion date of the objective was not specified. Further, for three individuals (Individual #179, Individual #265, Individual #522), the number of months in which criteria were to be met was not specified.

5. In every case, the data used to evaluate the individual's progress was determined to be unreliable. Data timeliness was not addressed and inter-observer agreement measures were not consistently detailed. One individual, Individual #276, was observed engaging in repeated self-injurious behavior (SIB) by the Monitoring Team. When her data were reviewed for the specific date and time, there was no evidence that these events had been recorded. When the director of behavioral services was asked to explain the data sheet, he indicated that the staff recorded the duration of episodes of SIB. Episodes, however, were not defined in her PBSP; a frequency count was the identified data collection system in both her plan and progress report graphs.

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

Summary: Functional assessment protocols and content needed improvement in quality in order to meet a generally accepted professional standard, as detailed in the comments below for indicator 12. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
10	The individual has a current, and complete annual behavioral health update.	50% 4/8	1/1	0/1	1/1	1/1	1/1	N/A	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
12	The functional assessment is complete.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:

10. All of the individuals had a current behavioral health assessment, but only four were considered complete (Individual #142, Individual #205, Individual #146, Individual #179). The others did not include a review of the individual's medical/physical health over the previous 12 months. Although Individual #142's was considered complete, some of the information was outdated because she was no longer a new admission having resided at the facility for six months, not one month as indicated.

11. All of the eight individuals had a current functional assessment.

12. None of the functional assessments were considered complete. Although most of the necessary components were present, these all lacked a clear summary statement based on the hypothesized antecedent and consequent conditions. Individual specific comments are provided below:

- Individual #142's assessment was based on one observation and two rating scales, all completed two to three days after her admission to the facility. Similarly, Individual #146's assessment was based on one observation about a month after his admission. No indirect assessments were completed. It is suggested that these should have been updated.
- Although Individual #128's IDT had recommended an updated assessment following her return from North Texas State Hospital, there was no evidence that this had been completed.
- Individual #205's assessment was based upon three, 10-minute observations, during which no target behaviors occurred.
- Individual #179's assessment included one older observation and multiple interviews with him. It is suggested that repeated current observations should have been conducted.
- Individual #265's assessment was based upon two observations completed via videotape. While this is an appropriate use of this technology, it is suggested that repeated observations should have occurred in both his home and school program.
- It was hypothesized that Individual #522's problem behaviors were maintained by attention. However, this was based on his observed distress when he was unable to call his mother. It is suggested that this may better represent a tangible function.

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

Summary: PBSPs remained current for all individuals for this review and the previous two reviews (with one exception in April 2016). Therefore, indicator 14 will be moved to the category of requiring less oversight. That being said, implementation within proper timelines and content of PBSPs remained at low performance. The Monitoring Team has provided a lot of detail regarding PBSP content below in the comments for indicator 15. These two indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
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	1/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1

Comments:

13. The facility provided a spreadsheet indicating dates of consent and plan implementation. Based on this information, the PBSP for Individual #128 was implemented within 14 days of all necessary consents/approvals. Four plans (Individual #205, Individual #146, Individual #179, Individual #265) were implemented before all consents/approvals had been obtained and two (Individual #276, Individual #522) were implemented one to two months after consents/approvals had been obtained. It appeared that the consent information provided for Individual #142 addressed the plan that was implemented upon her admission, because the Behavior Therapy Committee consent was from seven months later.

14. Although each of the eight individuals had a current PBSP, the dates provided for plan implementation did not correspond to the dates noted on the PBSP document that was provided. In two cases, Individual #128 and Individual #179, the discrepancy was only a few days. For all others, the dates differed by a month or more.

15. Although none of the PBSPs were complete, the majority of indicators were met. This included operational definitions of target and replacement behaviors, consequent strategies, a description of data-collection procedures, the training/reinforcement of functionally equivalent replacement behaviors, and treatment objectives. (Elsewhere in this report, concerns regarding these objectives are reviewed.) Elements that were missing from most plans included the use of positive reinforcement in a manner that is likely to be effective, and sufficient opportunities for replacement behaviors to occur/be trained. Half the plans were found to include adequate antecedent strategies. Individual specific feedback on PBSPs and strategies described in ISPAs is provided below.

- For several individuals (Individual #142, Individual #128, Individual #179, Individual #265) a token economy was mentioned in their plan. While this is potentially a very positive strategy, there was little to no information in the PBSP regarding token delivery and exchange. In Individual #179's case, his documents noted that he engaged in problem behavior more often on weekends and during the evening hours, but token exchange was restricted to weekdays at 4:00 pm. It had been suggested by the External Peer Review Meeting that more information regarding Individual #128's token program be included in her PBSP, but this had not occurred. Individual #146 had requested a token program, but this was not provided.
- An outing restriction had been approved by the HRC for Individual #128 "…until she can display appropriate interactions." This criterion is not operationally defined.
- Individual #205's plan included non-contingent reinforcement, but this was implemented for only two and one-half hours in the morning.
- It was noted that Individual #276 may display increased self-injurious behavior when she experienced pain or discomfort. There were no antecedents to address either of these issues.
- Identified antecedents for Individual #265's problem behaviors included medication pass and meals/snacks. There were no strategies in the plan to address these scheduled activities.
- There were several concerns regarding Individual #522's plan. He had restricted access to a radio/phone, tablet/DVD player, but this was last approved by HRC on 7/4/16. Regarding his phone restriction, when staff suggested that his problem behaviors often occurred following phone calls with his mother, it was suggested that, if data supported this conclusion, perhaps a stronger restriction could be implemented. There was no apparent discussion regarding other preventative strategies (e.g., providing access to a highly-preferred activity when he terminates the call without difficulty). Not all of the target behaviors identified in the PBSP were addressed with consequent strategies.
- Both Individual #146 and Individual #179 were expected to sleep with their hands on top of their covers. It was unclear how this was to be implemented and how it may interfere with their ability to get adequate sleep.
- Individual #128 was moved from her home to a vacant home for five days before she was admitted to North Texas State Hospital. Although the IDT met and HRC approved this move, the facility is cautioned regarding this strategy. If use of a respite home were to be available, a policy should be developed to ensure that all necessary procedures and supports are outlined.
- In general, many of the plans reviewed included restrictions. It was not always clear that these were reviewed and approved by HRC, nor were new restrictions or revisions to restrictions consistently updated in the individual's PBSP.

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

Summary: With the departure of the Center's on-campus counselor, counseling was assigned to BCBA/BHS staff. These staff, however, were not qualified to provide the type of counseling needed for these individuals. Therefore, indicator 24 will be returned to active monitoring. At the end of the onsite week, the director of behavioral health services reported that a counseling consultant had been identified. Indicator 25 will also remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, given that counseling was not being provided by a qualified professional (due to turnover at the Center), this indicator will be moved back to active monitoring.									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/5	N/A	0/1	N/A	0/1	0/1	N/A	N/A	0/1	0/1

Comments:

24. The IDT determined that five individuals (Individual #128, Individual #146, Individual #179, Individual #265, Individual #522) would benefit from counseling services. Because the on-campus counselor had resigned, only Individual #179 was participating in counseling with a community-based provider. As the director of behavioral health services explained, the individual's BCBA or BHS was providing informal counseling. It was not clear that these staff members were qualified to provide this service. For several individuals, behavioral concerns were quite significant. These included suicidal ideation, extremely harmful self-injury, and gender identity issues. It was suggested to the department director that qualified professionals should be recruited from nearby major city areas (e.g., Austin, Houston) if local providers cannot be identified. The last day of the visit, the director did inform the Monitoring Team that a limited contract had been approved for a consulting counseling provider.

25. Counseling plans were provided for four of the individuals. None of these plans were considered complete. Individual #128's plan included goal directed services and a data based criterion for review. This latter component was also found in the plan for Individual #522. The facility did not have the plan for Individual #179.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.	
Summary: Although Indicator b was moved to the category requiring less oversight,	Individuals:

in reviewing individuals' annual medical assessments for other purposes, the Monitoring Team noted that two of eight individuals' annual medical assessments were not timely, and for a third individual, the Center did not submit the previous annual medical assessment. If such issues are not corrected, then Indicator b might move back to active monitoring at the time of the next review. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active monitoring.											
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. However, due to problems noted with timeliness of some annual medical assessments, Indicator b is at risk of moving back to active monitoring.									
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.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: b. The following individuals' AMAs were not completed within 365 days of the prior AMA: Individual #167, and Individual #25, and the Center did not provide the previous AMA for Individual #403, despite a second request for the document while the Monitoring Team was on site. c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. Although four individuals had quarterly reviews completed, their IHCPs did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. For a few individuals (e.g., Individual #522, seizures for Individual #473, and infections for Individual #554), ISPs defined the frequency of review, but then PCPs did not conduct reviews at that frequency.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Center staff should continue to improve the quality of the medical assessments. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall	522	142	167	287	554	25	403	318	473

		Score									
a.	Individual receives quality AMA.	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

Comments: a. It was positive that four individuals' AMAs (i.e., Individual #142, Individual #554, Individual #403, and Individual #473) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, childhood illnesses, past medical histories, lists of medications with dosages at the time of the AMA, and updated active problem lists. Most, but not all included family history, complete interval histories, allergies or severe side effects of medications, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #522 – cardiac disease, and seizures; Individual #142 – weight, and other: pica behavior; Individual #167 – constipation/bowel obstruction, and cardiac disease; Individual #287 – cardiac disease, and urinary tract infections (UTIs); Individual #554 – infections, and aspiration; Individual #25 – aspiration, and osteoporosis; Individual #403 – skin integrity, and circulatory; Individual #318 – respiratory compromise, and UTIs; and Individual #473 – seizures, and UTIs].

As noted above, the ISPs/IHCPs reviewed often did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. For one of the two risk areas reviewed, Individual #473's ISP defined the frequency of review for seizures as quarterly, quarterly reviews were completed, and they were of sufficient quality.

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.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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	22% 4/18	2/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2

	pathways/guidelines.										
	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 #522 – cardiac disease, and seizures; Individual #142 – weight, and other: pica behavior; Individual #167 – constipation/bowel obstruction, and cardiac disease; Individual #287 – cardiac disease, and UTIs; Individual #554 – infections, and aspiration; Individual #25 – aspiration, and osteoporosis; Individual #403 – skin integrity, and circulatory; Individual #318 – respiratory compromise, and UTIs; and Individual #473 – seizures, and UTIs). None of their IHCPs sufficiently addressed the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations. b. As noted above, most of the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. The exceptions were the ISPs for cardiac disease and seizures for Individual #522, seizures for Individual #473, and infections for Individual #554.										

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 examinations (Round 9 – 100%, Round 10 – 89%, and Round 11 - 100%), Indicators a.i and a.ii will move to the category requiring less oversight. Over this review and the last one, improvement was noted with regard to the quality of dental exams and annual dental summaries. If the Center sustains its progress with the latter, Indicator c might move to the category requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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	1/1	N/A	N/A	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.	100% 8/8	1/1	N/A	1/1	1/1	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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	78% 7/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									

Comments: a. It was positive that all individuals reviewed had timely dental exams.

b. It also was good to see that seven individuals' dental exams included all of the required components. The remaining two included most of the components needed. Individual #287 did not have x-rays taken during this exam, and the exam document did not indicate when the last x-rays were completed. Individual #25's odontogram was incomplete, as it did not include one of his fillings.

c. On another positive note, all of the dental summaries reviewed included the necessary components.

Nursing

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

Summary: Due to an issue with IRIS, full physical assessments were not documented for a number of individuals (i.e., missing were fall assessments, weight graphs, Braden scores, and assessments of reproductive systems). The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. All of these indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
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	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	17% 2/12	N/A	0/2	0/2	0/2	1/2	0/1	0/1	1/1	0/1

Comments: a. The Center did not submit an admission comprehensive nursing review for Individual #142. Problems were noted for all of the remaining individuals reviewed with regard to a lack of complete annual physical assessments, including fall assessments, weight graphs, Braden scores, and assessments of reproductive systems. Similar problems were noted with quarterly physical assessments. This largely appeared to be due to issues with IRIS. The nurses on the Monitoring Team have discussed this issue with the State Office Nursing Discipline Lead, and work is underway to correct the issues.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #522 – infections, and cardiac disease; Individual #142 – weight, and infections; Individual #167 – falls, and UTIs; Individual #287 – seizures, and infections; Individual #554 – circulatory, and GI problems; Individual #25 – choking, and falls; Individual #403 – cardiac disease, and skin integrity; Individual #318 – constipation/bowel obstruction, and infections; and Individual #473 – choking, and constipation/bowel obstruction).

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.

c. Nurses completed nursing assessments consistent with relevant guidelines for Individual #318's infection on 6/6/17, and for Individual #554's episode of emesis on 3/4/17. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- Individual #142's weight report indicated that he lost a significant amount of weight from 6/30/17 to 7/31/17 (i.e., 240 pounds to 211 pounds). No nursing assessment was found addressing this weight loss, nor was an ISPA submitted addressing this issue.
- On 7/20/17, an IPN at 10:49 p.m. noted that Individual #167 fell against a dresser. The IPN did not include an assessment of the individual's status that was consistent with applicable guidelines, including vital signs, assessment of gait, dizziness, mental status, if the individual was wearing socks/shoes, or a description of environmental issues that could have caused her fall.
- On 7/16/17 at 4:59 p.m., an IPN indicated that Individual #167's urine was "yellow with sediments present and with strong odor." There was no indication that the nurse conducted an assessment or notified the PCP. A PCP IPN, dated 8/8/17 at 2:38 p.m., noted there was a presence of bacteria in a urinalysis collected on 8/3/17 at the Urology clinic. At that time, the PCP prescribed an antibiotic. There was no indication that the PCP was aware of the findings from the nurse's IPN a couple weeks earlier.
- No RN assessment was documented in the IPNs prior to Individual #287 transfer to the ED on 9/7/17 in relation to an IPN on 9/6/17 at 8:33 p.m. from an LVN noting the individual was leaning to the left, drooling with a blank stare, and would not

respond. The LVN's note indicated: "Called for the unit RN for a second opinion, she called PCP."

- IPNs documenting Individual #25's injuries did not include how they were discovered; if witnessed, how they occurred and details of what occurred, or if unwitnessed. On the following dates and times, injuries occurred without sufficient nursing assessments: 3/2/17 at 5:16 p.m., 3/2/17 at 8:46 p.m., 3/7/17 at 6:04 p.m., and 3/10/17 at 11:50 a.m. (notes indicated Individual #25 fell, but did not provide any details of where, when, how and who witnessed the fall), 4/23/17 at 12:47 p.m., 4/30/17 at 3:54 p.m., 5/24/15 at 2:00 p.m. (the PCP noted bruises, but no nursing IPN was found).
- On 3/10/17, an IPN noted Individual #403's sitting blood pressure was 105/56 and standing blood pressure was 88/54. No other nursing assessment was noted addressing dizziness, light-headedness, feeling faint, gait, tremors, pain, nausea, or blurred vision, especially since the individual was able to verbalize symptoms.

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 four 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: 522	142	167	287	554	25	403	318	473
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.	17% 3/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	2/2	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: b. The IHCPs that included preventative measures were for Individual #554 – circulatory, and Individual #318 for constipation – bowel obstruction, and infections.

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: The Center should focus on the timely referral of individuals to the PNMT, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT reviews and comprehensive assessments. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 1/3	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 1/3			0/1					0/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/2			0/1					0/1	N/A
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.	N/A			N/A					N/A	N/A
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% 0/2			0/1					N/A	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2			0/1					0/1	N/A
Comments: a. through d., and f. and g. For the three individuals that should have been referred to and/or reviewed by the PNMT:											

- Prior to referral to the PNMT on 7/25/17 for falls, Individual #167 fell a total of 24 times on the following dates: 2/27/17, 3/2/17, 3/5/17, 3/8/17, 3/14/17, 3/25/17, 3/27/17, 4/5/17, 4/6/17, 5/10/17, 5/17/17, 6/6/17, 6/9/17 (three falls), 6/10/17, 6/11/17, 6/13/17, 6/27/17, 7/3/17, 7/5/17, 7/14/17, 7/20/17, and 7/24/17. Waiting until Individual #167 technically met the criteria for referral of greater than three falls per month for two consecutive months was not a clinically sound decision, as it did not address the significant risk of injury that her drastic decline posed. After seven falls occurred over a four-week period of time, between 2/27/17 and 3/27/17, the IDT should have made a referral to the PNMT or the PNMT should have made a self-referral, and the PNMT should have at least conducted a review. As a result, Individual #167 did not have a timely referral or review and/or assessment to meet her needs. Behavioral Health Services staff and Pharmacy Department staff did not participate in the assessment meeting. Given that the PNMT identified her nighttime behavior and potential medication side effects as potential root causes, their participation was warranted.
- On 4/18/17, staff identified a Stage IV pressure ulcer on Individual #318's right ischial tuberosity (i.e., "sit bones"). Based on the documents provided, the Monitoring Team had difficulty identifying the actual referral date to the PNMT, but it appeared self-referral occurred on 5/9/17. The PNMT IPN, dated 5/9/17, indicated the IDT had not met to address the pressure ulcer. This delay in referral resulted in a delayed PNMT review and assessment.
- On 3/10/17, the PNMT conducted a review of weight gain of 10.7% in six months for Individual #473. The review did not include the required components. It included only the active problem list, and her weights over the previous six months, along with a statement that the weight was appreciated/desired.

h. The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- For Individual #167, as noted above, given that the PNMT identified her nighttime behavior and potential medication side effects as potential root causes, the lack of involvement of Behavioral Health Services staff and Pharmacy Department staff resulted in incomplete information and expertise in the analysis of related data, as well as likely an incomplete set of recommendations. The PNMT essentially reiterated the IDT's recommendations, but did not provide an analysis of data to demonstrate the efficacy of the recommendations (i.e., proof of what was working, or what was not working).
- For Individual #318, the PNMT included information from previous assessments, but did not make clear if, when, and where the PNMT conducted assessments and/or observed the individual. For example, the assessment referenced a head-of-bed elevation evaluation (HOBE) conducted in 2013, but did not indicate whether the PNMT reassessed positioning, particularly as it related to skin breakdown. The assessment also did not discuss medications' potential impact on the problem.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. While maintaining the quality of the other elements of the PNMPs, the Center is encouraged to correct the sections on risks and triggers. With this focus, the Center potentially could show significant improvement on the PNMP indicator at the time of the next review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473

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.	13% 1/8	0/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/10	0/1	N/A	0/1	0/1	0/2	0/1	0/2	0/1	0/1
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 skin integrity for Individual #522; GI problems, and weight for Individual #142; choking, and falls for Individual #167; choking, and falls for Individual #287; aspiration, and choking for Individual #554; choking, and falls for Individual #25; aspiration, and choking for Individual #403; choking, and skin integrity for Individual #318; and choking, and weight for Individual #473.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. Individual #142 did not have a PNMP or Dining Plan. The remaining eight individuals reviewed had PNMPs and/or Dining Plans. The PNMP for Individual #287 included all of the necessary components to meet the individual's needs. The problems noted for the seven PNMPs that did not meet criteria all related to the identification of risk levels, and individual triggers, if applicable. For example, Individual #522's IDT did not identify his risk for aspiration in relation to his seizure disorder (i.e., his risk for aspiration was significant if he had a seizure while eating), and, therefore, it was not included on his PNMP. In its comments on the draft report, the State disputed this finding, requested a change in score, and stated: "The PNMP was updated with the seizure information on 01/12/17. TX-BR-1710-I-….04 (pg. 2-3 of 3)." The Lead Monitor reviewed the document the State cited, and confirmed that aspiration was not listed as a risk. The only risk listed was choking. For a number of individuals, PNMPs referred to "general triggers" without listing them, or simply said to notify the nurse if triggers occurred without listing or defining triggers. While maintaining the quality of the other elements of the PNMPs, the Center is encouraged to correct the sections on risks and triggers. With this focus, the Center potentially could show significant improvement on this indicator at the time of the next review.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for choking for Individual #167, and aspiration for Individual #403.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight. However, at the time of the next review, Indicator a might move to the category of less oversight if IDTs continue to clearly justify the need for enteral nutrition.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	100% 1/1					1/1			N/A	
Comments: a. and b. For both individuals with enteral nutrition that the Monitoring Team reviewed, the IDTs included clear justification in their IRRFs for continuation of its full or partial use (i.e., Individual #554 received most meals by mouth, but still received medications enterally). Individual #554's IDT recommended continuation of his progression along the continuum to oral intake, and developed a corresponding SAP to allow him greater independence in feeding himself.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Timeliness of assessments was sometimes still an issue. The quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	75% 6/8	0/1	N/A	0/1	1/1	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.	78% 7/9	0/1	1/1	0/1	1/1	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; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/3	N/A	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	17% 1/6	0/1	N/A	N/A	0/1	0/1	N/A	1/1	0/1	0/1
Comments: a. and b. Seven of the nine individuals had timely OT/PT assessments. The following concerns were noted: • Individual #522's last OT/PT assessment was completed in 2016, at the time of his admission. At a minimum, the OT/PT											

should have completed an update in 2017, because the individual had a PNMP that included modified strategies related to OT, as well as adaptive equipment. In addition, the 2016 assessment indicated that multiple side effects might be impacting his functioning, but the assessors were unable to determine this due to not being familiar with Individual #522. This should have been revisited.

In its comments on the draft report, the State disputed this finding and requested that the Monitor change all of the scores for Individual #522 to reflect compliance with the indicators a through e. As justification for this request, the State indicated: "This information was covered in the dysphagia assessment and this assessment was part of the original document request. The dysphagia assessment is no longer a part of the OT/PT assessment and is a stand-alone assessment. TX-BR-1710-II-...76 (pg. 2-9 of 9)." Upon re-review of information the Monitoring Team reviewed to make its initial findings, the scores remain the same as in the draft report. While adaptive equipment related to meals was reviewed within the dysphagia assessment, his level of functioning identified in the 2016 assessment did not reflect the Monitoring Team's observations and was inconsistent with the functional deficits identified as part of the Functional Skills Assessment (FSA), dated 5/30/17. Further OT/PT assessment was and is warranted.

- Beginning in approximately March 2017, Individual #167 had a decline in ambulation resulting in an increase in falls. No evidence was found of an OT/PT assessment/consult in response to the increase in falls until 6/16/17, and then again in July 2017. Consults were fairly focused and narrow in scope, focusing largely on gait, and did not explore other areas that might have been causing the problem, including, for example, medication review and analysis, and a thorough shoe assessment beyond assessment of the ones she was wearing during the evaluation.

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

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: The assessors did not discuss whether or not medication side effects were potentially impacting an OT/PT problem(s);
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: Two 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: Recommendations that should have been made to address individuals' needs were not, and, as noted above, clinical justification for not making such recommendations was not provided.

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

- 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;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard

components do not require a rationale);

- 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; and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

e. It was positive that Individual #403's update included all of the required components, and addressed his strengths and needs, and incorporated his preferences. As noted above, Individual #522 should have had an update, but did not. The following summaries the requirements and some examples of concerns noted with regard to the OT/PT updates reviewed:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: The updates did not discuss the impact of medications on OT/PT supports, and/or failed to identify whether or not the individual experienced potential side effects;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living (ADLs) with examples of how these skills are utilized throughout the day: About half of the updates provided little information about the individuals' strengths and needs in relation to ADLs;
- 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: One of the assessments was missing a comparative analysis;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Most updates did not review monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services: Because individuals often did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, justification was not provided for not developing OT/PT supports to address identified needs. At times, because the underlying cause of the issues was not identified, it was unclear whether or not the individual needed more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Most updates did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exceptions were for Individual #287, and Individual #403. However, it is important to note that consultations that identified a loss in balance for Individual #403 did not provide a clear justification for why direct therapy was not an option.

On a positive note, as applicable, all of the updates reviewed provided:

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

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: Given that over the last two review periods and during this review, IDTs reviewed and made changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually (Round 10 – 78%, Round 11 – 100%, and Round 12 - 100%), Indicator b will move to the category requiring less oversight. Although it was positive to see that IDT addressed the recommendations included in the OT/PT assessments, as discussed above, recommendations often were missing from the assessments and updates. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 8/8	1/1	N/A	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.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	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.	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A
Comments: c. and d. Although it was positive to see that IDT addressed the recommendations included in the OT/PT assessments, as discussed above, recommendations often were missing from the assessments and updates.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: A significant problem was individuals not receiving communication assessment updates when they had unmet communication needs. This negatively impacted the development of relevant communication goals/objectives. Since the last review, the communication assessments that were completed showed improvement. With some additional focus on specific areas, the Center could move	Individuals:

forward in terms of the overall quality of the communication assessments. These indicators will remain in active oversight.											
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	38% 3/8	0/1	N/A	0/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/3	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1
d.	Individual receives quality Comprehensive Assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	13% 1/8	0/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1	0/1

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

- Individual #167's last communication assessment was completed in 2015. According to the assessment, Individual #167 had many communication deficits that could have been the focus of therapy or a SAP, such as in the areas of topic maintenance, ability to follow instructions, and active listening. However, there had been no goals/objectives developed and/or reassessment.
- Similar problems were noted for:
    - Individual #522's screening showed communication issues that should have triggered an assessment/update to help determine methods to improve communication through AAC and meaningful SAPs.
    - Individual #403 only had a screening, but the previous assessment in 2014 identified multiple areas that could have been the focal point of therapy or a SAP.
    - Individual #318's last assessment in 2015 showed declines in multiple areas in comparison from the previous assessment, but offered no recommendations for therapy or SAPs. In its comments on the draft report, the State disputed this finding, and stated: "Individual #318 had a comprehensive communication assessment in 2015 which clearly notes reason for decline being related to a health decline, not a communication decline. This assessment gives a poor prognosis and clearly states that there are no recommendations for communication therapy or programming. There are no indications for an updated assessment due to the fact that her decline was related to health and not communication. TX-BR-1710-II-...80 (pg. 2 -8 of 8)." Although it is accurate that the assessment stated that the decrease in communication skills were believed to be related to a decline in health, the assessor did not sufficiently justify why supports or programming would not be beneficial to maintain language in the face of declining health. Statements such as "it is unlikely that she would develop understanding of and participation in simple cause-effect" should be supported by data outside of a single event, which in this case was the evaluation. Making determinations based upon a single point of data at a single moment in time is not enough to justify not providing or attempting to provide services.
    - Individual #473 most recently had only a screening, but the assessment in 2016 identified multiple areas for improvement, including, for example, her ability to follow directions, object identification, and understanding spoken language and the use of natural gestures.

c. Some of the problems noted with regard to communication screenings included:

- A lack of review or investigation related to AAC options;
- Screenings that largely consisted of the statement: "no changes," without a description of the evidence or observations that led to these determinations;
- Review of medications, and listing of possible side effects without discussion of whether or not the individual appeared to experience the side effects; and
- Lack of a recommendation for additional assessment, when the screening identified communication deficits that would have benefited from therapy or implementation of a SAP.

d. It was positive that Individual #142's assessment comprehensively addressed her communication strengths and needs, and

incorporated her preferences.

e. It was positive that Individual #287's communication update included all of the necessary components, and sufficiently assessed her strengths and needs, and incorporated her preferences.

As noted above, Individual #167, Individual #522, Individual #403, Individual #318, and Individual #473 should have had updates completed, at a minimum, but did not.

For Individual #554, the assessment included most of the necessary information. However, the goal/objective included in the recommendation section was not measurable, because it attempted to measure multiple activities (e.g., moving to the door, pushing a switch). In addition, the individual had a history of not self-propelling his wheelchair, but the goal focused on this activity. It was unclear whether or not the SLP considered other options, such as an AAC device attached to his chair.

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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.	100% 9/9	1/1	1/1	1/1	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.	13% 1/8	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. It was good to see that for all nine individuals reviewed, IDTs included complete functional descriptions of their communication skills in their ISPs.

b. Individual #142 had communication strategies outlined in her communication assessment, but did not have either a Communication Dictionary or a PNMP. Without either, these strategies were unavailable to staff working with her. Similarly, Individual #522's

communication was difficult for unfamiliar listeners to interpret, so he should have had a communication dictionary, but did not. In its response to the draft report, the State disputed this finding, requested a change of score for Individual #522 and Individual #318, and stated the following: "Both the ISP documents for #318 & #522 show "yes" for approval of plan related to communication dictionaries. The communication dictionaries were updated with current dates and information. TX-BR-1710-II-[Individual #318].01 (pg. 10-11 of 35), TX-BR-1710-II-[Individual #554].01 (pg.11-12 of 42)." Neither of the documents the State cited were related to Individual #522. Moreover, the Center's response to Document Request #87 for Individual #522, which asked for the Communication Dictionary, stated: "N/A." With regard to Individual #318 and Individual #554 (if this is whom the State was actually referring), the Lead Monitor reviewed the referenced pages in their ISPs. As indicated in the Monitors' draft report: For other individuals, simply including a stock statement such as "Team reviewed and approved communication strategies" or "Communication Dictionary… Approved: Yes" did not provide evidence of what the IDT reviewed, revised, and/or approved.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Summary: There was no improvement in individuals' goals/objectives for skill acquisition. Same as last time, not all individuals had sufficient number of SAPs, especially school aged children, many SAPs were not meaningful for the individual, and even fewer SAPs had reliable data compared to the last review. These five indicators require attention from the IDTs and QIDPs and all will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
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% 21/21	1/1	3/3	3/3	3/3	2/2	1/1	3/3	3/3	2/2
3	The individual's SAPs were based on assessment results.	48% 10/21	0/1	1/3	2/3	1/3	0/2	0/1	3/3	1/3	2/2
4	SAPs are practical, functional, and meaningful.	52% 11/21	0/1	0/3	3/3	2/3	2/2	0/1	3/3	0/3	1/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/21	0/1	0/3	0/3	0/3	0/2	0/1	0/3	0/3	0/2

Comments:

1. All of the individuals had at least one skill acquisition plan (SAP). Of the five school-aged individuals who were reviewed, however, three had only one (Individual #142, Individual #147) or two (Individual #522) SAPs. A total of 21 SAPs were reviewed.

2. All 21 SAPs were measurable. Even so, staff are advised to ensure that the verbs used in the objective match the skill described. Examples where this wasn't the case included Individual #179's budgeting, Individual #265's food safety, and Individual #522's letters of the alphabet.

3. Ten of the 21 SAPs were based on assessments. Exceptions included skills that had been identified as mastered in the individual's functional skills assessment (e.g., Individual #128 - wash hair, Individual #146 - floss teeth, Individual #147 - wash clothing, Individual #265 - street crossing) or the individual had the skills needed to complete the task (e.g., Individual #142 - log money, Individual #128 - make jewelry, Individual #179 - budgeting and making a schedule). In other cases, the skill wasn't assessed due to the lack of materials (Individual #146 - make pancakes) or the lack of a completed assessment (Individual #205 - replace the shredder bag).

4. Eleven of the SAPs were considered practical, functional, and/or meaningful. The others were not because those skills had been identified as mastered and, in addition, also included the following: Individual #128 was to learn to tell time using an analog clock/watch, but she was already able to tell time digitally; Individual #265 was to learn to categorize photos of safe and unsafe kitchen practices, but this would be better addressed by teaching him to cook, an area of expressed interest; and Individual #522 was to learn to verbally identify letters, but he could identify his name and would be better served by learning to read sight words.

5. None of the 21 SAPs had reliable and valid data. While there was evidence that SAP monitoring had occurred for seven SAPs, there was no indication that this was completed by observing SAP implementation and recording of the individual's performance.

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: Performance decreased since the last review. These indicators will remain in active monitoring. Assessments are important for guiding the selection of skills for skill acquisition programming.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
10	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

10. Six of the nine individuals had assessments that were current. The exceptions were Individual #142, Individual #205, and Individual #276, none of whom had a vocational assessment.

11. For four of the individuals (Individual #179, Individual #276, Individual #265, Individual #522), their assessments were available to the IDT at least 10 days prior to the ISP meeting.

12. The assessments for four individuals (Individual #142, Individual #205, Individual #276, Individual #265) included SAP recommendations. Even so, these recommendations were often quite limited in number and scope although the FSA, in particular, assesses a wide range of skill domains.

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 related to the provision of clinical services. At the time of the last review, 13 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators in the areas of psychiatry, dental, and OT/PT will move to the category of less oversight, which places the entirety of Outcome #1 for psychiatry in less oversight. Two indicators in the area of behavioral health will return to active 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 Facility had 2.5 full-time equivalent (FTE) staff psychiatrists. As such, there was no longer a need for reliance on contract or locum tenens providers. This should allow for the development of stability in the doctor-patient relationship and in the consistent provision of psychiatric services.

The Facility had a number of school-aged children who received psychiatric services, but none of the current providers were trained in child and adolescent psychiatry. Thus, there was a strong need to access consultation with a provider in the community or a child psychiatry provider within the SSLC or HHSC system.

There were six Board Certified Behavior Analysist (BCBAs) at Brenham SSLC, including the Director of Behavioral Health Services. All of the other Behavior Health Specialists were either enrolled in coursework, obtaining supervision, or preparing to take the exam.

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

In psychiatry, without measurable goals and objectives, progress could not be determined. However, 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 (though there was one exception with a delay in development of a PBSP).

In behavioral health, without reliable data, it was impossible to assess progress. For half of the individuals, if the Facility staff determined no progress or regression, actions were proposed. And for those, half were implemented.

Acute Illnesses/Occurrences

Based on information the State provided, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

With regard to medical treatment for individuals with acute illnesses/occurrences, some of the areas on which the Center should continue to focus include: 1) for individuals transferred after hours, Primary Care Practitioners (PCPs) need to summarize the events leading up to the transfer and results within one business day; 2) when individuals are transferred to the hospital, the PCP or a nurse should communicate necessary clinical information with hospital staff; and 3) IDTs should hold ISPA meetings and identify follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.

For the two applicable individuals, when dental emergencies occurred, the Dentist saw the individuals within 24 hours, which was good to see. Neither required treatment or pain management.

The protections and protocols required when crisis intervention restraint has occurred frequently for an individual were not implemented for all individuals and for all occurrences.

Implementation of Plans

Reiss screens were being conducted as required for all individuals. There were noticeable improvements in the collaboration between psychiatry and behavioral health services, and in the conduct of joint neuropsychiatry clinics.

The conduct of quarterly psychiatric clinics continued to slide, to 44% at this review. Quarterly review documentation did not contain all of the required components, however, it was good to see that psychiatric clinics, when observed, met criteria. There were delays in the review of assessments of possible side effects of psychiatric medications by the prescribing practitioner.

Staff training on PBSPs was not occurring as it needed to occur.

Behavioral health services monthly reviews were occurring, but the progress notes did not comment on progress. Further, attention needs to be paid to making graphs useable, readable, and informative. Based upon the concerns with data timeliness and reliability, the data collections systems did not adequately measure either target or replacement behaviors.

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.

Much improvement is needed to ensure for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate.

Given the multiple concerns (i.e., five separate concerns for three of nine individuals reviewed, as well as concerns related to two individuals who died) identified with regard to a lack of guidance from the Pharmacy Department to the Medical Department and these concerns' impact on the clinical evaluation and treatment of the individuals at Brenham SSLC, the Medical Director is encouraged to require improvements in the Quarterly Drug Regimen Reviews (QDRRs), and seek the assistance of State Office, if necessary. Pharmacology consistent with current standards of care is a significant part of the medical treatment that the Center is required to provide the individuals it serves.

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 assigned to the PCPs that IDTs had included in IHCPs.

It was good to see some improvement with regard to PCPs writing IPNs related to consultations that were in accordance with State Office requirements. However, the Center needs to focus on ensuring PCPs complete timely reviews of consultation reports, and refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The Center should 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.

Over the past four reviews, the Monitoring Team has found a lack of clinical justification for the Do Not Resuscitate (DNR) Orders in place for individuals that is consistent with State Office policy. It is essential that Center staff review all individuals with a DNR Order in place, and for those individuals who do not meet the requirements of State Office policy, Center staff should take action to comply with the policy, and when appropriate, remove the DNR Orders from individuals' records.

The Dental Department sustained its high performance in relation to the provision of tooth brushing instructions to individuals and/or their staff, and the provision of fluoride treatment. As a result, two indicators will move to less oversight. Improvement was noted with regard to the Dental Department's development and implementation of treatment plans for individuals with periodontal disease. However, some regression was seen with regard to the Dental Department's provision of prophylactic care to individuals. If improvements do not occur, this indicator is at risk of returning to active monitoring.

Since the last review, the Center showed progress with regard to IDTs including suction tooth brushing service objectives in ISPs, staff implementing them, and the Dental Department conducing monitoring of quality and safety. Although some improvement was noted, QIDPs should include specific suction tooth brushing data and analysis of the data in their monthly integrated reviews.

Adaptive equipment was generally clean. Because this was a consistent finding for the past two reviews as well, the related indicator will move to the category of less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still numerous instances (49% of 45 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

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: These indicators provide important protections for individuals who have frequent applications of crisis intervention restraint. Performance on this set of indicators was about the same as last time, with some indicators scoring higher and some scoring lower. With attention paid to meeting the requirements of these indicators, it is likely that performance will improve. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	179	147	265				
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	0/1	1/1	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.	100% 5/5	1/1	1/1	1/1	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,	60% 3/5	0/1	1/1	1/1	0/1	1/1				

	2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.										
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/5	0/1	0/1	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?	20% 1/5	1/1	0/1	0/1	0/1	0/1				
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.	20% 1/5	0/1	0/1	0/1	0/1	1/1				
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	80% 4/5	1/1	1/1	1/1	0/1	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).	60% 3/5	1/1	0/1	1/1	0/1	1/1				
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A	N/A				
27	The crisis intervention plan was complete.	33% 1/3	0/1	N/A	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 80% treatment integrity.	100% 4/4	1/1	1/1	1/1	N/A	1/1				
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 2/4	1/1	0/1	1/1	N/A	0/1				

Comments:
18-19. Five individuals, Individual #142, Individual #128, Individual #179, Individual #147, and Individual #265 experienced crisis restraint more than three times in a rolling 30-day period. With the exception of Individual #128, there was evidence that the individual's IDT met within 10 business days of the fourth restraint. There was evidence for all five individuals that the IDT had met a sufficient number of times following repeated restraint.

Information reviewed for assessing indicators 20-24 was found in the ISPA notes following the most recent repeated restraints for each

of the individuals. Specifically, these were the minutes from 5/16/17 for Individual #142, 6/13/17 for Individual #128, 3/24/17 for Individual #179, 6/20/17 for Individual #147, and 7/13/17 for Individual #265.

20. For four individuals (Individual #128, Individual #179, Individual #147, Individual #265), there was a discussion regarding the potential role of adaptive skills, and biological, medical, and psychosocial issues. The IDT was taking steps to address Individual #128's psychiatric issues and Individual #179's team had enrolled him in community-based counseling. Although members of Individual #265's team had suggested steps to address his problems around meals and snacks, this suggestion was not pursued following the home manager's comments that a snack pack of healthy food items would not likely be effective. It is suggested that such recommendations be implemented to determine the efficacy or lack thereof. Only Individual #147's team did not immediately take any steps to address her reduced contact/visits with her mother.

21-22. Although minutes from the ISPA meetings indicated that the team had identified possible environmental variables for Individual #142 (no community outings), Individual #179 (new housemate), and Individual #265 (peer to peer agitation), there was no evidence the teams had taken actions to address these. Immediate antecedents were reviewed for Individual #142 with recommendations for staff to address these triggers.

23. Consequences that were potentially maintaining the targeted behaviors displayed were identified for Individual #265, and it was noted that he had replacement behaviors to learn alternative means to obtain the same outcome.

24. Four of the five individuals (Individual #142, Individual #128, Individual #179, Individual #265) had a PBSP at the time of repeated restraint. Although the IDT had been recommending the development of a PBSP for Individual #147 since April 2017, she was still being supported by a Psychiatric Support Plan (PSP) at the time of the onsite visit.

25. At the time of the repeated restraint, Individual #142, Individual #179, and Individual #265 all had Crisis Intervention Plans. Individual #128 did not, although a CIP was later developed. Although recommended, Individual #147 did still not have a CIP at the time of the onsite visit.

26. PBSPs are reviewed in detail in the Psychology/Behavioral Health sections of this report.

27. The Crisis Intervention Plan for Individual #265 was considered complete. However, the plan provided to the Monitoring Team prior to the onsite visit was not dated; it was only when combined with the requested approval for an individualized restraint plan that the date of implementation could be determined. For Individual #142 and Individual #179, the description of a crisis situation was identical or very similar to the operational definitions of the targeted behaviors in each individual's PBSP. For all three individuals, their IDTs are advised to review the CIPs to ensure that criteria for termination of the restraint are clearly defined. While all indicated that the individual should no longer be struggling, or displaying other unwanted behaviors, the duration (e.g., immediately, five seconds) was not specified

28. There was evidence of integrity checks for all four individuals who had PBSPs during the months in which repeated restraint occurred. In every case, integrity was measured at 80% or better. Concerns with assessment methods are reviewed in the

Psychology/Behavioral Health sections of this report.

29. There was evidence for Individual #142 and Individual #179 that their PBSPs had been reviewed and revised. Although the IDT recommended an updated functional behavior assessment following Individual #128's return from the state hospital, there was no evidence that this had occurred. As mentioned earlier, a PBSP had not been developed for Individual #147, although the IDT had recommended this.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Based upon 100% performance for this review and the last two reviews, too (with one exception in April 2016), these three indicators will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	318	473	554	287	25				
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4	1/1	1/1	1/1	1/1	N/A				
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	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.	100% 1/1	N/A	N/A	N/A	N/A	1/1				

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, four individuals were not receiving psychiatric services. Individual #318, Individual #473, Individual #554, and Individual #287 were assessed utilizing the Reiss screen. Based on the results of the screen, no further evaluation was necessary for any of these individuals.

2-3. Individual #25 was referred for an assessment by the treatment team. The Reiss screen was performed and indicated that further evaluation was necessary. Per the ISP for this individual, he was assessed by psychiatry and while no medications were recommended, psychiatry planned to monitor him for two subsequent quarters.

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, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all of the individuals (with one exception for which a PBSP was needed for an individual). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	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. In one example, regarding Individual #147, there was a recommendation dated April 2017, that a PBSP should be developed in lieu of the PSP. At the time of the monitoring visit, this recommendation had not been implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Both indicators showed improvement from 0% scores at the last review. The improvements also highlight the improved collaboration between psychiatry and behavioral health services. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	33% 3/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1

Comments:
23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health. The psychiatrist attempted to correlate the behavioral health target behaviors to the diagnosis. In addition, the functional assessment generally included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors.

24. There was documentation of the psychiatrist's review of the PBSP in the psychiatric clinical documentation in three examples regarding Individual #179, Individual #276, and Individual #522. Per a conversation with the facility psychiatrists, they attended

behavioral health meetings regarding behavior support plan development. They also reported that they provided written comments to the behavioral health staff regarding the PBSP documents. No additional comments were located for the other individuals.

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: Both indicators improved to 100% from 33% at the last review. Joint neuro psychiatry clinics were occurring regularly. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
26	Frequency was at least annual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments:
25-27. These indicators applied to two individuals, Individual #522 and Individual #179. This facility had a neuro psych clinic that occurred on campus and was attended by psychiatry and primary care. This allowed for collaborative care for those individuals where medications were being utilized for a dual purpose.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: The conduct of quarterly psychiatric clinics continued to slide, from 100% in April 2016, to 56% in January 2017, and to 44% at this review. Further, quarterly review documentation did not contain all of the required components. It was, however, good to see that psychiatric clinics, when observed, met criteria (indicator 35). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
33	Quarterly reviews were completed quarterly.	44% 4/9	0/1	0/1	0/1	1/1	1/1	1/1	1/1	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.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	N/A

Comments:

33. Quarterly reviews were not completed in a timely manner for five individuals.
- Individual #142 was admitted to the facility in January 2017 and the first quarterly review was dated June 2017.
- The most recent quarterly review regarding Individual #128 was dated in April 2017. There should have been a review performed in July 2017.
- Individual #205 had a quarterly review in October 2016 with the next review dated in April 2017. There should have been a quarterly review in January 2017.
- Individual #265 had a quarterly review in October 2016 with the next quarterly dated in February 2017.
- Individual #522 had a quarterly review in August 2016 with the next review dated February 2017.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing three to six components; most commonly, basic information such as height and weight and vital signs, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, and psychiatric diagnoses with a description of symptoms that support the diagnoses. In some of the examples, the psychiatrist had included the date of the MOSES and AIMS assessment, which was good to see.

35. Psychiatry clinic was observed for two individuals. Overall, the psychiatric treatment providers did a good job of leading the clinical discussion and reviewing available information. In both examples, the behavioral health data were graphed and explained by behavioral health staff. In both examples, the data focused on challenging behaviors. There was some discussion of psychiatric symptoms utilizing the ADAMS in both examples.

It was good to see that there was some additional discussion of psychiatric indicators and the need to develop psychiatric indicators. One issue regarding psychiatry clinic that was reviewed with the psychiatrists during the monitoring visit was that individuals did not routinely attend clinic and that individuals should be encouraged to attend and participate in psychiatry clinic.

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.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:
36. The record regarding Individual #147 contained assessments that were conducted and reviewed by the prescriber within the required timeframe.

There were delays in the review of the assessments by the prescribing practitioner for the other eight individuals. When reviewing the assessments, it appeared that the assessments that were performed more recently were reviewed in a timely manner.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.												
Summary: Brenham SSLC psychiatry department was fully staffed, held frequent psychiatry clinics (however, see indicator 33 above), and was available when individuals needed emergency/interim clinics. Moreover, individuals who were at risk or were under 18 years old were seen monthly. This indicator showed progress since the last review and will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
38. Emergency/interim clinics were available to individuals and there was documentation of emergency/interim clinics occurring for all individuals. This was a strength of this facility in that individuals were seen on a monthly basis if they were under age 18 or determined to be high risk.

The facility now had 2.5 full time psychiatrists. As such, they were fully staffed. They currently attempted four quarterly reviews plus an annual for every individual. Then, in addition, monthly clinical contacts for a large percentage of the caseload, as noted above. During the monitoring visit, the Monitoring Team discussed workload and the possibility of performing three quarterly reviews plus an annual rather than four quarterly plus an annual.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
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.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	followed policy.										
Comments: 42. As discussed above, the IDT recommended that Individual #147 should have a PBSP. Although this was recommended in April 2017, the PBSP had not been implemented at the time of the monitoring visit. As such, this individual was receiving psychotropic medication in the absence of a treatment program.											

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: With some attention, criteria could be met for justification (indicator 44). This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	57% 4/7	1/1	1/1	1/1	N/A	0/1	0/1	1/1	0/1	N/A
45	There is a tapering plan, or rationale for why not.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.										
Comments: 44. These indicators applied to seven individuals. Polypharmacy justification was appropriately documented for four individuals. 46. Polypharmacy meeting was observed during the monitoring visit. This meeting, while well intended, was not a facility level review of the polypharmacy regimens, but rather a case review attended by behavioral health staff, primary care, psychiatry, and pharmacy.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without reliable data, it is impossible to assess progress. However, the Monitoring Team rated indicators 7, 8, and 9 based upon the Center's own reports. Performance on all four indicators remained low and all four will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	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.	43% 3/7	N/A	0/1	0/1	1/1	1/1	N/A	1/1	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	50% 1/2	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A

Comments:
6. Although the graphs included in the behavioral health services progress notes for Individual #142, Individual #276, and Individual #522 suggested progress over time, this indicator is rated zero for all eight individuals due to the lack of reliable data. For two individuals, Individual #179 and Individual #265, there were notes indicating a change in the data collection system had occurred, which made an assessment of progress difficult.

7. None of the individuals had met their objectives.

8-9. For three individuals (Individual #146, Individual #179, Individual #276), corrective actions were suggested. A token program was put in place for Individual #179. Although this was also recommended for Individual #146, who also requested this addition, it had not been implemented at the time of the onsite visit. The use of noise cancellation headphones had just recently been recommended for Individual #276, therefore, this action step was excluded when calculating this indicator.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: Staff training on PBSPs was not occurring as it needed to occur. That is, many staff were not trained on the PBSPs for most individuals. Similarly, for half of the individuals, short summaries were not available for float staff to use. As a result, indicator 17 will be moved back to active monitoring. Indicator 18, however, had improved to 100%. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
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.	13% 1/8	0/1	0/1	0/1	0/1	1/1	N/A	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, poor availability of summaries for float staff for half of the individuals resulted in this indicator being moved back to active monitoring.									
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.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1

Comments:
16. When the lists of assigned staff were compared to training rosters, there was evidence for Individual #179 that more than 80% of his assigned staff had been trained on his PBSP. For all the others, the percentage of staff trained ranged from 0% (Individual #265) to 68% (Individual #128). While staff training requires a good amount of effort, it is essential that all staff working with the individual be trained to competency in implementing his or her plan.

17. Documents for four individuals (Individual #205, Individual #276, Individual #265, Individual #522) could be considered PBSP summaries. These were two to three pages in length and were labeled Staff Instructions or, in Individual #205's case, Pull Staff Inservice. For the remaining individuals, documents were either four to seven pages in length, or there was no short version available (Individual #146).

18. Seven individuals had functional assessments and PBSPs that had been written by a BCBA. The exception was Individual #205, however, this indicator is scored positively because the author was enrolled in coursework and there was evidence that a review had been conducted by the Behavior Therapy Committee.

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

Summary: Reviews were occurring, but the progress notes did not comment on progress, which resulted in indicator 19 being returned to active monitoring. Attention needs to be paid to making graphs useable, readable, and informative. Furthermore, conduct and follow-up to peer review meetings did not meet criteria. It was positive, however, to see that data were presented at clinical meetings. All of these indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
19	The individual's progress note comments on the progress of the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, during review of progress notes for monitoring of this outcome, most individuals' progress notes did not properly comment on the individual's progress. Therefore, this indicator will be moved back to active monitoring.									
20	The graphs are useful for making data based treatment decisions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	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.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A
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.	0% 0/4	N/A	0/1	N/A	0/1	0/1	N/A	N/A	0/1	N/A

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. Comments on the individual's progress were found consistently for two individuals, Individual #128 and Individual #205. In all others, there was often a lack of data review or analysis of progress in the text of the report.

20. Graphs were provided for seven of the eight individuals. The exception was Individual #205 whose progress notes lacked this important information. None of the graphs were considered useful for making data based decisions. The graphs for three individuals (Individual #142, Individual #128, Individual #522) were difficult to read due to the number of data paths (e.g., four to seven). Individual #128's graphs were also quite small making it difficult to read the information related to phase change lines. The graphs for the other six individuals lacked phase change lines.

21. Clinical meetings were held for three individuals while the Monitoring Team was onsite. In the psychiatric clinics for Individual #205 and Individual #276 data were presented and reviewed. The same was true at an ISPA meeting held for Individual #128.

22. In the six-month period prior to the onsite visit, four of the nine individuals had been presented in peer review. In no case was there evidence that all recommendations had been incorporated into the individual's PBSP.

- For Individual #128, there was evidence that a token program had been added following a recommendation from internal peer review, however, recommendations from external peer review, including integrating the token program into the PBSP, noting whether she could bank tokens, and identifying coping mechanisms when she is denied a daily exchange, were not addressed.
- There was no evidence that the recommendations made for Individual #146 had been incorporated into his PBSP.
- While most of the recommendations were addressed in Individual #179's PBSP, the final recommendation from the meeting was to submit his case to external peer review. When asked, the facility reported that this had not occurred.
- Although a progress note from July 2017 referenced a token program for Individual #265, there was no evidence of this in his current PBSP.

23. Documentation provided by the facility indicated that over a six-month period, internal peer review was held three times in three months and external peer review occurred four times. It should be noted that the behavioral health services department was undergoing a number of changes during this period.

Outcome 8 – Data are collected correctly and reliably.											
Summary: Data collection remained a challenge for Brenham SSLC. These five indicators maintained at 0% from the last review, too. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522

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

Comments:
26-27. Based upon the concerns with data timeliness and reliability, the data collections systems did not adequately measure either target or replacement behaviors.

28. Although there were established measures of IOA and treatment integrity, there was no system for assessing data timeliness. This matter was discussed with the director of behavioral health services.

29. With the exception of Individual #128, each individual's PBSP identified goal frequencies for IOA and treatment integrity. In most cases, measures were to be collected at a minimum of once each month. Individual #142's plan indicated that treatment integrity would be assessed weekly. Individual #265's plan indicated that IOA would be assessed every other month. Staff are advised to revise this to ensure monthly assessment. Acceptable levels were 80% or better. None of the plans identified goal frequencies or levels for data timeliness.

30. Goal frequencies and levels were not achieved for any of the eight individuals.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	measure the efficacy of interventions.	0/18									
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 #522 – cardiac disease, and seizures; Individual #142 – weight, and other: pica behavior; Individual #167 – constipation/bowel obstruction, and cardiac disease; Individual #287 – cardiac disease, and UTIs; Individual #554 – infections, and aspiration; Individual #25 – aspiration, and osteoporosis; Individual #403 – skin integrity, and circulatory; Individual #318 – respiratory compromise, and UTIs; and Individual #473 – seizures, and UTIs). None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable.

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

Outcome 4 – Individuals receive preventative care.

Summary: Six 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. It will be important for the Center's quality assurance/improvement mechanisms related to preventative care to meet the requirements of the Settlement Agreement. The Center also should 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	522	142	167	287	554	25	403	318	473
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	N/A	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1

	iii. Breast cancer screening	100% 3/3	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A	1/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 7/7	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	0/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	44% 4/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments: a. The following provide examples of problems noted:

- For Individual #522, Tdap was documented as having been administered on 7/8/04. It was not available until 2005. It likely was Td, but IRIS immunization software apparently does not distinguish between tetanus immunizations.
- Individual #473's PCP gave the guardian the option of deferring the well-woman exams indefinitely, but did not clearly document a reason, such as the need for general anesthesia to complete the exam.

b. For a number of individuals, PCPs cut and pasted information from the QDRRs, but did not provide a plan or next steps for issues identified. 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: Over the past four reviews, the Center's scores for this indicator have been 0. It is essential that Center staff review all individuals with a DNR Order in place, and for those individuals who do not meet the requirements of State Office policy, Center staff should take action to comply with the policy, including, as appropriate, removing the DNR Order from individuals' records. The Monitoring Team will continue to review this indicator.

Individuals:

#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual with DNR Order that the Facility will execute has clinical	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A

	condition that justifies the order and is consistent with the State Office Guidelines.	0/1									
Comments: a. In 2013, Individual #318's brother signed a DNR Order with the qualifying condition listed as "vegetative state." Individual #318's documentation, and well as the Monitoring Team's observations of her did not support the diagnosis of vegetative state, and based on review of documentation, it did not appear she had a terminal condition. The IDT should meet with Individual #318 and her family to review the DNR and her current status, and specifically document the origin and status of her diagnosis of being in a vegetative state. An updated medical evaluation might be indicated.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Some of the areas on which the Center should continue to focus include: 1) for individuals transferred after hours, PCPs summarize the events leading up to the transfer and results within one business day; 2) when individuals are transferred to the hospital, the PCP or a nurse communicates necessary clinical information with hospital staff; and 3) ISPA meetings are held and IDTs identify follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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.	56% 10/18	2/2	1/2	1/2	1/2	2/2	1/2	0/2	0/2	2/2
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.	100% 11/11	N/A	1/1	N/A	2/2	2/2	N/A	2/2	2/2	2/2
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.	58% 7/12	N/A	2/2	0/1	0/1	1/2	1/1	1/2	1/1	1/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	80% 4/5		1/1	0/1	N/A	N/A	1/1	N/A	1/1	1/1
e.	Prior to the transfer to the hospital or ED, the individual receives	Due to the Center's sustained performance with this indicator, it has									

	timely treatment and/or interventions for the acute illness requiring out-of-home care.	moved to the category requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	42% 5/12		0/2	0/1	0/1	1/2	0/1	1/2	1/1	2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 1/2		N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	90% 9/10		2/2	1/1	N/A	2/2	1/1	1/1	1/1	1/2

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 18 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #522 (knot on head on 4/13/17, and upper respiratory infection on 4/12/17), Individual #142 (lying on the ground on 8/23/17, and lying on the ground on 8/21/17), Individual #167 (productive cough on 5/1/17, and abraded skin on 5/30/17), Individual #287 (unable to walk on 3/24/17, and fever on 3/31/17), Individual #554 (rash on trunk on 2/10/17, and ear infection and abdominal rash on back on 3/13/17), Individual #25 (bacterial conjunctivitis on 5/8/17, and bruise on 5/24/17), Individual #403 (unsteady gait on 2/1/17, and left elbow and left foot pain on 3/6/17), Individual #318 (skin integrity issue on 3/1/17, and decubitus on 4/18/17), and Individual #473 (nystagmus on 4/26/17, and seizures on 4/19/17).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #522 (knot on head on 4/13/17, and upper respiratory infection on 4/12/17), Individual #142 (lying on the ground on 8/23/17), Individual #167 (abraded skin on 5/30/17), Individual #287 (unable to walk on 3/24/17), Individual #554 (rash on trunk on 2/10/17, and ear infection and abdominal rash on back on 3/13/17), Individual #25 (bruise on 5/24/17), and Individual #473 (nystagmus on 4/26/17, and seizures on 4/19/17). For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them.

It was positive that for the acute illnesses/occurrences reviewed for which follow-up was needed, documentation was 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.

c. through h. For eight of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses requiring hospital admissions, or ED visits, including the following with dates of occurrence: Individual #142 (ED visit for syncope on 8/18/17, and ED visit for heat exhaustion on 8/15/17), Individual #167 (ED visit for fall with laceration on 3/26/17), Individual #287 (ED visit for change in mental status on 9/6/17), Individual #554 (ED visit for blood in stool on 2/26/17, and ED visit for fall on 5/20/17), Individual #25 (ED visit for facial trauma on 3/3/17), Individual #403 (ED visit for laceration to scalp on 4/29/17, and hospitalization for emesis on 7/16/17), Individual #318 (ED visit for UTI on 6/6/17), and Individual #473 (hospitalization for seizures on 4/20/17, and hospitalization for seizures on 3/24/17).

For Individual #167 fall on 3/26/17, PCP IPNs were not submitted. For Individual #287's transfer due to a change in mental status on 9/6/17, nursing IPNs were available, but no PCP IPNs were submitted. Although nursing staff called the PCP on 5/20/17, prior to Individual #554 going to the ED for a fall, a PCP IPN was not submitted. For Individual #403 (ED visit for laceration to scalp on 4/29/17), and Individual #473 (hospitalization for seizures on 3/24/17), PCP IPNs were not completed on the next business day.

f. The individuals that were transferred to the hospital for whom documentation was submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff were Individual #554 (ED visit for blood in stool on 2/26/17), Individual #403 (hospitalization for emesis on 7/16/17), Individual #318 (ED visit for UTI on 6/6/17), and Individual #473 (hospitalization for seizures on 4/20/17, and hospitalization for seizures on 3/24/17).

g. No ISPA was submitted for Individual #473's hospitalization for seizures on 3/24/17. However, her IDT met after her 4/20/17 hospitalization for seizures, and discussed a number of action steps.

h. It was good to see that for the individuals reviewed, upon their return to the Center, there generally was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness. The exception was for Individual #473, for whom the documentation did not show PCP follow-up upon her return on 4/3/17.

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

Summary: It was good to see some improvement with regard to PCPs writing IPNs related to consultations that were in accordance with State Office requirements. The Center also needs to focus on ensuring PCPs complete timely reviews of consultation reports, and refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	78% 14/18	2/2	2/2	2/2	1/2	2/2	2/2	0/2	1/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	56% 10/18	2/2	1/2	1/2	1/2	2/2	1/2	0/2	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 recommendation(s), and whether or not there is a need for referral to the IDT.	72% 13/18	2/2	1/2	2/2	0/2	2/2	2/2	0/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	78% 14/18	2/2	1/2	2/2	1/2	2/2	2/2	0/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/10	N/A	0/1	0/2	0/2	N/A	N/A	0/2	0/1	0/2

Comments: For the nine individuals, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #522 for neurology on 7/12/17, and cardiology on 4/13/17; Individual #142 for ear, nose, and throat (ENT) on 4/26/17, and podiatry on 4/27/17; Individual #167 for nephrology on 5/8/17, and endocrinology on 5/11/17; Individual #287 for neurology on 8/9/17, and ophthalmology on 2/16/17; Individual #554 for neurology on 7/12/17, and neurology on 4/12/17; Individual #25 for dermatology on 8/3/17, and neurology on 4/12/17; Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17; Individual #318 for general surgery on 6/29/17, and podiatry on 4/13/17; and Individual #473 for neurology on 3/8/17, and neurology on 7/13/17.

a. The consultation reports for which PCPs did not indicate agreement or disagreement with the recommendations were for Individual #287 for ophthalmology on 2/16/17; Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17; and Individual #318 for general surgery on 6/29/17.

b. The reviews that did not occur timely were for Individual #142 for podiatry on 4/27/17; Individual #167 for endocrinology on 5/11/17; Individual #287 for ophthalmology on 2/16/17; Individual #25 for dermatology on 8/3/17; Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17; and Individual #473 for neurology on 3/8/17, and neurology on 7/13/17.

c. The consultations for which no IPN was found, or the IPN did not include the components State Office policy requires were for Individual #142 for podiatry on 4/27/17; Individual #287 for neurology on 8/9/17, and ophthalmology on 2/16/17; and Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of the following: Individual #142 for ENT on 4/26/17, Individual #287 for neurology on 8/9/17, and Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17.

e. PCPs did not provide guidance about whether or not individuals' IDTs should meet to discuss the following: Individual #142 for podiatry on 4/27/17; Individual #167 for nephrology on 5/8/17, and endocrinology on 5/11/17; Individual #287 for neurology on 8/9/17, and ophthalmology on 2/16/17; Individual #403 for orthopedics on 3/3/17, and podiatry on 4/27/17; Individual #318 for general surgery on 6/29/17; and Individual #473 for neurology on 3/8/17, and neurology on 7/13/17.

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

Summary: Much improvement is needed to ensure for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18	0/2	0/2	1/2	0/2	1/2	1/2	0/2	1/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #522 – cardiac disease, and seizures; Individual #142 – weight, and other: pica behavior; Individual #167 – constipation/bowel obstruction, and cardiac disease; Individual #287 – cardiac disease, and UTIs; Individual #554 – infections, and aspiration; Individual #25 – aspiration, and osteoporosis; Individual #403 – skin integrity, and circulatory; Individual #318 – respiratory compromise, and UTIs; and Individual #473 – seizures, and UTIs).

a. It was positive that for the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #167 – constipation/bowel obstruction, Individual #554 – aspiration, Individual #25 – aspiration, Individual #318 – respiratory compromise, and Individual #473 – seizures, and UTIs. The following provides examples of concerns noted:

- Individual #167 had cardiovascular disease, including dyslipidemia, and hypertension. She had a history of obesity, but lost considerable weight reportedly due to resolution of lower extremity edema. In the past, the PCP determined she had metabolic syndrome, with four of the five risk factors present. In the past, she developed severe chronic hyponatremia, with her sodium (Na) level down to 119, which is considered severe hyponatremia. This was attributed to Tegretol. At the time, she was living in a different home on campus, and the IDT refused to follow the PCP's and psychiatrist's recommendation to taper the Tegretol, reportedly due to a history of recurrence of psychiatric signs and symptoms when the medication was reduced. In response to the hyponatremia, Individual #167 was placed on a fluid restriction of 1500 milliliters (ml) per day. Additionally, the PCP prescribed sodium chloride (NaCl) tablets at 1000 milligrams (mg) three times a day (TID). On 8/25/15, cardiology recommended reducing the calcium channel blocker, stopping the hydrochlorothiazide (HCTZ), continuing Lasix, starting Hydralazine, and initiating or continuing a fluid restriction. On 10/8/15, cardiology recommended discontinuing the calcium channel blocker and increasing hydralazine and Lasix. She was also taking a beta blocker at that time and it was reduced. An echocardiogram indicated pulmonary hypertension with moderate to severe tricuspid regurgitation. The ejection fraction (EF) was 55 to 60%, which was very good. On 11/9/15, the cardiologist discontinued the beta blocker, and referred her to a pulmonary hypertension specialist. The diagnosis was later removed.

  Since November 2015, Individual #167 lost over 40 pounds and was then within her estimated desired weight range. Her most recent AMA indicated no edema. In 2017, her thyroid stimulating hormone (TSH) was 1.21, her cholesterol was 218, with high-density lipoprotein (HDL) of 113 and triglycerides of 44, which overall was good. On 2/28/17, her abdominal girth was 34.4 inches, which was good. Nephrology was consulted due to her continuing hyponatremia. Most recently, her blood pressure was difficult to control. During the past year, she moved to a different home on campus, and the new IDT was not as adamant in requiring continuation of Tegretol. The PCP reduced the Tegretol dose slowly, and to date there had been no exacerbations of her psychiatric symptoms. The PCP made continuous adjustments to her hypertension medication regimen due to her labile hypertension. She was currently taking five medications for blood pressure control. Her B-type natriuretic peptide (BNP) remained elevated. In September 2017, an echocardiogram did not indicate diastolic dysfunction. With normalization of her Na level, reduction of NaCl tablets in her regimen began, which might theoretically assist in improved blood pressure control. She remains on a fluid restriction.

  Based on a review of her ISP, it did not appear that Pharmacy staff participated, which would have been important to assist the PCP in discussing with the IDT the need to reduce Individual #167's Tegretol, considering the severity of the hyponatremia and potential difficulties that adding NaCl to her regimen would have on controlling hypertension. The QDRRs did not underscore the need to reduce and replace as needed the Tegretol. The QDRRs did not include information about the last trial to reduce Tegretol, including a description of the symptoms which occurred.

  The IDT's decision to continue Tegretol, despite recommendations from the PCP and psychiatrist to taper it, might have

contributed to increased cardiovascular risk along with placing Individual #167 at risk for seizures due to the hyponatremia. The Pharmacy Department should have challenged the IDT, and could have provided some in-service education to the IDT. Moreover, the PCP and psychiatrist should have elevated the disagreement to the Center's administration for review, as the decision to continue Tegretol increased the individual's health risks. Unfortunately, this was not done, and the PCP added medications that might have exacerbated her cardiovascular health issues. Fortunately, most recently, the PCP and psychiatrist had been able to wean Individual #167 to a low dose of Tegretol, once she moved to a new home with a new IDT.

- Prior to moving to Brenham SSLC, Individual #287 had a cardiac history requiring the use of chest compressions twice (i.e., on 8/14/13, when she developed status epilepticus related to a UTI, and on 1/15/15, during recurrent seizure activity). On 3/23/16, she moved to Brenham SSLC. TED hose were ordered to be worn during the day. An electrocardiogram (EKG), dated 5/4/16, indicated a normal sinus rhythm, and no ischemic changes. More recently, a BNP was normal. She continued to have lower extremity edema with an unclear etiology. She was treated with Lasix and Aldactone with improvement in the edema. She was also found to have mild to moderate cirrhosis. Given the two events which "required chest compression," as well as ongoing issues of peripheral edema and mild global cardiomyopathy, there was need for further evaluation. This might have been completed prior to transfer to Brenham SSLC, but there was no documentation of this in the AMA. A cardiology consult did not appear to have occurred since admission, despite the "serious" episodes requiring chest compression.

- In the remote past, Individual #287 had an abdominal hysterectomy and ovarian cystectomy, and lateral vaginal cuff cyst excision. Since 2012, she had ED visits and hospitalizations for status epilepticus triggered by UTIs. In 2014, she developed resistant UTIs. In April 2014, she was considered colonized with E coli in her urine, and an attempt at eradication with antibiotics failed. On 7/1/15, a renal ultrasound did not indicate renal abnormalities, stones, hypronephrosis, or abnormalities of the bladder. On 3/23/17, the PCP prescribed Macrobid and AzoCranberry tabs for prophylaxis of UTIs. On 3/31/17, Individual #287 developed a low-grade fever, and subsequent recurrent seizure activity was treated with Diastat. Topamax was increased at that time. The urine culture was positive for E coli, but the colony count was less than 10,000 per ml. She was treated with a short course of Doxycycline. She subsequently developed oral thrush. Current treatment for UTI prevention continued to be Macrobid, AzoCranberry, as well as vaginal Estrace. Post-void residuals were in the range of 100 cubic centimeters (cc). She continued with intermittent incontinence. Individual #287 had not had a urological consult to review her case of bacteriuria and associated seizures, as well as her incontinence. It was unclear if she was developing a cystocele or other weakness in her vaginal wall that might be contributing to her ongoing urological problems.

- Individual #318 had a long history of UTIs, and nephrolithiasis. In 2009, she developed bilateral hydronephrosis and underwent extracorporeal shock wave lithotripsy (ESWL). On 2/1/10, a ureteral stent was placed. On 4/7/10, ESWL of the right kidney occurred. On 9/7/12, Individual #318 developed urosepsis. On 11/20/15, she was hospitalized for urosepsis (Morganella and Proteus culture positive) associated with bilateral staghorn calculi. At that time, no interventions for the stones were recommended. On 8/26/16, Individual #318 was hospitalized for pseudomonas urosepsis. She was placed on long-term vaginal Estrace cream and Ceftin for prophylaxis. It was noted that her renal stones were potentially infected, but were "not a modifiable risk factor." On 4/6/17, she developed a UTI, which the ED diagnosed. Hydration was increased by adding water to the gastrostomy tube (G-tube) flushes. Hibiclens was utilized for bathing. Urology continued to follow her. In July 2017, she underwent general anesthesia. Given that she successfully underwent lithotripsy twice in the past, and more

recently underwent general anesthesia without problems, documentation was not clear as to the rationale for a non-aggressive approach to the nephrolithiasis, especially as the nephrolithiasis might be a source of ongoing infection. Based on the Monitoring Team's observations, Individual #318's clinical status was also confusing regarding whether or not she actually had a persistent vegetative state, because she appeared to respond to her environment. Information in the ISP also suggested interaction with her environment. Clarification of her neurological status might be needed prior to any further decision-making about procedures.

- Individual #403 had a history of hyponatremia and orthostasis. He was prescribed Tegretol, which was considered the etiology of the hyponatremia. He was placed on a fluid restriction, which might have aggravated any tendency to orthostasis. He was also placed on NaCl tablets. The QDRR did mention the potential drug interactions between Tegretol and his other psychotropic medications, which increases the metabolism of these medications. This increased metabolism might have contributed to his ongoing difficult behaviors, and considering the side effects and treatment of side effects, the benefit of the Tegretol was questionable, but not addressed in the QDRR.

  In November and December 2016, he then developed ataxia. The QDRR mentioned a high anticholinergic burden can be associated with ataxia. However, there was no discussion in the record, nor QDRR recommendation as to next steps concerning his high anticholinergic burden. His Active Problem List indicated giddiness and dizziness, vertigo, and ataxic gait. The AMA discussed gait instability precipitating fractures might have been related to vertigo and/or orthostatic hypotension. The Clinical Pharmacist has a role to be more proactive in recommending changes and options, not simply providing information.

  He then began to have persistent orthostatic hypotension. On 12/7/16, he was referred to the ED for intravenous (IV) hydration, which his fluid restriction to combat the side effect of Tegretol might have exacerbated. On a computed tomography (CT) scan completed on 1/28/17, he was found to have prominent spondylitis of the cervical spine. On 1/28/17, a CT of the head was negative for acute problems. On 2/1/17, he was noted to have recurrent severe orthostasis. EKG and lab work were considered unremarkable. He had been prescribed Flomax and this was discontinued. An IPN indicated that multiple other drugs "might need to be discontinued," but there did not appear to be further action concerning this option. Florinef was started. Sudafed was added, and Florinef was eventually increased. NaCl tabs were increased. By mid-March 2017, his hypotension appeared to be responsive to the change in medication. His ataxia and vertigo clinically resolved. On 5/4/17 at 12:25 a.m., IPNs indicated that he fell or sat on the floor. It could not be determined whether this was triggered by orthostatic hypotension. His most recent orders were not available, because according to staff, he was deceased and the records had been archived or otherwise removed. It could not be determined whether the fluid restriction was maintained.

  The cause of Individual #403's significant orthostatic hypotension appeared to be multi-factorial, or at least aggravated by several factors, including treatment of hyponatremia due to the side effect from Tegretol, and high anticholinergic burden. The addition of Sudafed and Florinef appeared to be effective. However, the use of additional medications to combat side effects rather than removing the potential offending medication is problematic. The QDRRs did not address the orthostatic hypotension in guiding the PCP in options to be considered. Evaluation of his orthostatic hypotension and hyponatremia were appropriate and timely. However, the treatment needed further multi-departmental discussion and recommendations.

- Individual #554 had a history of infections at many body sites. He had a gastrostomy site, a suprapubic ostomy site, and an ileostomy site. He had cellulitis of his right knee (1987), sinusitis (1989), cellulitis of his left foot (1989), cellulitis of his right foot (2000), pneumonia (2004), ascending cholangitis (2011), latent tuberculosis (2012), epididymitis (2012), pneumonia (4/14 and 10/14), sepsis with persistent pneumonia (2016), right ear infection (2016), and recurrent UTIs treated prophylactically with Macrobid. He was currently prescribed Prolia.

  This individual has had several serious infections, including pneumonia and sepsis. The two most recent QDRRs mentioned that "Prolia may lower the ability to fight infection. If serious infections occur while on Prolia, prescribers should assess the need for continued Prolia therapy." However, in the final recommendation section, there was no recommendation to discontinue Prolia and seek alternative therapy for improving bone density. It was not clear if the clinical pharmacist was unaware of Individual #554's serious infections, or was aware of other failed treatments for osteoporosis necessitating continuing this medication despite the bouts of infection. However, there needed to be further guidance to the PCP concerning whether Prolia was still justified in its use in this individual, yet the QDRR and IPNs were silent on this matter.

  In its comments on the draft report, the State disputed this finding, and stated: "While there were no signs and symptoms of infection during the drug regimen review and no recent use of antibiotics for treatment, the Clinical Pharmacist made a general statement as an educational reminder (TX-BR-1710-II-….09 pg 8 of 18). The QDRR also notes that oral bisphosphonates were not an option for Individual #554 due to aspiration risk and that Reclast could be considered if clinically indicated (TX-BR-1710-II-….09 pg 9 of 18." Although there might not have been specific severe infections during the prior two QDRR reviews, the use of Prolia covered a prolonged time period with several infections. Since the order date of 7/14/16 and start date of Prolia on 9/19/16 (on the LTC Active Medication Order list), Individual #554 had pneumonia, an ear infection, and a severe infection necessitating hospitalization for sepsis but with unclear locus, as well as ongoing treatment with an antibiotic to prevent recurrent UTIs. The Clinical Pharmacist needs to play a more active role in the morning meetings to discuss acute infections and ongoing prevention of infection, along with the risks of Prolia administration and specific recommendations and options for individuals through the QDRRs.

  Given the multiple concerns (i.e., five separate concerns for three of nine individuals reviewed, as well as concerns related to two individuals who died) identified with regard to a lack of guidance from the Pharmacy Department to the Medical Department and these concerns' impact on the clinical evaluation and treatment of the individuals at Brenham SSLC, the Medical Director is encouraged to require improvements in the QDRRs, and seek the assistance of State Office, if necessary. Pharmacology consistent with current standards of care is a significant part of the medical treatment that the Center is required to provide the individuals it serves.

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/ISPs. This indicator will remain in active oversight until full sets of medical	Individuals:

action steps are included in IHCPs, and PCPs implement them.											
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	73% 8/11	2/2	1/1	0/2	1/1	2/2	1/1	N/A	0/1	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.											

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	522	142	167	287	554	25	403	318	473
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
Comments: a. and b. Individual #167's IDT rated her at low risk for dental, but she had Stage II periodontal disease, and the Dental Department recommended continuation of a SAP for tooth brushing. Based on review of the ISP, it did not appear the IDT addressed this recommendation. Individual #473 was edentulous, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental. c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports with data and analysis of the data on existing goals were often not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary										

action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: Although three individuals had untreated caries, plans were in place to treat two individuals, and for the other, the risk of treatment outweighed the benefits. Except for an individual who was edentulous, all of the individuals reviewed had gingivitis or a more severe form of periodontitis. Of these, two individuals showed improvement over the last year.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	Individuals have no diagnosed or untreated dental caries.	63% 5/8	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	N/A
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.	N/A									
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	86% 6/7	1/1	N/A	1/1	1/1	1/1	1/1	0/1	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: a. and b. Individual #473 was edentulous. Individual #522 and Individual #142 had diagnosed and untreated dental caries, but plans were in place to treat them. Individual #318 also had untreated caries, but the risk of treatment outweighed the benefit, so the IDT deferred treatment.

b. Individual #473 was edentulous, so this indicator did not apply. Individual #142 was newly admitted, so this indicator could not be assessed, but her dental exam indicated she had gingivitis. The remaining seven individuals had periodontal disease.

- Individual #403's periodontal disease worsened from Type I to Type III.
- Individual #167's periodontal disease improved from Type III to Type II, and Individual #522's from Type II to Type I.
- Three of the remaining individuals had Type III periodontal disease, and one had Type IV periodontal disease.

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: Based on the Monitoring Team's review of dental documentation for review of other indicators, some individuals had not had needed prophylactic care. If at the time of the next review, improvements are not noted, then Indicator a will move back to active monitoring. Given that over the last two review periods and during this review, the Dental Department generally provided tooth brushing instruction for the individuals reviewed (Round 10 – 100%, Round 11 – 100%, and Round 12 – 88%), and provided fluoride treatments to individuals needing them (Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%), Indicators b and d will move to the category requiring less oversight. Improvement was noted with regard to the Dental Department's development and implementation of treatment plans for individuals with periodontal disease. These efforts should continue.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight. However, based on the Monitoring Team's review of dental documentation for review of other indicators, two out of seven individuals had not had needed prophylactic care. If at the time of the next review, improvements are not noted, then Indicator a will move back to active monitoring.									
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
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.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 3/3	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	75% 6/8	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A
f.	If the individual has need for restorative work, it is completed in a timely manner.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
g.	If the individual requires an extraction, it is done only when										

	restorative options are exhausted.	

Comments: Individual #473 was edentulous.

a. At the time of the last review, this indicator was removed from active oversight due to good performance. However, in reviewing information for individuals with periodontal disease, problems were noted for two out of seven individuals. More specifically:

- The Dental Department made attempts to provide Individual #25 with periodontal maintenance visits, but they were unsuccessful.
- For Individual #554, after two unsuccessful attempts to provide prophylactic care, an appointment under TIVA was scheduled. On 5/18/17, the TIVA attempt was unsuccessful due to an inability to thread the catheter necessary for the anesthesia.

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

Summary: For the two applicable individuals, when dental emergencies occurred, the Dentist saw the individuals within 24 hours. Neither required treatment or pain management.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									

Comments: a. through c. On 4/17/17, the Dentist saw Individual #287 for recent meal refusals and a white tongue. The exam was negative, and no treatment was needed.

On 5/7/17, Individual #403 expressed pain in his molar. Nursing staff referred him to the dental clinic the next morning. At 10:38 a.m. on 5/8/17, the Dentist documented that the dental exam was negative, and the individual had no pain.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

Summary: Since the last review, the Center showed progress with regard to the suction tooth brushing indicators. The Monitoring Team will continue to review all of these indicators.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A

	suction tooth brushing.										
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3					1/1		1/1	1/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 3/3					1/1		1/1	1/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	67% 2/3					1/1		1/1	0/1	

Comments: a. and b. It was good to see that for the applicable individuals, IDTs included staff service objectives in their ISPs defining suction tooth brushing expectations. In addition, data generally showed implementation of the objectives, with a few exceptions.

c. It was positive that Dental Department staff were regularly monitoring staff's implementation of suction tooth brushing for quality, as well as safety.

d. Individual #318's monthly integrated reports did not include data, although the QIDP did include the staff service objective for suction tooth brushing.

Outcome 9 – Individuals who need them have dentures.

Summary: Improvements were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	71% 5/7	0/1	N/A	1/1	1/1	N/A	0/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: a. For two individuals, the reasons the Dentist offered for not providing dentures were not clinically justified. For example, Individual #533 had all of his teeth, but the Dentist indicated dentures were not recommended due to lack of muscle control. For Individual #25, the reasoning was also lack of muscle control. However, this individual fell and broke his front teeth. The reason for not recommending dentures more appropriately would focus on the concern that falls with dentures might pose a greater risk due to the potential for injury to his mouth and other teeth.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on information the State provided, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									

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

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

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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 #522 – infections, and cardiac disease; Individual #142 – weight, and infections; Individual #167 – falls, and UTIs; Individual #287 – seizures, and infections; Individual #554 – circulatory, and GI problems; Individual #25 – choking, and falls; Individual #403 – cardiac disease, and skin integrity; Individual #318 – constipation/bowel obstruction, and infections; and Individual #473 – choking, and constipation/bowel obstruction). None of the goals/objectives reviewed were clinically relevant, achievable, and measurable. c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.										

Outcome 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 four review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	The nursing interventions in the individual's ISP/IHCP that meet their	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0/18									
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/13	0/1	0/2	0/2	0/2	0/2	0/1	0/1	0/1	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

The following provide examples of concerns noted with regard to IDTs' responses to individuals' risks:

- For Individual #522, in spite of the fact that the goal was for his blood pressure to be below 130/80 with medication, his current IHCP included no action step for monitoring blood pressure. The ISPA, dated 2/2/17, indicated that while he was in the hospital for an altered mental status, his blood pressure was low ("80's/40's to 90's/50's"). His blood pressure medication was lowered in response to these values. However, there was no indication that his IDT modified his IHCP to include an action step for nursing staff to monitor his blood pressures. Moreover, it was not clear from the documentation in the AMA and annual and quarterly nursing assessments if the problem was related to hypertension or hypotension, or both.
- A review of the ISPAs, IPNs, nursing quarterlies provided, and Nutrition Assessment, dated 1/26/17, found that Individual #142's IDT was not monitoring her weight issues. In fact, a list of weights showing her actual monthly weights since her admission was not found in the documents noted. The weight report that was provided indicated that on 6/30/17, her weight was 240 pounds, on 7/31/17, it was 211 pounds, and on 8/31/17, it was 209 pounds. No ISPAs were found addressing this significant weight loss. In fact, the nursing quarterly, for the period from 4/5/17 through 7/12/17, indicated that she had gained 10 pounds over the last month, but did not provide specific information regarding weights each month in order to show when she had a 10-pound weight gain. The documentation provided did not show that her IDT provided necessary oversight of her high-risk weight issues.
- The Monitoring Team found no ISPAs or other documents addressing Individual #142's recurrent episodes of otitis media (i.e., ear infections). From the documentation provided, it was not clear if she had had chronic issues with ear infections in the past, but in February 2017, she was seen by an ear, nose, and throat (ENT) specialist for a perforation of her tympanic membrane (the nursing quarterly did not indicate that both tympanic membranes were perforated). Even after this acute issue, her IDT did not modify her IHCP to include regular nursing assessments of her ears, nose, and throat to assess for enlarged tonsils and adenoids that could cause recurrent ear infections.
- Although Individual #167's IDT met a number of times to discuss her falls, the documentation in the ISPAs did not reflect a

comprehensive analysis of her falls, including analysis of the data related to the issues the IDT believed might be contributing to her falls (e.g., sleep data, blood pressure issues, episodes of hyponatremia, medication changes, weakness to her left leg, being tired from an increase in activity, bouts of orthostatic bradycardia, and giving her extra snacks so she did not get up at night to find food). The IDT did not compare data for any of these issues that they raised with her fall data. In fact, along with these possible factors, there was no indication that Habilitation Therapies staff conducted a root cause analysis or that the PCP and/or PT conducted an assessment of her right knee and muscle pain, as discussed in the ISPAs. The IDT's lack of urgency and coordination regarding the 32 falls the Center reported from 2/27/17 through 9/18/17 (request IV.1-20) for this individual was very concerning.

- For Individual #167, the ISPAs noted minimal IDT discussion regarding her urinary issues. While in the hospital in February 2016, she was found to have significant urinary retention and had a history of UTIs. An x-ray of her bladder noted it was distended, which made it difficult for her to completely empty her bladder when she urinated, which in turn increased her risk for UTIs. In addition, she had been on and off fluid restrictions, and the ISPA, dated 6/2/17, noted she was not drinking the allotted amount for a 24-hour period and did not ask for additional fluids. Aside from the unknown etiology of the hyponatremia, her fluid intake was not mentioned in the ISPAs, IPNs, or the nursing quarterly assessments. The documentation did not reflect that her IDT proactively assessed, addressed, and monitored this issue.
- Individual #287's IDT had not use the historical and current clinical information to develop and implement a goal and related action steps to prevent UTIs, especially from E coli, which could have and should have been prevented. For this individual, preventing UTIs was related to preventing seizure activity, which the AMA linked as a precipitating factor. It was also of significant concern that this information, which was not included in any of the annual or quarterly nursing assessments, IRRF, or the IHCP, might be lost as systems and staff change over time.
- Individual #554's IDT increased the risk rating for circulatory, because of "edema requiring compression hosiery." However, the IDT did not include in the IHCP a system for nursing staff to regularly monitor the edema and skin of his lower extremities. Thus, the IDT did not have a way to determine the progress in addressing this risk.
- The following describes issues found with regard to proactive follow-up and monitoring of Individual #25l's falls: no analysis of his falls was found in an ISPA; the documentation in the IPNs lacked specific details regarding how injuries occurred, if witnessed, where they occurred, or if unwitnessed; in many of the IPNs, it was not clear if the falls/injuries referenced were previous falls or injuries, or if Individual #25 had additional falls/injuries; the IHCP lacked proactive interventions addressing his fall risk; and the nursing quarterlies lacked information and analysis of the falls. The ISPA, dated 7/19/17, noted that: "several times during this assessment (visiting Bowie C) the PT provided assistance to prevent a fall while stepping off of a sidewalk onto grass, while stepping off of a curb, while guiding around wet floor signs and while walking through doorways." This ISPA noted a number of incidents when Individual #25 needed "hands on assistance" to prevent him from falling, which showed that he remained at significant risk for falls.
- None of the ISPAs addressed the combination of risk issues that could have played a role in some of the symptoms Individual #403 experienced, including: ataxia on 12/7/16, orthostatic hypotension on 12/7/16, fractures of the left second, third, and fourth metatarsals on 12/9/16, a fall resulting in three staples to the head on 1/28/17, and an occipital laceration from rolling or stepping out of bed on 4/29/17, warranting three staples again. The AMA, dated 5/12/17, noted these issues. However, no documentation was found to show that the IDT reviewed and analyzed specific data related to these incidents, such as the individual's blood pressures, to analyze the onset of symptoms and attempt to identify an etiology(ies). In addition, these significant data were not found in the AMA or nursing annual and quarterly assessments.

- No documentation was found to show that Individual #318's IDT discussed her previous UTIs and cultures showing E coli, and put actions in place to ensure that she was promptly changed when incontinent and that staff used the correct hygiene practices. The ISPA, dated 7/19/17, indicated the CT scan for the decubitus ulcer on her right hip showed fairly necrotic bone extending into the right hip and biopsy results were positive for E coli. The PCP indicated that the wound could heal, but the bone would not fully heal and that she was at high risk for sepsis. This situation was so serious that part of the IDT's discussion was about hospice care.
- Although the documentation from Individual #473's IRRF, AMA, and nursing annual and quarterly assessments indicated that the constipation/bowel obstruction risk area was "stable," her significant issue regarding poor fluid intake affected this risk area, as well as issues with her medications (i.e., dehydration can cause blood levels of medications to increase to toxic levels), UTIs, dry skin (i.e., which increases the risk for cracks and infections), electrolyte imbalances, cognitive functioning, and her overall health. Although it was clearly documented throughout the annual discipline assessments that she does not drink well, there was no ISPA or other document reflecting the IDT comprehensively reviewed all of the health issues that her poor fluid intake affects. There was some evidence that the IDT had been making attempts to increase her fluid intake by offering eight ounces of fluid at medication times and adding Jell-O and ice cream to her diet to provide more fluids. However, no clear analysis of her daily intake was found to show whether or not these interventions actually increased her overall daily intake.

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: 1) nurses administering medications according to the nine rights; and 2) nurses adhering to infection control procedures while administering medications. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 522	142	167	287	554	25	403	318	473
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R							N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										

	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 7/7	1/1		1/1	1/1	1/1	1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	86% 6/7	1/1		1/1	0/1	1/1	1/1		1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #522, Individual #167, Individual #287, Individual #554, Individual #25, Individual #318, and Individual #473.

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

d. The following concerns were noted:

- Individual #554's IHCP did not include the completion of lung sound assessments to address his high risk for aspiration. However, an ISPA, dated 3/30/17, addressed initiating lung sounds, but only for seven days to obtain a baseline.
- Individual #318's IHCP did not include the completion of lung sound assessments to address his high risk for aspiration.

f. It was positive that medication nurses followed the PNMPs of the individuals observed.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was the nurse that touched the eyedropper to Individual #287's eyes, which contaminated the bottle and then contaminated her other eye when the drops were administered. The eye drops were for conjunctivitis.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It is essential that referral to the PNMT occurs when individuals' increased risks warrant it, but referral for one of three individuals was significantly delayed, and the falls that occurred in the intervening months placed her at significant risk. Overall, IDTs and/or the PNMT also 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	522	142	167	287	554	25	403	318	473
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% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1

	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 2/3	N/A	N/A	0/1	N/A	N/A	N/A	N/A	1/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3			0/1					0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/3			0/1					0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/3			0/1					0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/3			0/1					0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/3			0/1					0/1	0/1

Comments: The Monitoring Team reviewed 15 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and skin integrity for Individual #522; GI problems, and weight for Individual #142; choking for Individual #167; choking, and falls for Individual #287; aspiration, and choking for Individual #554; choking, and falls for Individual #25; aspiration, and choking for Individual #403; choking for Individual #318; and choking for Individual #473.

a.i. and a.ii. None of the IHCPs included clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed three 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: falls for Individual #167, skin integrity for Individual #318, and weight for Individual #473.

Prior to referral to the PNMT on 7/25/17 for falls, Individual #167 fell a total of 24 times on the following dates: 2/27/17, 3/2/17, 3/5/17, 3/8/17, 3/14/17, 3/25/17, 3/27/17, 4/5/17, 4/6/17, 5/10/17, 5/17/17, 6/6/17, 6/9/17 (three falls), 6/10/17, 6/11/17, 6/13/17, 6/27/17, 7/3/17, 7/5/17, 7/14/17, 7/20/17, and 7/24/17. Waiting until Individual #167 technically met the criteria for

referral of greater than three falls per month for two consecutive months was not a clinically sound decision, as it did not address her significant risk of injury. After seven falls occurred over a four-week period of time, between 2/27/17 and 3/27/17, the IDT should have made a referral to the PNMT or the PNMT should have made a self-referral, and the PNMT should have at least conducted a review.

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

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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.	38% 3/8	0/1	0/1	0/1	N/A	2/2	0/1	N/A	0/1	1/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	1/1

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, data/documentation was generally not available to show the action steps included in IHCPs were implemented.

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

- Individual #522's IDT did not fully discuss or address the potential impact and risk that his increased seizures and lethargy posed. During the ISPA meeting on 1/12/17, Habilitation Therapy staff suggested adding information to the IHCP and PNMP to require the nurse to clear him for oral intake after the use of Diastat. However, evidence was not submitted to show that this recommendation was based on the OT or Speech Language Pathologist's (SLP) direct observation or assessment. Although the risk of aspiration is significantly increased when seizures occur during meals, the IDT did not increase his aspiration risk level, even though they added the seizure concern to the PNMP.
- For Individual #142, based on review of ISPA documentation, the IDT did not comprehensively discuss her weight increase, the

potential impact of medications, and the potential impact of her behavior during mealtimes. Moreover, the IDT did not develop an IHCP that set forth a plan for mitigating the weight risk.

- Despite Individual #167's frequent falls, the IDT did not make a referral to the PNMT. In addition, in March 2017, the IDT accepted a recommendation to track her sleep, but did not meet to discuss the results until July 2017. The IDT also recommended the PCP consider further testing of her knee and request a CT scan of her head. However, according to the ISPA, dated 8/2/17, it did not appear there had been follow-through on and/or discussion of these recommendations.
- On a positive note, Individual #554's IDT met in response to his hospitalization, and the OT and SLP conducted timely observation to ensure his safety during swallowing and intake.
- Although Individual #25's IDT met to discuss his falls and trial different equipment, missing from all the consults and assessments was justification for whether or not he would benefit from therapy to help improve his gait by increasing his safety awareness or teaching him to walk at a slower pace. No evidence was found to show that the IDT considered methods to improve his response to objects in his path. For example, Individual #25 had difficulty responding to wet floor signs and often ran into them. He also hit doorways. The IDT had not documented discussion of possible solutions, such as painting the door jams or raising the height of the wet floor signs.
- On 4/18/17, staff identified a Stage IV pressure ulcer on Individual #318's right ischial tuberosity (i.e., "sit bones"). No evidence was found to show that the IDT met to address the pressure ulcer.

c. It was positive that the PNMT met with IDTs to comprehensively discuss the PNMT assessment and integrate next steps into individuals' IHCPs.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Although some improvement was noted in comparison with previous reviews (i.e., Round 9 – 30%, Round 10 – 35%, Round 11 -35%, and Round 12 – 51%), during numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	51% 23/45	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 2/4	

Comments: a. The Monitoring Team conducted 45 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 15 out of 23 observations (65%). Staff followed individuals' dining plans during eight out of 22 mealtime observations (36%).

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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.	100% 1/1					1/1			N/A	
Comments: a. It was good to see that the plan Individual #554's IDT developed was consistently implemented.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. To explain, without clinically relevant, measurable goals that are included in ISPs, and on which data and analysis of data is included in QIDP reviews, IDTs did not have a valid method for measuring individual outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 3/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	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 have been achieved, the	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	IDT takes necessary action.	0/9									

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #167 (i.e., walking safely by picking up both feet), and Individual #287 (i.e., ambulation). Although Individual #403's goal/objective (i.e., for safe swallowing) was clinically relevant, it was not measurable, because "slow rate" was not defined.

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

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	13% 1/8	0/1	N/A	1/1	0/1	0/1	0/1	0/1	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.	50% 1/2	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. For the individual that scored positively on this indicator, evidence was found in the OT/PT IPNs.

b. On 8/21/17, Individual #167's IDT held an ISPA meeting to discuss her discharge from OT/PT services. Falls had decreased, but were still occurring. It was unclear what supports the IDT added to her IHCP to address the continued falls.

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 clean adaptive equipment (Round 10 – 97%, Round 11 – 100%, and Round 12 - 90%), Indicator a will move to the category requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 10 – 84%, Round 11 – 65%, and Round 12 - 79%), Indicator c 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	8	597	422	453	291	554	91	43	96
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	90% 26/29	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	2/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	79% 23/29	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	2/2
		Individuals:									
#	Indicator		437	37	233	287	26	465	14	519	366
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		2/2	1/1	1/1	2/2	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.		2/2	1/1	1/1	2/2	1/1	0/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		257	492	318	272	595	276	323	254	
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	0/1	0/1	1/1	0/1	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	0/1	1/1	1/1	1/1	1/1	

Comments: a. The Monitoring Team conducted observations of 29 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exceptions were Individual #595's Velcro shoes that appeared worn and torn, and Individual #323's seatbelt cover that was worn thin, ripped, and dirty.

c. Based on observation of Individual #8, Individual #453, and Individual #519 in their wheelchairs, the outcome was that they were not positioned correctly. Individual #554, and Individual #465's chest straps were around their upper waists as opposed to their chests. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. Individual #272's hand positioner was missing.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. At the time of the last review, none of these indicators had sustained high performance scores sufficient to move to the less oversight category. Presently, no indicators will move to the category of 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.

Without ISP personal goals that are individualized, measurable, and for which data are collected, it is impossible to determine progress. Further, action steps were not consistently implemented for any individuals. It was, however, positive that many staff members knew the preferences of individuals.

Same as last time, attention to SAP development and implementation is required in order to meet criteria. For instance, none of the SAPs were complete and, in no case observed by the Monitoring Team, was the SAP implemented as written.

Overall, engagement in activities was quite poor. Visits to multiple homes and day programs revealed individuals sitting without activities and often with very little interaction with staff. Some individuals were observed with their shirts up over their heads or off completely. It was good, however, to see that the Center was measuring engagement and had set goals for all sites on campus. These goals were not yet being met.

Collaborative work between Brenham SSLC and Brenham Independent School District (ISD) had occurred since the last review and progress was made in working together on activities, such as attending ISP and Individual Education Plan (IEP) meetings and conducting observations.

Overall, IDTs did not have a way to measure communication outcomes for individuals. It also was concerning that often individuals' alternative and augmentative communication (AAC) devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.												
Summary: Without personal goals that are individualized, measurable, and for which data are collected, it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	179	146	522	167	25			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
Comments: As Brenham SSLC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators. Examples of how this might be accomplished are provided in this report. 4-7. A personal goal that meets criterion for outcomes 1 through 3 is a pre-requisite for evaluating whether progress has been made. None of the personal goals met criterion for indicators 1 through 3 as described in Domain 1. There was no basis for assessing progress because the IDTs failed to develop personal goals that were also measurable. The Monitoring Team found there to be continued a lack of implementation, monitoring, and reliable and valid data.											

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: It was good to see that staff were generally knowledgeable about individuals' preferences. An ongoing need is to ensure that the goals and action plans are implemented. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	179	146	522	167	25			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments: 39. It was positive that many staff knew the preferences of individuals, however, overall staff knowledge regarding individuals' ISPs												

was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation. For example, when asked about Individual #167's day program, staff stated her goal was to keep her at the program site for as long as possible.

40. Action steps were not consistently implemented for any individuals, as documented elsewhere in this section and throughout this report.

Skill Acquisition and Engagement

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

Summary: These indicators will remain in active monitoring. Same as last time, attention to SAP development and implementation is required in order for the indicators of this outcome to make progress towards meeting criteria.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
6	The individual is progressing on his/her SAPS	0% 0/16	N/A	0/2	0/2	0/2	0/2	0/1	0/2	0/3	0/2
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.	0% 0/13	N/A	0/2	0/1	0/2	0/2	N/A	0/2	0/2	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 16/16	N/A	2/2	2/2	2/2	2/2	1/1	2/2	3/3	2/2

Comments:

6. Sixteen of the 21 SAPs had sufficient data to assess progress. The exceptions were SAPs that had not been introduced/initiated/implemented (e.g., Individual #142's log money SAP not been introduced between her ISP in February 2-17 and her transition to another facility in September 2017; Individual #205's learning to dial a phone not introduced between March 2017 and August 2017; Individual #146's making pancakes SAP not introduced since his ISP in March 2017; and Individual #147's learning to do her laundry not introduced since her ISP in April 2017). Other SAPs had data for only one month of implementation (e.g., Individual #128 making jewelry and Individual #276 mixing Crystal Light).

Of the 16 SAPs that were assessed, data presented for 13 SAPs indicated the individual was not making progress. Of the remaining three SAPs, it was determined that the data were not reliable. In one case, the IDT decided to discontinue Individual #265's street crossing SAP due to his completing the objective. The data presented did not support this finding.

It should be noted that graphs depicting progress, or the lack thereof, often included information regarding the number of trials implemented each month. For 15 SAPs, there was evidence that the scheduled number of trials were implemented (or were exceeded) in each reported month. In six SAPs, the number of scheduled trials was never implemented and in the remaining six SAPs, the number

of scheduled trials were implemented between 17% and 80% of the time.

7. As indicated by the data, no individual had met his or her SAP.

8. In no case was there evidence that the IDT had identified action to take when the individual was not making progress. For example, repeated monthly reports of problems with the electronic data system did not result in a change in implementation of Individual #128's making jewelry SAP.

9. Monthly reviews and SAP graphs reflected a review of data, however, timely action was often not taken to address a lack of progress.

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

Summary: Although none of the SAPs contained all of the necessary components, most of the SAPs included some of the components. Critical missing components were specific instructions for staff and responses/consequences for correct performance. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
13	The individual's SAPs are complete.	0% 0/21	0/1	0/3	0/3	0/3	0/2	0/1	0/3	0/3	0/2

Comments:
13. None of the SAPs were complete. While most included a task analysis (where appropriate), a behavioral objective, operational definitions, relevant discriminative stimuli, and a plan for maintenance and generalization, other necessary components were missing. These included:

- Specific instructions for teaching the skill were minimal and not individualized. Often, instructions were related to the individual's communication skills (an important consideration, but not specific to how to teach the skill) or a review of the individual's problem behaviors.
- Teaching schedules were often quite limited and, as noted elsewhere in this report, were often not met. This resulted in limited opportunities for the individual to acquire the skill.
- Consequences for correct responding were often limited to praise. Only in one case (Individual #205's learning to replace the shredder bag), was a positive response to praise observed.
- Staff are advised to provide teaching instructions that include appropriate presentations of materials, schedules that ensure sufficient opportunities for learning to occur, and the use of individual specific reinforcers following correct responding.

The facility scheduled a weekly meeting of the Skill Acquisition Plan Review Committee. When this meeting was observed during the onsite visit, there was evidence of good participation by habilitation therapies staff. Feedback and helpful recommendations were provided by the therapies director and her staff. It was not evident that other members of the committee were present. Per the policy, the BCBA/BHS is expected to discuss preference assessments and barriers to the proposed SAP. There was little evidence of this input. Further, the behavior health assistant who developed the SAP was often not supported by the more advanced behavioral health services

staff members as he or she responded to questions posed by the committee members. It was also concerning that 45 minutes after the meeting had started, three staff members arrived, two of whom were BCBAs. Also, an area discussed with the director of behavioral health services was the expectation that SAPs developed by habilitation professionals would be reviewed first in this committee. This, however, can result in a delay in implementation of SAPs designed to address therapeutic skills (e.g., communication, physical, occupational). As such, the Center may want to make an exception for SAPs developed by trained habilitation therapists, that is, to expedite implementation, these could be reviewed by the IDT at an ISPA, thereby, removing one additional step in the process.

Outcome 5- SAPs are implemented with integrity.

Summary: Performance fell from low scores at the last review to 0% for both indicators for this review. Much work is needed to ensure SAPs are implemented as written (and that they are written correctly, which is indicator 13 above). These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	128	205	146	179	147	276	265	522
14	SAPs are implemented as written.	0% 0/4	N/A	N/A	0/1	N/A	0/1	N/A	0/1	N/A	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/17	N/A	0/3	0/2	0/2	0/2	N/A	0/3	0/3	0/2

Comments:

14. The Monitoring Team was able to observe one SAP being implemented for each of four individuals. In no case was the SAP implemented as written.

- For Individual #205, the staff member followed the plan, used an appropriate discriminative stimulus, and offered praise upon task completion. But Individual #205 did not touch the bottom of the shredder bin with his hand as described in the task analysis. Staff may want to consider a revision of this SAP as this will be difficult for him to do as he completed the task while seated in a chair.
- Individual #179 was asked to complete his SAP while lying on his bed. While the staff member appropriately provided instruction in recording the number of receipts and the date, these steps were not in the plan. Once the calculation was completed, the staff member told the individual to record the amount of money he had remaining. Again, although this was appropriate, according to the SAP, this last step should be completed by staff.
- While teaching Individual #276 to use the Joy Player, the staff member did not follow the guidelines following an incorrect response. Rather than increasing the level of prompting, the staff member repeated the initial instruction multiple times before using a pointing prompt. This was followed by additional verbal prompts before a partial physical prompt resulted in a correct response. It was, however, positive to observe staff prompting Individual #276 to use her dominant, left hand.
- While working on letter recognition with Individual #522, the staff member presented each letter in the individual's last name in a sequence different than that identified in the SAP. Additionally, error correction procedures were not followed as written.

The director of behavioral health services reported that, currently, the individual's BCBA or behavioral health specialist did not get

involved in the training of SAPs. This task was instead left to the behavior health assistant who typically had the least amount of training in applied behavior analysis. The assistant trained the individual's home manager, who hen trained the direct support professionals, and then the QIDP, who was to assess treatment integrity.

15. A schedule of SAP integrity had been established by the facility. However, of the 17 SAPs that had been implemented, there was no indication that staff had been observed actually implementing the SAP in vivo.

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

Summary: Both indicators showed improvement since the last review. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
16	There is evidence that SAPs are reviewed monthly.	71% 15/21	0/1	1/3	3/3	2/3	2/2	0/1	3/3	3/3	1/2
17	SAP outcomes are graphed.	95% 19/20	N/A	3/3	3/3	2/3	2/2	1/1	3/3	3/3	2/2

Comments:

16. There was evidence that monthly data based review had occurred for 15 of the 21 SAPs. The exceptions were Individual #142's SAP, Individual #128's making jewelry and washing hair SAPs, Individual #146's flossing teeth SAP, Individual #147's laundry SAP, and Individual #522's letters of the alphabet SAP. In some cases, problems were attributed to the electronic data recording system.

17. Graphs were provided for 19 of 20 SAPs. The exception was Individual #146's making pancakes SAP that was reviewed in the QIDP monthly report even though it had not been introduced. Individual #142's SAP was excluded from this indicator because it was not implemented before she transitioned from the facility.

It should be noted that SAP data presented in graphic format did not always correspond to the data reviewed in the QIDP monthly review. Staff are advised to check for correspondence between these two reports.

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

Summary: Individuals were not usually engaged in activities when directly observed by the Monitoring Team. It was good, however, to see that the Center was measuring engagement and had set goals for all sites on campus. These goals were not yet being met. These indicators will remain in active monitoring. With sustained high performance, indicator 20 might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522

18	The individual is meaningfully engaged in residential and treatment sites.	13% 1/8	N/A	0/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments:

18. During the onsite visit, the Monitoring Team observed seven of the nine individuals in their homes. The exceptions were Individual #142 who had transitioned to another state supported living center and Individual #147 who was either asleep or not present when the Monitoring Team arrived. Observations in all homes reflected very limited engagement. Of the three individuals observed in their day programs, Individual #205 was observed shredding paper and Individual #146 was helping staff record his arrival time. Individual #276 was not engaged when observed in her day program. Others were not observed at their day programs either because they were in school or working in their community-based job. Even individuals with one-to-one staffing were often observed unengaged on their homes. Similarly, school-aged individuals were often observed without meaningful engagement on their homes. Day programs, with the exception of paper shredding sites, reflected individuals sitting without meaningful engagement and often very limited interaction from staff.

19-20. The facility had established a schedule for regularly assessing engagement in all homes and day program sites, with the exception of school and competitive employment sites. Goal levels were expected to be 80% engagement.

21. In each of the individual's homes, engagement had been assessed at least monthly over a six-month period. Acceptable levels of engagement were found in the homes in which Individual #142, Individual #205, Individual #146, Individual #179, and Individual #147 resided. Engagement was not assessed in the public school or in Individual #179's community-based work site. For Individual #205 and Individual #276, engagement was not assessed each month in their day programs, and when it was assessed, it was below 80%. For Individual #146, although engagement was adequate, it was not assessed a sufficient number of times in his day program.

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

Summary: Many individuals had few opportunities for community outings for recreational and/or for SAP training in the community. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	205	146	179	147	276	265	522
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	are established and achieved.	0/9									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. Evidence indicated that two individuals, Individual #147 and Individual #276, had achieved their identified frequency of community-based activities. None of the individuals had goal frequencies for community-based SAP training identified in their ISPs. There was no evidence of actions taken to improve community-based access for recreational or training purposes.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

Summary: Collaborative work between Brenham SSLC and Brenham ISD had occurred since the last review and progress was made in working together on activities, such as attending ISP and IEP meetings and conducting observations. Not all of the sub-indicators for these five individuals were yet at criteria. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	128	147	265	522				
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. The Monitoring Team reviewed five individuals who were attending school. Individualized Education Programs were available for all, but Individual #147. In these programs, there was evidence that the QIDP had attended IEP meetings for Individual #128, Individual #265, and Individual #522, but not Individual #142. All of the IEPs reflected a discussion regarding inclusion and an extended school year. The ISPs for all five individuals included public school-related information, with action plans identified for all, but Individual #522. Examples of good action plans included: Individual #147 whose team was interested in researching possible volleyball game participation at school and, after receiving the IEP, would meet to develop SAPs related to math and science goals; and Individual #265 whose team wanted to meet with the school to incorporate his interest in flag care and his participation in clubs.

It was not clear that these action plans had been implemented. There was no evidence that the IDT regularly reviewed an individual's progress at school. This was discussed with facility staff who were encouraged to meet when report cards were distributed.

The facility and the local public school district had taken steps to ensure better communication and coordination of services. Regular meetings were now held, special education staff were participating in ISP meetings, and facility staff could now make observations at school without prior scheduling. Some changes in classroom environments and teacher assignments had occurred to better serve the school-aged individuals from Brenham SSLC. The facility staff reported that they were also trying to ensure that efforts were made to carry the school curriculum over to programs offered 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	522	142	167	287	554	25	403	318	473
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: a. through e. Based on the records provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed refused dental care.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure communication outcomes for individuals. To explain, without clinically relevant, measurable goals that are included in ISPs, and on which data and analysis of data is included in QIDP reviews, IDTs did not have a valid method for measuring individual outcomes. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
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	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	22% 2/9	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	measurable goal(s)/objective(s).	0/9									
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, as well as measurable was Individual #142's goal/objective related to articulation.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #287 (i.e., choosing activities, and signing for "music").

c. through e. For Individual #142's goal/objective related to articulation, although data were submitted in the SLP consults to show it was implemented, no evidence was found to show the QIDP had reviewed or analyzed the data in the integrated monthly reviews. Habilitation Therapy staff should work with the QIDPs to ensure an analysis of the data is available for all IDT members.

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

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	522	142	167	287	554	25	403	318	473
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	22% 2/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included:

- Programs were not run at the stated frequency.
- No evidence was found of the use of communication strategies or their effectiveness.
- In its comments on the draft report, the State disputed the Monitoring Team's findings with regard to Individual #318, and requested a change in scoring. More specifically, the State indicated: "Individual #318 does not have formal communication services so there is no a need for an action plan. TX-BR-1710-II-...80 (pg. 2-9 of 9). The Lead Monitor reviewed Individual #318's ISP and confirmed that, at the recommendation of the SLP, the IDT agreed upon a SAP that read: "Choose Preferred Items: Use bright color objects to get her attention and have her choose it. Independence eye gaze." (Pages 8 and 19 of TX-BR-

1710-II-[Individual #318].01).

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
Summary: The Center should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring. [**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	91	97	26	37	465	453	450	332	Common Area Devices Driscoll
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	39% 9/23	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	2/9
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	4% 1/23	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/9
			Individuals:								
#	Indicator		Common Area Devices Bowie								
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		4/6								
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/6								
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 often were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. In its comments on the draft report, the State questioned the findings regarding Individual #465. The State indicated that he did not have an AAC device, and referenced a response to a Tier I document request. Unfortunately, the Center provided conflicting information in its document request responses. Although the referenced Tier I document did not list Individual #465 as having an AAC device, Tier II document request #TX-BR-1710-II.K listed him as having a pocket talker. This was the more recent document, and the one on which the Monitoring Team relied while on site. The Center should determine whether or not Individual #465 has an AAC device, and correct its records as needed.										

In Driscoll, two of the nine devices were in working condition, and in Bowie, four of the six devices were in working condition.

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. This is only the second round of reviews in which the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, early in 2016, the Center began additional post-move monitoring responsibilities, and had begun 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.

Since the last review, some progress was made, but more work was needed to make supports in the CLDPs measurable. Similarly, although progress occurred since the last review, a number of 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, and scoring the presence or absence of supports based on IDTs' identification of timeframes that meet individuals' needs.

Neither individual reviewed had experienced PDCT events, which was good to see.

Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments, although some assessors had made some good improvements. The Center still needed to improve upon its training practices to ensure that staff have all needed knowledge and competencies prior to transition. A focus also was needed on Center staff collaborating with community clinicians, as appropriate.

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: Since the last review, some progress was made, but more work was needed to make supports in the CLDPs measurable. Similarly, although progress occurred since the last review, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	#200	#256							

		Score									
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. IDTs must describe supports in clear and measurable terms to ensure a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. For the currently reviewed CLDPs, the Monitoring Team noted some evidence of incremental progress since the previous report, but supports still did not consistently fulfill the requirements for compliance or provide the Post-Move Monitor with measurable criteria or indicators that could be used to ensure supports were being provided as needed. In particular, the IDTs still needed to focus considerable attention on the development and implementation of pre-move training supports. It is essential for the Center to be able to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. The Center had made some strides in constructing pre-move training supports for measurability, but still needed to make additional improvements. To achieve compliance, pre-move training supports should address the content of training that provider staff would need, as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. At the time of the last monitoring visit, the Monitoring Team found pre-move training supports did not include any descriptions of the training methodologies or competency demonstration criteria. The evidence required for all the in-service supports called only for signed rosters, with no competency testing or demonstration, or even any staff interview.

Specific examples of pre-move and post-move supports that met criterion and those that did not are provided below.

- Pre-Move: The IDTs developed only one pre-move support for Individual #200 and 13 pre-move supports for Individual #256.
  - Individual #200 transitioned to a provider home after she had been on an extended home visit with her parents. She did not return to Brenham SSLC prior to moving to the provider home, and provider staff had begun to provide some HCS services in the parents' home before the final move took place. The IDT developed one pre-move support, for the QIDP to provide training on the Preferences and Strengths Inventory (PSI). The pre-move training support did not provide any competency expectation for staff or provide any criteria by which the PMM could assess for the presence of the support. Training material provided for review consisted only of a training roster and included no competency testing. The IDT addressed the remaining training needs as post-move supports, including support needs in the areas of safe dining techniques and communication strategies. However, it would have been important for the IDT to confirm that the supports provided in the family home in the interim before the final move to the new provider's location met the individual's needs, and staff providing them were competent.
  - The CLDP for Individual #256 contained 13 pre-move supports, including eight supports for pre-move provider staff training in areas such as the use of his communication device and symbols; implementation of recommended communication strategies; dining/feeding strategies; medications; allowing his legs to relax after transferring to and from his wheelchair; preferences, likes/dislikes; and, a skill objective to wipe his mouth after eating. Most of these training supports provided a statement of the purpose of each type of training, which was a positive step forward, but

they did not set any competency expectation or specific criteria by which the PMM could effectively monitor. For example, one support called for Brenham SSLC Habilitation staff to provide instruction to the provider staff regarding how to implement recommended communication strategies. It provided no additional information as to what specific knowledge provider staff should gain or how that knowledge or competency could be assessed. Similarly, a training support called for the RN Case Manager to provide instruction regarding Individual #256's medication, but provided no further detail.

- Post-Move: The respective IDTs developed 30 post-move supports for Individual #200 and 27 post-move supports for Individual #256. Both CLDPs included some measurable supports that met criterion, especially related to arranging for medical appointments and consultations and laboratory testing requirements within specific timelines. This was positive, but the IDTs did not yet consistently identify post-move supports that met criterion for measurability. Examples included:
  - For Individual #200, the CLDP included a post-move support to obtain/review a Modified Barium Swallow Study (MBSS) that had been completed while she was in her family's care for the purpose of determining the safest diet texture. The IDT did not specify who would review the MBSS and/or make the determination regarding texture, or to whom and how this information would be disseminated. The support had a due date of 8/2018. Given the urgency of staff having current knowledge of Individual #200's safest diet texture, a due date that was one year later would not be sufficient to describe when the support needed to be in place. The Monitoring Team noted many of the post-move supports used that same due date format.
  - Overall, Individual #256's IDT integrated measurable criteria in his post-move supports on a more consistent basis than Individual #200's, but often did not provide clear due dates that were consistent with the purpose and/or urgency of the supports. The IDT needed to make some additional improvements to enhance measurability as well. For example, the CLDP included a post-move support for Individual #256 to be referred to his primary care practitioner (PCP) should there be any concerns regarding his hearing acuity. The IDT did not provide any guidance as to how staff could be alert to or recognize concerns related to his hearing. This was of some concern because the CLDP narrative noted Individual #256 had been unavailable for hearing testing prior to transition, but that previous testing indicated he had a slight to mild hearing loss in the better ear.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. These two CLDPs did not comprehensively address support needs and did not meet criterion. In addition to those identified above under Indicator 1, other examples included:

a. Past history, and recent and current behavioral and psychiatric problems: Supports in this area demonstrated improvement from the previous monitoring visit, but did not yet sufficiently reflect past history, and recent and current behavioral and psychiatric problems in a consistent manner. Examples included:
   - The CLDP did not fully address the need for staff knowledge regarding Individual #200's behavioral history. For example, she had a recent history of physical and verbal aggression. The IDT did not develop any support to ensure staff were familiar with her history of behavioral needs or strategies that had been either effective or ineffective at the Center. Instead, the CLDP included only a support stating she would need a behavior support plan in the community to address physical aggression and verbal aggression as medication changes are made. The due date was 8/2018, or one year after transition.
   - At the time of Individual #200's ISP in February 2017, the IDT considered her to be at high risk for side effects due to

psychotropic polypharmacy, a history of adverse reactions to psychotropic medications, and many medication changes. At the time of her CLDP, the IDT expressed concern that her psychotropic medication regimen was negatively impacting her functional status, but the Legally Authorized Representative (LAR) was not in agreement. The IDT did not develop assertive supports regarding this history and the IDT's current concerns.

- Overall, Individual #256 did not have significant behavioral needs at the time of transition. He had required a PBSP at the time of his admission to Brenham SSLC in September 2015, due to a history of mouthing and self-injurious behavior defined as biting his hand. The Center had discontinued the PBSP, because those behaviors had not been observed since his admission. It was positive Individual #256 was doing well behaviorally, but it would have been prudent for the CLDP to ensure that provider staff were familiar with his history and to be alert for recurrence.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: Overall, the Center evidenced some progress in developing supports that addressed safety, medical, healthcare, therapeutic, risk, and supervision needs. As noted with regard to Indicator 1, the respective IDTs developed many supports to ensure medical/healthcare treatments and consultations were provided as needed and in a timely manner, which was positive. Both CLDPs also included either pre- or post-move training supports that specified direct support staff needed to be trained for medical, healthcare, therapeutic and risk needs. Overall, however, the respective IDTs did not develop comprehensive supports for some significant needs in these areas. Examples included:
    - The CLDPs did not include comprehensive supports regarding required level of supervision in the community for either individual.
    - Both individuals had a diagnosis and recent history of constipation, but neither CLDP included supports for staff knowledge of this need or for tracking bowel movements.
    - Individual #200 had a lumbar shunt due to a diagnosis of Chiari malformation. In July 2017, she had been hospitalized for a full work-up of brain and spine function and a full brain MRI due to signs and symptoms of a malfunction of the lumbar shunt. A living options addendum, dated 6/28/17, indicated the Brenham SSLC medical team stated she needed to be monitored for signs and symptoms of such a malfunction. The IDT did not develop any supports for staff knowledge of these signs and symptoms.
    - Individual #256 had many physical and nutritional management needs, including, for example, specialized food texture and mealtime strategies for safe dining, mobility and positioning, and bathing. He also had various adaptive equipment needs. His 14-day ISPA held at the time of referral indicated he would need physical therapy/occupational therapy (PT/OT) on a consultative basis, as well as access to a wheelchair technician for repairs and adjustments. Based on his needs, these would have been important supports. The IDT did not include these supports in the CLDP.

c. What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, PSI, and the CLDP for the section that lists the outcomes important to the individual. Neither of the CLDPs met criterion for addressing this component. Examples included:
    - For outcomes that are important to an individual, the IDT should develop specific and measurable expectations.
        - Individual #200's CLDP did not include any narrative in the section describing her important outcomes, although it did address some of her preferences in the narrative and with supports.
        - For Individual #256, the CLDP identified increased opportunity to spend time with his family, but did not include any related supports. The Monitoring Team took note that the family had been very involved in the location and selection of the provider home, and indicated an intention to visit regularly. This was positive,

but the IDT still needed to develop specific supports that provided a baseline of expectation as well as a way to measure whether that important interaction was occurring. This would further allow the IDT to determine if there were issues or concerns that needed to be resolved.

- The IDT should also consider supports that formalize the expectation that transition will offer enhanced opportunities for an individual to partake in community life as well as the normal rhythms of day-to-day home life.

d. Need/desire for employment, and/or other meaningful day activities in integrated community settings: Both individuals were of school age. Individual #200's CLDP included a broadly stated support for school attendance or home-bound services to be provided. Individual #256's CLDP did not include a support defining such an expectation. Neither CLDP included specific supports for meaningful day activities in an integrated community setting.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: Neither CLDP met criterion.
   - For Individual #200, the behavioral health assessment included several strategies for positive reinforcement and other motivating factors, such as calming strategies. For example, the assessment noted she preferred a calm environment and to ask her if she would like to move to another location if the house became loud and or chaotic. It further indicated she was not a morning person, so it would be helpful to give her a few minutes to sit up in bed before starting her morning routine. If Individual #200 became upset, the behavioral assessment instructed that staff should not tell her she needed to go to her room to calm down, but to prompt her replacement behaviors instead. The CLDP did not include any support for staff knowledge of these strategies.
   - For Individual #256, the PT/OT assessment noted he had a personal massager for vibratory sensory input with an effective calming response. It also indicated he liked vibration and vibrating manipulatives, to relax on the patio, and to be outside. The personal massager was included in a list of equipment to be provided as a pre-move support, but the CLDP did not include any supports that required staff knowledge of using the massager or other vibrating manipulatives for the purpose of sensory input or to produce a calming effect. The IDT did not develop supports for spending time outside or on the patio.

f. Teaching, maintenance, participation, and acquisition of specific skills: Neither CLDP included specific supports for skill acquisition and maintenance.

g. All recommendations from assessments are included, or if not, there is a rationale provided: The Center had a process for reviewing CLDP assessments, documenting discussion, and making final recommendations. The IDTs did not yet consistently address all recommendations or provide a coherent rationale why those recommendations should be modified or not included. For example:
   - For Individual #200, the psychiatric assessment included an "urgent" recommendation to have a face-to-face evaluation with her new psychiatric provider within seven days to assess for medication efficacy and side effects. The IDT developed post-move supports calling for the provider registered nurse, rather than a psychiatrist, to complete an assessment of side effects of medications within in seven days of admission and for monthly review of psychiatric medications monthly by a psychiatrist. The IDT did not provide a clear rationale as to why these supports would address the urgency of the recommendation or the overall concern related to her functional deterioration.
   - For Individual #256, the OT/PT assessment included a recommendation for access to a qualified wheelchair technician, but the IDT did not develop a related support or indicate why the recommendation did not need to be addressed.
   - Also for Individual #256, the nursing assessment indicated meal and fluid intake should be tracked daily and reviewed

	by the provider nursing staff weekly. The CLDP included a support for tracking meal intake and refusals daily, but did not provide for nursing review at any point. Another support called for the PCP to be notified of weight changes of five pounds or in one month, but this did not obviate the need for proactive nursing oversight of intake.

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, and scoring the presence or absence of supports based on IDTs' identification of timeframes that meet individuals' needs. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	#200	#256								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1								
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A								
	Comments: 3. For both Individual #200 and Individual #256, post-move monitoring had been completed on a timely basis for the seven-day PMM periods. The PMM completed each of these post-move monitoring visits in the proper format. For both individuals, the PMM typically provided comments regarding the provision of supports. These post-move monitoring visits both met criterion for timeliness. Still, some improvements were needed in relation to the documentation of this process, as described throughout the discussion of this Outcome.											

4. The PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports in some instances, but there were issues that compromised reliability and validity. IDTs should carefully consider how the PMM can best assess whether a support is being met as required and review what types of evidence would be needed to demonstrate this. Such evidence can include interviews, observation, and documentation, which should not be considered mutually exclusive. Reliability and validity are enhanced when more than one source of data can be cross-checked. Concerns regarding reliable and valid data available for these two CLDPs included:

- Individual #200's did not set clear and reasonable due dates, as described above. As a result, some supports were marked as not applicable, based apparently on the PMM's opinion that the supports were not required to have been in place within the first seven days.
- Neither CLDP consistently specified how the PMM could reliably measure the presence of many of the staff training and knowledge supports for both individuals, as described elsewhere in this section.

5. Based on information the Post Move Monitor collected, neither individual had consistently received supports as listed and/or described in the CLDP. For example:

- For Individual #200, many post-move supports did not provide due dates consistent with the need or purpose addressed by those supports. At the time of the seven-day PMM visit, Brenham SSLC had not yet completed provider staff training regarding her needs for communication, showering, and dining. The PMM Checklist indicated these trainings would take place once Individual #200 transitioned from her family's home to the provider group home, but this did not take into account the reality that provider staff were already providing services in the family home. The PMM's comments indicated these staff were assisting Individual #200 with showering and dining, and were ostensibly communicating with her in the process, so they needed to have been trained in how to do these things safely and effectively.
- As described further below, Individual #256 had not yet received supports for weekly outings or use of an electric toothbrush.

6. Based on the supports defined in the CLDP, the Monitoring Team could not verify the PMM scoring was consistently correct for these two CLDPs. For example:

- At the time of transition, Brenham SSLC had not yet completed provider staff training for some of Individual #200's important needs, as described above. The CLDP indicated the due date for these trainings as 8/2018. At the time of the seven-day PMM visit, the PMM marked these supports as not applicable, but provider staff were actively assisting Individual #200 in these important areas and should have received the relevant training.
- The CLDP included a support for Individual #256 to have opportunities to participate in community outings at least weekly. The PMM documented he had not had any such opportunities, but marked the support as not applicable, because Individual #256 had only transitioned seven days earlier. While an IDT might decide that outings would not be prioritized for the first week after transition, this CLDP did not indicate the IDT made such a determination. The prescribed due date of 8/2018 left this up to the PMM to make a judgement call.
- Also for Individual #256, the CLDP called for him to participate in tooth brushing with an electric toothbrush at least two times daily. The PMM documented the provider had not yet begun formally tracking this requirement, because Individual #256 had only transitioned seven days earlier. The comments also noted that staff interview indicated Individual #256 was being assisted to brush his teeth twice daily, but that an electric tooth brush was not yet available. The PMM marked this support as

present, in part because Individual #256's father stated he would be bringing an electric toothbrush and because staff reported they were assisting with tooth brushing twice a day as required. The PMM should accurately mark supports that are not in place for the purpose of ensuring appropriate follow-up, even when the provider, or in this case the family, indicates a plan for resolving the issue. It was positive the PMM addressed this need and plan for resolution in the section for documenting areas of concern or unmet supports, but still should have initially marked the support as not in place.

7. through 8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. The Monitoring Team noted some good examples of activities to ensure needed follow-up took place. For example, it was positive the PMM followed up on the need for bowel movement tracking for Individual #256, even though the CLDP did not include a needed support in the area. To move toward compliance, the IDTs should focus on developing measurable supports that provide the PMM with clear criteria for evaluating whether corrective action is needed, and the PMM should, at a minimum, adhere to those requirements. As described above, the IDTs did not consistently provide clear parameters, and the PMM sometimes made judgement calls about the presence of supports that could have hampered the identification of a need for follow-up.

9. through 10. Post-move monitoring did not occur during the week of the onsite review. Therefore, these two indicators were not scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.

Summary: Neither individual had experienced PDCT events, which was good to see. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	#200	#256							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							
	Comments: 11. Neither individual had experienced a PDCT event. Since her transition, Individual #200 had moved from her family home to the provider home as indicated in the CLDP. In an abundance of caution, the Center identified this as a PDCT event, since technically she had a change of residence after transition occurred. This was a part of the plan, however, and therefore not a disruption.										

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: Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments, although some assessors had made some good improvements. The Center still needed to improve upon its training practices to ensure that staff have all needed knowledge and competencies prior to transition. A focus also was needed on Center staff collaborating with community clinicians, as appropriate. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	#200	#256							
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.	0% 0/2	0/1	0/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the	0%	0/1	0/1							

	day of the move.	0/2									

Comments: 12. Assessments did not yet 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 Integrated Risk Rating Form (IRRF) for these 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 Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.
  - Similarly, the Center did not provide updated pharmacy assessments or the most recent Quarterly Drug Regimen Review (QDDR) or reference it in the CLDP review of assessments for either individual.
  - For Individual #200, the behavioral health assessment indicated it was developed in preparation for her annual ISP meeting on 2/27/17, which was approximately six months prior to her transition date.
  - For Individual #256, other assessments were updated on a timely basis.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments did not consistently meet criterion, but the assessments for Individual #256 showed improvement in this area in comparison with assessments reviewed during the last monitoring visit. Individual #200's assessments were complicated by the fact she had been on extended home visit for some months prior to her transition, such that some clinicians had not been able to make recent observations. Thus, they relied on reporting by others to assess her current status. For example, it was commendable that Center OT/PT staff made a visit to the home to complete a current assessment update, particularly since Individual #200's family reported that her overall physical and functional status had declined significantly. The nursing update did not benefit from this first-hand knowledge.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Examples of improvement in this area included the OT/PT and speech assessments for these two individuals, as well as the dysphagia assessment for Individual #256. This was positive, but overall, assessments did not consistently meet criterion for this indicator. Updated assessments did not consistently provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not consistently address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization.

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. Neither CLDP met criterion for this indicator, due to the failure of the IDTs to set clear and reasonable timeframes for each action to be completed. For both individuals, the CLDP indicated due dates of 8/2018, or one year after transition, for most supports.

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 Monitoring Team requested and reviewed the training documentation, including the training and testing materials. As described above in Indicator 1, the Center still needed to improve upon its training practices to ensure that staff have all needed knowledge and competencies prior to transition. Neither of the CLDPs met criterion for this indicator.

- For Individual #200, documentation did not demonstrate that training had been offered to provider staff as needed. As described above under Indicator #1, the CLDP included only one pre-move training support, for the Brenham SSLC QIDP to complete PSI training. Per the Transition Log and the pre-move site review (PMSR), this was completed on 8/25/17. As detailed with regard to Indicators #5 and 6, post-move supports called for various training, but no documentation was available to demonstrate it had been completed. Per interview with the transition staff, the Center did not offer this training to provider staff while Individual #200 was still in her family home, but should have. Staff training did occur when Individual #200 transitioned to the provider home, per transition staff, but training materials and documentation were not made available.
- For Individual #256, the Monitoring Team was similarly unable to evaluate whether the training met the needs of the individual. The training supports did not identify competency criteria for staff and the documentation provided did not include training materials.

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

- For Individual #200, the IDT had expressed considerable concern about the need for collaboration with the community PCP. Per the documentation and interview with Individual #200's QIDP at the Center, Individual #200's mother often obtained medical and health care services in the community, but would not share the consults with Center staff. Documentation further indicated the Center PCP had made attempts to contact the community PCP in advance of the CLDP, but had not been able to do so. This issue was raised at the CLDP meeting, and Individual #200's mother provided the name of the assistant through whom the community PCP could be contacted. The CLDP did not assertively address this in the supports; instead, it included a post-move support for a certified letter to be sent to the community PCP. It was not clear why the CLDP did not include a pre-move support to attempt contact the PCP through the named assistant. Even if that turned out to be unsuccessful, it was again not clear why the action step for sending the certified mail was not a pre-move support rather than a post-move action. This was particularly true given the expressed concerns of the Center's medical staff about possible medication interactions.
- Individual #256's CLDP did not include a specific statement as required.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on the individual's needs. Neither CLDP included a specific statement regarding this need.

17. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. Neither CLDP included a specific statement regarding this consideration.

18. LIDDA participation: These two CLDPs met criterion based on the participation of the LIDDA in the CLDPs as well as other documentation of liaison between the Center and the LIDDA.

19. The Pre-Move Site Reviews (PMSRs) for both individuals were completed prior to the transition date, but otherwise did not meet criterion.

- For both individuals, the PMSR failed to document that provider staff possessed required knowledge of important health and safety needs that should have been clearly in place at the time of transition.
- Neither PMSR provided any evidentiary documentation to confirm pre-move supports were in place. Each requirement was checked off as in place, but did not describe how that was determined. For example, most pre-move supports required PMM observations as evidence, and some required training rosters, but the PMSRs included no evidence (other than a checked box) to document the required evidence demonstrated the presence of the respective support. Just as with the PMM Checklists, the PMM should provide a succinct comment about the evidence he relied upon to verify the support was in place.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: This indicator will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	#200	#256								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	2/2 100%	1/1	1/1								

Comments: 20. Both CLDPs met criterion for this indicator.

- Individual #200 was referred on 6/28/17, at the request of her LAR, and transitioned on 8/25/17, which was within 180 days. The IDT had expressed concerns about the consistency of care the family provided in the months preceding the transition date, particularly as it related to health care decision-making. Per Individual #200's QIDP, an IDT member or members reported an allegation of possible neglect to the Texas Department of Family and Protective Services (DFPS) during the transition process. This allegation was not confirmed and the transition proceeded per the LAR's decision.
- Individual #256 was referred on 4/24/17, at the request of his father/LAR and with the agreement of the IDT, and transitioned on 8/16/17, also 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 and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted 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