United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

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Table of Contents

Background	2
Methodology	3
Organization of Report	4
Executive Summary	4
Status of Compliance with Settlement Agreement	
Domain 1	5
Domain 2	24
Domain 3	72
Domain 4	120
Domain 5	131
Appendices	
A. Interviews and Documents Reviewed	145
B. List of Acronyms	153

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 Center 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, 13 of these indicators, including two entire outcomes, had sustained high performance scores and moved to the category requiring less oversight. Presently, two additional indicators in the area of restraint will move to the category of less 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.

<u>Restraint</u>

The overall usage of crisis intervention restraint at Brenham SSLC increased since the last review and was now the fourth highest in the state, census-adjusted. According to the Director of Behavioral Health Services, this was due, at least in part, to new admissions and to incidents with multiple consecutive short restraints. The average duration of a crisis intervention physical restraint, however, was among the lowest in the state at about three minutes.

Correct implementation and documentation of crisis intervention continued to improve. The Center also corrected/improved implementation of crisis intervention chemical restraint in that behavioral health consultations were occurring prior to administration of the chemical restraint (for two of three cases).

An area for improvement is to correctly document usage of medical restraints. As a result, the Monitoring Team could not determine if the medical restraint was done safely and according to policy. Similarly, reviews of crisis intervention restraint by units and IMRT were not documented in a way that the Monitoring Team could determine if they happened as required. Recommendations, however, were implemented (or there was already a crisis intervention plan in place).

For four of the six physical restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals. However, numerous problems were noted with regard to nurses' monitoring of individuals after the administration of chemical restraints, which placed individuals at significant risk of harm. In addition, the Center provided no nursing documentation related to the monitoring of an individual's medical restraint (i.e., the use of mittens).

Psychiatry did not complete the reviews as required following crisis intervention chemical restraint.

Abuse, Neglect, and Incident Management

Brenham SSLC maintained nine indicators in the category of less oversight. This was good to see. Most other indicators were at criterion for some, but not all investigations.

In two investigations, investigators did not review available video and/or conduct needed staff interviews, thereby limiting the set of evidence collected and analyzed and the resultant conclusions drawn. Improvement were also needed in the thoroughness of supervisory reviews and in completion of investigations within the required timelines.

The Center was not doing thorough tracking, trending, analysis, or action planning (outcome 10). Requirements for individuals who are identified for streamlined investigations were not being met by APS (a quarterly review was not done) or by the SSLC (for one of the two individuals reviewed).

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: Scoring remained the same for indicator 1 and improved for indicator 2 compared with the last review. The overall usage of crisis intervention restraint at Brenham SSLC had increased since the last review and was now the fourth highest in the state, census-adjusted. According to the director of behavioral health services, this was due, at least in part, to new admissions and to incidents with multiple consecutive short restraints. The average duration of a crisis intervention physical restraint, however, was among the lowest in the state at about three minutes. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
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.	90% 9/10	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (October 2017 through June 2018) were reviewed. The overall usage of crisis intervention restraint at Brenham SSLC had increased since the time of the last review and showed a high stable frequency. The average across the nine-month period was the highest since monitoring of this indicator began in 2015. Moreover, the Center now had the fourth highest census-adjusted rate in the state. The director of behavioral health services attributed this, at least in part, to new admissions and to single incident that included multiple consecutive, short restraints. To that end, the director might consider creating a secondary graphic summary (for their own reviews) that separates new admissions (e.g., for first six months perhaps) from the center-wide data. The frequency of crisis intervention physical restraints was also high, paralleling the overall usage of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention restraint, however, remained one of the lowest in the state, at around two and one-quarter minutes.

The frequency of usage of crisis intervention chemical restraint showed a slightly increasing trend. There were, however, no occurrences of crisis intervention mechanical restraint and protective mechanical restraint for self-injurious behavior (PMR-SIB) was not being used at all. In fact, long-term usage of PMR-SIB for Individual #34 had been faded and discontinued since the last onsite review. This was good to see. For some individuals, crisis intervention restraint was no longer needed, but overall, the number of individuals who had one or more crisis intervention restraints each month was increasing. The number of injuries that occurred during or due to restraint application remained very low (but see indicators and comments related to assessment by nursing below).

There was little usage of non-chemical restraints and of pretreatment sedation for medical or dental procedures. There appeared to be less usage of TIVA for dental procedures. The Center should consider looking at these indicators together, that is, an increase in the use of non-chemical restraints and/or pretreatment sedation might be needed in order to reduce the usage of the more intrusive TIVA procedures.

Thus, facility data showed low/zero usage and/or decreases in seven of these 12 facility-wide measures, the same as at the last review (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).

Restraint reduction committee minutes for one month May 2018 were submitted. The Monitoring Team also attended the committee's meeting while onsite. At the meeting, facility-wide and individual-specific data and reports were presented. There was good participation from attendees. Video review of restraint incidents did not occur during the meeting, but the director of behavioral services reported that video review occurred during unit meetings. The review of restraints might benefit from video review also occurring at restraint reduction committee.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #177, Individual #145, Individual #490, Individual #155, Individual #168), and three received crisis intervention chemical restraint (Individual #145, Individual #155, Individual #168). In addition, medical restraint for healing was reviewed for one individual (Individual #51). Data from the facility showed a decreasing trend in frequency or very low occurrences over the past nine

months for three (Individual #145, Individual #490, Individual #168) and discontinuation of the medical restraint for Individual #51. Individual #155 was hospitalized during the onsite review and for a number of weeks following the onsite review week. 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: Implementation and documentation of crisis intervention continued to improve and meet more of this outcome's criteria. For instance, indicators 4 and 8 showed sustained high performance over this and the previous three reviews. Therefore, these two indicators (4 and 8) will be moved to the category of requiring less oversight. The Center also corrected/improved implementation of crisis intervention chemical restraint in that behavioral health consultations were occurring prior to administration of the chemical restraint (for two of three cases), and proper inclusion of restraint contraindications in the ISP. An area for improvement is to correctly document usage of medical restraints and consultation prior to administration of crisis intervention chemical restraint. Documentation was missing or incorrect in the one instance reviewed by the Monitoring Team. Indicators 5, 7, 9, 10, and 11 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	145	490	155	168	51			
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% 10/10	2/2	1/1	2/2	2/2	2/2	1/1			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 9/9	2/2	1/1	2/2	2/2	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
7	There was no injury to the individual as a result of implementation of the restraint.	90% 9/10	2/2	1/1	2/2	2/2	2/2	0/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 10/10	2/2	1/1	2/2	2/2	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% 0/2	0/2	Not rated	Not rated	Not rated	Not rated	Not rated			

10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	80% 8/10	2/2	0/1	2/2	2/2	2/2	0/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 10/10	2/2	1/1	2/2	2/2	2/2	1/1			

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for six different individuals (Individual #177, Individual #145, Individual #490, Individual #155, Individual #168, Individual #51). Of these, six were crisis intervention physical restraints, three were crisis intervention chemical restraints, and one was a medical restraint for healing post-procedure. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

7 and 10. Proper and full documentation regarding usage of medical restraint was not provided, for Individual #51. During the onsite week, the Center provided some documents, but nearly all of the items were blank. For Individual #145, consultation prior to administration of crisis intervention chemical restraint was not done/provided.

9. Because criterion for indicator #2 was met for five of the individuals, this indicator was not scored for them. Criteria for this indicator was not met for the other individual due to problems with all staff being trained in the PBSP and correct implementation of the PBSP (Individual #177).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

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

#	Indicator	Overall Score	Individuals: 177	145	490	155	168	51			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 2/2	1/1	1/1	Not rated	Not rated	Not rated	Not rated			

Comments:
12. Because criteria for indicators 2-11 were met for four individuals, this indicator was not scored for them. Staff for the other five individuals correctly answered all of the Monitoring Team's questions. This was good to see.

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: Completion of the requirements for indicator 13 improved to 100% for the first time. Proper documentation (and perhaps implementation) of medical restraints was not occurring. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	145	490	155	168	51			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 9/9	2/2	1/1	2/2	2/2	2/2	N/A			
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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			
Comments: 14. Proper and full documentation regarding usage of medical restraint was not provided, for Individual #51.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: For four of the six physical restraints reviewed, nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals. However, numerous problems were noted with regard to nurses' monitoring of individuals after the administration of chemical restraints, which placed individuals at significant risk of harm. The Center provided no nursing documentation related to the monitoring of an individual's medical restraint (i.e., the use of mittens). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	145	490	155	168	51			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	40% 4/10	2/2	0/1	1/2	1/2	0/2	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	70% 7/10	2/2	0/1	1/2	2/2	2/2	0/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 5/10	2/2	0/1	1/2	1/2	1/2	0/1			
Comments: The restraints reviewed included those for: Individual #177 on 2/24/18 at 2:50 p.m., and 4/28/18 at 8:26 a.m.; Individual #145 on 11/6/17 at 7:10 p.m. (chemical); Individual #490 on 1/21/18 at 3:35 p.m., and 2/10/18 at 5:53 p.m.; Individual #155 on 3/27/18 at 11:24 a.m.; and 3/27/18 at 11:38 a.m. (chemical); Individual #168 on 4/7/18 at 7:15 p.m. (chemical), and 4/27/18 at 4:53 p.m.; and Individual #51 from 1/30/18 to 2/5/18 [medical restraint for wound healing (i.e., mittens)].											

a. through c. For Individual #177's physical restraints on 2/24/18 at 2:50 p.m., and 4/28/18 at 8:26 a.m.; Individual #490's restraint on 2/10/18 at 5:53 p.m.; and Individual #155's restraint on 3/27/18 at 11:24 a.m.; the nurses performed physical assessments, documented whether there were any restraint-related injuries or other negative health effects, and took action, as needed to meet the needs of the individuals.

In addition to the four restraints listed in the paragraph above, for the following restraints the nurses documented whether or not the individual sustained restraint-related injuries of other negative health effects: Individual #155 on 3/27/18 at 11:38 a.m. (chemical), and Individual #168 on 4/7/18 at 7:15 p.m. (chemical), and 4/27/18 at 4:53 p.m.

The following provide examples of problems noted:

- For Individual #145's chemical restraint, the staff that completed the Restraint Checklist noted Ativan 2 milligrams (mg) intravenous (IV) was administered. The order noted it was an intramuscular (IM) injection, not an IV administration. These routes are significantly different. The nurse did not note the site of the injection in the progress note. The nurse did not list the route or site on the Medication Administration Record (MAR) provided. The nurse did not take and/or document vital signs as required or complete an Integrated Progress Note (IPN) to explain why they were not taken. The nurse did not conduct and/or document follow-up addressing any injuries present.
- For Individual #490's restraint on 1/21/18 at 3:35 p.m., and Individual #168's restraint on 4/27/18 at 4:53 p.m., their mental status was only described as "no change from baseline." A more detailed description is necessary.
- For Individual #155's chemical restraint on 3/27/18 at 11:38 a.m., no physician's order was included in the documents provided for Ativan 2 mg IM. The nurse's IPN did not justify the reason and/or describe the individual's behaviors at the time the Ativan IM was given, and indicated that it was given "without any problems." The note did not indicate if the individual had to be restrained for the administration of the IM injection. If he was cooperative, then the justification for the administration of a chemical restraint was questionable. In addition, the nurse only noted one set of vital signs and one mental status exam in the IView document provided, which is not consistent with accepted practice for a chemical restraint. The nurse also did not note the site of the IM injection on the MAR document.
- For Individual #168's chemical restraint on 4/7/18 at 7:15 p.m., the staff that completed the Restraint Checklist noted he received Ativan 2 mg IV, but it was not IV, rather it was IM. As noted above, these routes are significantly different. The nurse completed and/or documented only one set of vital signs and one mental status exam in the IView documentation provided. The nurse did not document the site of the IM injection on the MAR. However, in the IPN, the nurse did a good job documenting his mood and the behaviors that warranted the chemical restraint, including his interactions with the police.
- For Individual #51's medical restraint for wound healing (i.e., mittens) from 1/30/18 to 2/5/18, the Center did not submit nursing documentation.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.	
Summary: Documentation of medical restraints was not occurring. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	177	145	490	155	168	51			
15	Restraint was documented in compliance with Appendix A.	90% 9/10	2/2	1/1	2/2	2/2	2/2	0/1			
Comments: 15. Proper and full documentation regarding usage of medical restraint was not provided, for Individual #51.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Reviews of crisis intervention restraint by units and IMRT were not documented in a way that the Monitoring Team could determine if they happened as required. Recommendations, however, were implemented or there was a crisis intervention plan in place. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	145	490	155	168	51			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	22% 2/9	0/2	1/1	1/2	0/2	0/2	N/A			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	89% 8/9	2/2	1/1	2/2	2/2	1/2	N/A			
Comments: 16. For two restraints, documentation (i.e., IRIS) was provided correctly and the review was evident. In the others, IRIS forms did not show date of unit review and IMRT review was a handwritten entry. Moreover, the Monitoring Team could not determine the actual dates of reviews and whether the reviews looked at the restraints in question. This was discussed with the restraint management staff during the onsite week. A plan was described to address this going forward. 17. For each instance (with one exception), the Center showed documentation of recommendation implementation (e.g., staff training) or provided documentation showing that a CIP was in place at the time of the restraint application. The one exception was Individual #168 4/7/18. Documentation showing that a CIP was in place on this date was not provided.											

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 did not complete the reviews as required following crisis intervention chemical restraint (pharmacy, however, did do the pharmacy reviews). Given the Center's previous high performance, the staffing changes in the psychiatry department, and the department's awareness of various tasks it needs to complete (including this one), the Monitor will leave this indicator (47) in the category of less	Individuals:

#	Indicator	Overall Score	145	155	168						
	oversight. However, this needs to be corrected in order for it to remain in this category. Indicator 49 will remain in active monitoring.										
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.										
49	Psychiatry follow-up occurred following chemical restraint.	67% 2/3	0/1	1/1	1/1						

Comments:
49. Review of the psychiatric documentation regarding Individual #168 and Individual #155 revealed psychiatric follow-up after the chemical restraint. Individual #145 experienced chemical restraint 11/6/17. Although she was seen by psychiatry on 11/8/17, 11/9/17, and 11/13/17, the documentation from these encounters did not include a discussion of the restraint.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Brenham SSLC looked at data and trends, and plans were in place to address these trends (primarily PBSPs for this set of investigations). For three individuals, implementation and/or staff training was not occurring sufficiently. Requirements for individuals who are identified for streamlined investigations were not being met by APS (a quarterly review was not done) or by the SSLC for one of the two individuals reviewed. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	471	163	145	490	293	155	168	51
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	75% 9/12	1/1	1/1	0/1	2/2	1/1	1/1	1/2	1/2	1/1

Comments:
The Monitoring Team reviewed 12 investigations that occurred for nine individuals. Of these 12 investigations, seven were HHSC PI investigations of abuse-neglect allegations (four unconfirmed, one unfounded, one administrative referral, one clinical referral). One of these was designated as a streamlined investigation. The other five were for facility investigations of serious injuries (fracture, lacerations), unauthorized departure, 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 #177, UIR 18-095, HHSC PI 45864209, unconfirmed allegation of neglect, abbreviated investigation, 11/20/17
- Individual #471, UIR 18-143, HHSC PI 46156529, unconfirmed allegation of neglect, 1/10/18
- Individual #163, UIR 18-181, discovered injury, cut/laceration, lip, 2/11/18
- Individual #145, UIR 18-227, HHSC PI 46704615, unfounded allegation of physical abuse/neglect, streamlined investigation, 4/7/18
- Individual #145, UIR 18-249, suicide threat, 5/3/18
- Individual #490, UIR 18-223, HHSC PI 46691492, unconfirmed allegation of physical abuse, also OIG unsubstantiated, 4/5/18
- Individual #293, UIR 18-248, HHSC PI 46862347, clinical referral of an allegation of neglect, included two other individuals, 5/2/18
- Individual #155, UIR 18-195, HHSC PI 46490891, unconfirmed allegation of physical abuse, 2/27/18
- Individual #155, UIR 18-232, witnessed injury, fracture, head, 4/10/18
- Individual #168, UIR 18-226, HHSC PI 46735147, administrative referral of an allegation of neglect, 4/7/18
- Individual #168, UIR 18-213, unauthorized departure, law enforcement contact, 3/24/18
- Individual #51, UIR 18-087, discovered injury, cut/laceration, genitalia, 11/16/17

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.

Nine of the 12 investigations met criteria for the above four sub-indicators. Seven 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 five investigations were facility-only investigations and criteria were met for three of the five. In particular, trends were examined and protections were in place, such as PBSPs and PNMPs. Individual #163 UIR 18-181, Individual #155 UIR 18-232, and Individual #168 UIR 18-213 did not meet criteria because the PBSP was not implemented as written at the time of the occurrence of the injury and/or some staff were not trained in the PBSP.

Four individuals at Brenham SSLC were identified for streamlined investigations by DFPS. The Monitoring Team chose two for review (Individual #145, Individual #268). APS submitted its quarterly review of its determination of the rationale for each individual to be identified for streamlined investigations. The document was from February 2018 and had not been updated. The May 2018 meeting minutes were reviewed, but there was nothing in them about this update. For the SSLC, a plan needs to be in place to address the frequent false calling (or a rationale is provided as to why it might be counter therapeutic to do so). This was in place for Individual #268 as part of his PBSP. For Individual #145, however, her plan included what to do if she wanted to make a complaint (which was good to see), but there were no data regarding frequency of making false calls and no comments in her monthly behavioral health services progress notes.

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

Summary: All but one of the incidents met criteria. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	471	163	145	490	293	155	168	51
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/1	1/1	1/1	1/2	1/1	1/1	2/2	2/2	1/1

Comments:

2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other one was rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criteria are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- For Individual #145 UIR 18-227, the allegation was reported by the individual three days after it allegedly occurred. As noted in the UIR, however, the facility director/designee was not notified within one hour of the incident being reported to the Center.

An overall comment about investigations at Brenham SSLC is that the UIR stated that reporting was timely in instances where actions took place when the Center received notification from HHSC PI. The UIR, however, should examine if the incident should have been reported earlier by someone at the Center.

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: All staff interviewed answered most questions correctly. Some incorrect answers were regarding reporting protocols. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	471	163	145	490	293	155	168	51
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 3/3	Not rated	Not rated	1/1	Not rated	Not rated	Not rated	1/1	1/1	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. All staff answered most questions correctly. Some staff, however, incorrectly answered questions about reporting protocols, such as to whom the report should be made and about required timelines for reporting. This information was shared with the Center's IMC during the onsite review.

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

Summary: One investigation did not include alleged perpetrator reassignment information in the UIR. Documentation was provided to show that reassignment did occur, but in the future (as Brenham SSLC has done in the past), this information should also be in the UIR.

Individuals:

#	Indicator	Overall Score									
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

Outcome 5– Staff cooperate with investigations.

Summary:

Individuals:

#	Indicator	Overall Score									
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

Summary: In two investigations, investigators did not review available video and/or conduct needed staff interviews, thereby limiting the set of evidence collected and analyzed and the resultant conclusions drawn. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	471	163	145	490	293	155	168	51

#	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, this indicator was moved to the category of requiring less oversight.									
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	83% 10/12	0/1	1/1	0/1	2/2	1/1	1/1	2/2	2/2	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	83% 10/12	0/1	1/1	0/1	2/2	1/1	1/1	2/2	2/2	1/1

Comments:
9. For Individual #177 UIR 18-095, HHSC PI (and the Center) did not review video evidence to confirm an interviewee's testimony that she provided 1:1 supervision while the alleged perpetrator was assigned a different task for approximately 35 minutes. Additionally, because this was at mealtime, there were presumably other staff in the room who could have corroborated the interviewee's testimony, but there is no evidence that any were interviewed. Further, this occurred during the evening meal, so video would have been available. Therefore, not all relevant evidence was collected, etc.

For Cole UIR 18-181, video should have been reviewed to determine whether any individuals or staff entered/exited his bedroom in the hour prior to discovery of the injury.

10. For Individual #177 UIR 18-095, the practices noted in indicator 9 resulted in an insufficient analysis. Absence of video review and/or staff interview corroboration resulted in a conclusion based solely on one staff's testimony.

For Cole UIR 18-181, the UIR on page 1 shows injury was of determined cause, but on page 2 shows that it was of undetermined cause. Then on page 22, it states the injury probably happened when he was attempting to get out of bed again resulting in him falling. The UIR did not reconcile these statements to make a final determination whether the cause of this this discovered injury was determined (supported with actual evidence) or undetermined (supported with a reasonable hypothesis). The post-incident ISPA (2/12/18) addressed this with a final determination of undetermined cause, but this information was put into the UIR.

Outcome 7– Investigations are conducted and reviewed as required.

Summary: Improvement was needed in the thoroughness of supervisory reviews (indicator 13). In addition, one-quarter of the investigations were not completed within the required timelines. The Center showed it had met and discussed this issue with HHSC PI and OIG. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	471	163	145	490	293	155	168	51
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	0/1	0/1	1/1	1/2	1/1	1/1	2/2	2/2	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.	58% 7/12	0/1	0/1	0/1	1/2	1/1	1/1	1/2	2/2	1/1

Comments:

12. Three investigations were not completed within the required timeline and/or did not have extension requests.
- For Individual #177 UIR 18-095, the incident was reported to DFPS intake on 11/20/17 and the investigation was completed on 12/22/17. The first direct interview of a staff member was on day seven. Extension rationales were not adequate (e.g., additional interviews needed, extraordinary circumstances).
- For Individual #471 UIR 18-143, the incident was reported to DFPS intake on 1/10/18 and the investigation was completed on 2/9/18. The first direct interview of a staff member was on day 20. Extension rationales were not adequate (e.g., extraordinary circumstances).
- For Individual #145 UIR 18-227, the incident was reported to DFPS intake on 4/7/18 and the investigation was completed on 5/7/18. The extension request was to conduct further interviews, but none were ever conducted. This was designated to be a streamlined investigation.

The Center provided minutes of their quarterly HHSC PI/OIG/Center meeting. The minutes showed that this issue was raised and discussed. The minutes noted HHSC PI investigator turnover and resultant training of new hires as contributory factors in delayed completion of some investigations.

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. Four investigations did not have a supervisory review that identified late reporting, absence of collection of video or interview evidence, or problems with documentation of alleged perpetrator reassignment.

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: Conduct of audits of serious injuries were again occurring for all individuals. Non-serious injury investigations were conducted correctly when done, but some injuries were not subjected to this process, but should have been. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	177	471	163	145	490	293	155	168	51
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	44% 4/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:
15. When non-serious injury investigations were done, they were done correctly. However, for five individuals, the Center's list of injuries showed one or more that should have been subjected to a non-serious injury investigation, but were not.

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. The Center was not doing any tracking, trending, analysis, or action planning. 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. Tracking and trending were not occurring at Brenham SSLC. That is, none of the seven topic areas were being tracked or trended. The Center reported that it did not have trend reports due to the open data analyst position. The reports created by the IMC, however, contained some, but an insufficient amount of data and information. Deficiencies were in the level of detail within the various sets of data. Without sufficient detail, it is difficult (almost impossible) to determine areas of concern that require formal corrective action planning. A new data analyst was reportedly recently hired.

20-23. The Center reported that a second QAQI Council meeting was being held (started in June 2018). The purpose of this was to review tracking and trending of abuse, neglect, and incident management data. It was being designed to replace the executive safety committee.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. As discussed in the last report, the Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA needed to be expanded and improved. For this review, the Center submitted dental policies from 2014, which did not address these concerns, and the Center submitted no Medical Department policy related to medical clearance for the use of TIVA. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For Individual #125's use of TIVA on 2/15/18, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and nurses completed post-operative vital signs. b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: a. On 2/15/18, Individual #125 underwent TIVA. This use of TIVA was for dental, as well as for an eye exam, nail clipping, and ear lavage. Because this was not oral pre-treatment sedation, it is addressed above in the indicator related to the use of TIVA.											

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: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
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.										
4	Action plans were implemented.										
5	If implemented, progress was monitored.										

6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.									
Comments:										

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.										
Summary: These indicators will continue in active oversight.			Individuals:							
#	Indicator	Overall Score	88	406	318	437				
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.	67% 2/3	0/1	1/1	1/1	Not rated				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1				

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

- On 10/17/17, Individual #269 died at the age of 70 with causes listed as cardiorespiratory failure, sepsis, and multi-lobar pneumonia.
- On 11/9/17, Individual #407 died at the age of 62 with the cause listed as lymphoma.
- On 11/21/17, Individual #88 died at the age of 74 with causes listed as septic shock from obstructive ureterolithasis, possibly a component of pneumonia; and worsening pneumonia, respiratory failure, and cardiac arrest. On 12/7/17, the Center completed the Clinical Death Review; and on 1/11/18, the Center completed the Administrative Death Review.
- On 1/13/18, Individual #406 died at the age of 73 with causes listed as cardiopulmonary arrest, schizophrenia, and mental retardation.

- On 1/25/18, Individual #318 died at the age of 71 with causes listed as sudden cardiac arrest, chronic hypercapnic respiratory failure, and complicated polymicrobial urinary tract infection.
- On 1/27/18, Individual #37 died at the age of 61 with causes listed as sepsis, pneumonia, and lung cancer.
- On 5/15/18, Individual #437 died at the age of 47 with causes listed as pseudomonas pneumonia, and staphylococcal pneumonia. On 5/24/18, the Center completed the Clinical Death Review. The Administrative Death Review should have been completed by 6/7/18, which was the date of the Monitoring Team's Tier II request. As a result, the Monitoring Team did not rate this indicator for this death.
- On 5/23/18, Individual #176 died at the age of 12 with causes pending.
- On 6/19/18, Individual #517 died at the age of 72 with causes pending.

b. through d. Evidence was not submitted to show the Center 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. The following provide examples of concerns noted:

- For Individual #318's death, recommendations should have been made, but were not, for PCPs to complete training on the vegetative state, palliative care, and decubitus ulcer care.
- For Individual #437's death, a recommendation was made and implemented related to PCPs completing an in-service training on the long-term use of Prolia for osteoporosis, which involved a review of two recent articles concerning Prolia and infection. However, additional recommendations were needed to: 1) conduct a periodic review of the literature to keep pace as information evolves concerning infection and Prolia use; and 2) implement a person-centered approach for those prescribed Prolia, requiring a review of the individual's previous three- to five-year baseline for infections and then conducting ongoing monitoring of the type, frequency, and severity of infections after the introduction of Prolia, with trend analysis and consideration of discontinuation of the medication, if an increase in severity and/or frequency of infections occurred for that individual.
- In addition, in relation to Individual #437's death, several infections considered multiply drug resistant organisms (MDROs) indicated that the SSLC would benefit from an infection control educational program, as well as monitoring of an antibiotic stewardship program and follow-up of any trend in resistance through antibiograms, as well obtaining copies of monthly antibiogram reports from the local hospital.
- As indicated in previous reviews, 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. The reports did not reflect comprehensive reviews of 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.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, the Center indicated that on 11/28/17, the PCPs participated in training and they were updating and revising lists as ISPs became due to address a recommendation that read: "Review of the Medical Active Problem list revealed several redundancies and also a diagnosis of 'Current Drug Use' which is not consistent with other information submitted for review. Both of these issues are likely related to the newness of the electronic health record and underscore the need to review the list at intervals to update them and edit them when indicated." The recommendation should have been written in a manner that required monitoring to determine whether or not PCPs were making the

needed changes, and that this occurred more quickly than annual ISP updates (e.g., at the time interim medical reviews were completed).

For Individual #88, one of the recommendations was: "Nursing should monitor the incidence of post cath UTIs, as this is especially important when an individual has been troubled with phimosis." The Center noted that the Infection Control nurse would monitor UTIs incidences to trend any patterns noted. However, these data would need to be gathered for individuals who received straight catheterizations, and then, the occurrence of UTIs for those individuals would need to be monitored. The Center did not provide such data, and the Center's response did not reflect the actual recommendation.

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, 17 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, 10 additional indicators in the areas of psychiatry, behavioral health, dental, enteral nutrition, OT/PT, communication, and skill acquisition/engagement 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.

<u>Assessments</u>

The IDT did not consider what assessments the individual needed and would be relevant to the development of most individuals' ISPs. Further, IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting.

In psychiatry, continued improvement was shown in that annual updates were completed, had the required content, and the psychiatrist attended annual ISP meetings. PSPs contained the relevant content.

In behavioral health, all but one of the annual behavioral health updates were current, and about half met the content requirements. Missing from the others was information about physical health factors. Similarly, the functional assessments were current for all but one individual, and half met criteria.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), and/or 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.

Two 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, that are consistent with current standards of care/clinical guidelines.

Due to sustained performance with regard to the quality of dental summaries, the related indicator will move to the category of less oversight. However, additional work is needed with regard to the quality of annual dental exams. More specifically, unless clinical justification is provided, annual dental exams need to include an updated periodontal chart.

Good progress was noted with regard to the timely completion of annual and quarterly nursing assessments, including physical assessments. However, continued focus is needed to ensure nurses complete quality nursing assessments for the annual ISPs that identify and analyze relevant clinical data and use this information to offer relevant recommendations to IDTs. In addition, when individuals experience changes of status, nurses need to complete and document assessments in accordance with current standards of practice.

Since the last review, the scores during this review generally showed improvement with regard to the timely referral of individuals to the PNMT. The Center should focus on sustaining its progress in this area, as well as ensuring the PNMT completes reviews for individuals that meet criteria for PNMT review. The quality of the PNMT comprehensive assessments also needs improvement. It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results.

For newly-admitted individuals, OTs/PTs have consistently completed initial assessments, so the related indicator will move to the category of less oversight. The Center should focus on improving the timeliness of OT/PT consults when individuals experience changes in status. The quality of OT/PT assessments also needs improvement.

For newly-admitted individuals, Speech Language Pathologists have consistently completed initial assessments, so the related indicator will move to the category of less oversight. Work is needed to ensure that individuals receive the right type of communication assessment (i.e., screening, comprehensive, or update). Significant work also is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated.

Individualized Support Plans

Brenham SSLC showed progress in the development of ISP goals. That is, more met criterion for individuality and measurability compared with the last two reviews. That being said, collecting data for each goal (i.e., for each action plan or step) remained at 0%. It was good to see stability in the QIDP Coordinator and QIDP Educator positions. QIDPs, overall, were more knowledgeable about individuals' needs than during previous visits and better prepared to discuss personal goals and action plans.

Lack of timely implementation continued to be a problem and competed with individuals making progress (and receiving supports), as well as with the Center's ability to meet the requirements of many of the outcomes and indicators reviewed by both Monitoring Teams.

The indicators in ISP outcomes 3 and 4 (indicators 8 to 29) speak directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring these outcomes. Some focus or specialized approach to improvement is warranted.

It was good to see that all individuals attended their own ISP meetings (at least for a part of it), though appropriate and full attendance and participation needed improvement.

In psychiatry, the Center made progress in that, for most individuals, some psychiatric indicators were identified. For some individuals, some sub-indicators met criteria. The next steps, of defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed.

In behavioral health, the Center addressed concerns raised at the last review regarding providing a PBSP for all individuals who needed one and in creating goals for counseling programs. The goals/objectives were written in measurable terminology, an improvement from the previous two reviews when most were not written this way. On the other hand, the Center did not demonstrate that data collected for PBSP target and replacement behaviors were reliable. This should be a priority for the Center.

Brenham SSLC now made sure that PBSPs were implemented timely and after consents/approvals were obtained. PBSPs had also improved, such that more required components were included.

All individuals had SAPs and all were written in measurable terms. Although the total number of SAPs across the individuals in the review group was the same as at the last review, this time, there was only one individual who had only one SAP.

Most individuals had a current FSA, PSI, and vocational/day program assessment. The vocational assessments, however, did not present a complete profile of the individual's work skills.

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: Brenham SSLC showed progress in indicators 1 and 2. That is, more indicators met criterion for individuality (indicator 1) than ever before (i.e., 14 versus eight and 10 the last two times, respectively). Further, six goals met criterion for measurability, compared with zero for the last two reviews. Further work on collecting data for each goal (i.e., for each action plan or step) remained at 0%. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	163	145	155	242	59			
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	2/6	4/6	2/6	2/6	2/6			
2	The personal goals are measurable.	0% 0/6	1/6	0/6	3/6	0/6	1/6	1/6			
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 Center: Individual #145, Individual #177, Individual #155, Individual #163, Individual #242, and Individual #59. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Brenham SSLC campus.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

The IDTs continued to work toward developing measurable personal goals. For this review period, none of the six ISPs contained individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion.

1. Fourteen personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the

community, maintaining good health, and choosing where and with whom to live. This was a significant improvement from the previous monitoring visit, when eight goals met criterion. Findings included:

- It was positive that Individual #145 had personal goals that met criterion for leisure, relationships, independence, and living options.
- Overall, personal goals that met criterion included:
  - Leisure goals for Individual #145, Individual #177, and Individual #59;
  - Relationship goals for Individual #145 and Individual #242;
  - Work/day/school goal for Individual #177;
  - Independence goal for Individual #145, Individual #155, Individual #163, Individual #242, and Individual #59; and,
  - Living options goals for Individual #145, Individual #155, and Individual #163.

Although this did indicate some improvement, of the 30 possible goal areas across this review group, six (20%) were considered to not be a priority by the IDT, and that three of the six individuals (50%) did not have a relationships goal at all. The IDTs did not offer rationales that would explain why an individual would not benefit from having a goal in these major life activities.

2. The Monitoring Team reviewed the 14 personal goals that met criterion for Indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 14 personal goals, six met criterion for measurability. These were:

- Leisure, relationships and independence goals for Individual #145;
- Work/day/school goal for Individual #177;
- Independence goal for Individual #242; and,
- Leisure goal for Individual #59.

Otherwise, the IDT often stated personal goals in broad terms without projecting a timeframe for, or a clear path toward, achievement. Findings included:

- The IDT formulated many action plans as service objectives (SOs) or simply as descriptions of actions staff needed to complete. While some of these action plans were straightforward and indicated a single step needed with a projected timeframe for completion, many others required ongoing and successive implementation. The IDTs rarely developed service objectives with specific implementation methodologies and they did not require data collection that would support measurability.
- While there was some improvement in the measurability of skill acquisition plans (SAPs) that were intended to support personal goals, this remained an area of need.

3. For the six personal goals that met the criterion in indicator 2, none had reliable and valid data. This was largely due to a deficit of measurable action plans and due to a lack of consistent implementation.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: This set of indicators speaks directly to the overall quality of the ISP for the individual's upcoming year. The Monitoring Team looks across the entire ISP when scoring each of these indicators. Performance remained about the same as at	Individuals:

#	Indicator	Overall Score	177	163	145	155	242	59			
the time of the last review, indicating that some focus or specialized approach to improvement is warranted. These indicators will remain in active monitoring.											
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	2/6	0/6	1/6	1/6			
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.	17% 1/6	0/1	1/1	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	1/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	1/6	0/6	1/6	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 Center can achieve compliance with this outcome and its indicators.

8. For the most part, this group of individuals did not have personal goals that met criterion, as described under outcome 1 above (indicators 1-3). IDTs needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had no related

action plans, while others were minimally or tangentially related to the achievement of the goal. For example, Individual #163 had an independence goal to feed himself with cues from staff, but no related action plans that addressed self-feeding. There were a small number of positive exceptions to this finding. For example, Individual #145 had action plans that supported her personal goals for recreation and independence, which was positive.

9. None of six ISPs contained a set of action plans that clearly integrated preferences and opportunities for choice in an assertive manner. IDTs continued to demonstrate some increased proficiency in developing action plans that integrated preferences, but offered few opportunities for choice-making. Findings included:

- For Individual #163, the ISP action plan incorporated some preferences, but the IDT agreed not to implement a choice board until his behavior stabilized, instead of considering how the use of a choice board could help to stabilize his behavior.
- For Individual #242, the ISP included an action plan to develop a SAP to make choices, but it was never implemented and eventually discontinued.
- For Individual #59, the IDT did not continue or expand upon his progress in using pictures/gestures to make choices. The OT/PT assessment recommended incorporating this into his physical and nutritional management plan (PNMP), but that document did not specify use of pictures. Instead, it encouraged that he point/gesture to what he wanted. This, in turn, limited his ability to choose from what was present versus what he might want.

10. None of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. The IDTs had not developed such action plans for these six individuals. IDTs should consider that action plans that promote the ability to make choices can serve as stepping stones toward informed decision-making.

11. One of six ISPs (Individual #145) met criterion for supporting overall independence. For the remaining individuals, the IDTs did develop some action plans to support independence, but did often did not address identified needs in this area in an assertive manner. Examples included:

- For Individual #177, the ISP identified minimal skill acquisition, especially for a 10-year-old. The IDT should have taken an assertive approach to take advantage of this critical leaning and developmental phase.
- For Individual #155, the IDT also identified minimal skill acquisition for a young man and rarely implemented those that did exist. OT did not complete an assessment for using a choice board, which may have helped to support his independence in that area.
- Being able to communicate wants and needs is one of the most fundamental means of asserting independence. The IDTs for Individual #177, Individual #242, and Individual #59 did not assertively address their communication needs.

12. Overall, the IDTs did not assertively address risk areas in a consistent manner. IDTs were slow to react to both ongoing and emerging risks and often did not take assertive action to assess and develop needed interventions. Findings for this visit included:

- It was positive that the Center had undertaken an effort to complete root cause analyses (RCA) to address health and safety risks for several individuals, but IDTs needed additional training to implement RCA in an effective manner. For example, for Individual #145, the IDT made use of the "Five Whys" technique to attempt to determine the root cause for her behavior of ingesting inedibles. This technique is intended to identify a possible or likely cause and then drill down to the "root" by asking five successive questions about that singular cause. The IDT did not use the technique in this manner; rather, the team

identified five possible <u>different</u> causes. In addition, the IDT should ensure that all important members of the IDT participate in this process. For Individual #145, the IDT did not inform or include the primary care practitioner (PCP) in the RCA proceedings.

- For Individual #155, the IDT did not assertively address a multitude of needs in an interdisciplinary manner. These included behavioral and sensory needs, falls, and bowel management.
- For Individual #163, the PNMT assessment did not provide a comprehensive analysis of risk factors related to aspiration. It lacked a thorough investigation for a number of areas including, but not limited to, swallowing and head of bed elevation. The latter was significant: gastroesophageal reflux disorder was noted as a risk, but the IDT did not take it into consideration as being potentially relevant to the issue. The IDT also failed to discuss the impact of excessive salivation or poor oral hygiene on the risk for aspiration.
- For Individual #242, the IDT did not obtain a timely PNMT assessment for falls, some of which had resulted in injuries. They did not integrate all available data to address these and/or the mania presumed to be its root cause. For example, the IDT had not used sleep data to predict and intervene in the cycle. The IDT also had not considered possibility of the impact of menopause on increasing mania and behaviors, despite her the age and observation by IDT members that she liked to put her face on the cool wall in the bathroom.

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 #12 above, the IDTs did not assertively address other needs, such as the following:

- At the time of the last monitoring visit, the Monitoring Team identified a need for increased capacity to offer trauma-informed care at Brenham SSLC. This remained a significant need during this visit, especially for Individual #145 and Individual #177. The Center should avail itself of some additional technical assistance, training, and/or resources to meet this need. It was positive that the Center was scheduled to begin receiving training in Ukeru late this summer. Per its website, Ukeru is described as a safe, comforting and restraint-free crisis management technique. This is a good step forward in addressing the needs of individuals with significant trauma histories. Still, providing comprehensive trauma-informed care will require an approach that impacts the day-to-day environment to prevent crises rather than simply managing them.
- For Individual #59, the IDT did not assertively address his behavioral and communication needs.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration. Examples included:

- Individual #145's ISP action plans some had potential in this area, but lacked implementation plans that would have supported community participation and integration. For example:
  - She had an action plan to attend church off-campus at least once a month, but this was not assertive and did not have any methodology for promoting community integration. Also, it had not been implemented.
  - Her ISP included an action plan to volunteer to read to children at the public library, but this first required that she read to others on campus once a week. The IDT did not develop an SO or otherwise set any measurable expectation about when she could begin to participate in the community.
  - The ISP included an SO for community outings, such as going shopping and out to eat, but its methodology focused on restrictions, rather than on participation and integration.

- Individual #59's action plans in this area were minimal, limited to wheelchair walks in park once a month, and this was implemented just four times in 10 months. The IDT did not provide an adequate rationale for this lack of opportunity for community participation.

15. None of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Overall, these goals were broad and lacked assertive action plans that provided a path to achievement. Examples of those that did not meet criterion included:

- Individual #145 had a broad goal for obtaining a minimum wage job in town, but the ISP contained no specific action plans to support it.
- Individual #155 had a broad goal to work part-time at Education and Training, but the related action plans were not assertive. An action plan called for a vocational assessment to consider possible jobs he might like and assessment for recycling and paper route tasks, but it was only to be completed when his behavior improved. The IDT did not address the barrier to on-home work. The IDT discussed an afterschool program, but did not develop a related assertive action plan.
- For Individual #59, the IDT stated day programming was not a priority at this time. It did not provide a rationale that would explain why he didn't need to have a goal for how he could spend his day in a manner that was meaningful to him.

16. It was positive that some individuals (Individual #145, Individual #177) were more frequently engaged during observations by the Monitoring Team. Still, none of the six ISPs included action plans that laid out substantial opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet individuals' personal goals and needs. ISPs often provided limited opportunities for learning and functional engagement; action plans that did appear to provide substantial opportunities were frequently not implemented.

17. The IDT did not consistently address barriers to achieving goals. Overall, IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in Indicator 26 and did not consistently address barriers to lack of implementation of the ISP. For example, for Individual #155, Individual #163 and Individual #59, most action plans had been suspended.

The IDTs had a propensity for suspending action plans, and not replacing them with any alternative strategies, until an individual's health, behaviors, or other circumstances improved, apparently not recognizing that improvement was not likely to occur without an appropriate set of interdisciplinary interventions.

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. In addition, as described under Indicator #2, IDTs relied on SOs or other staff actions for the bulk of ISP implementation, but SOs were often absent or did not have specific implementation and/or relevant data collection methodologies

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Performance remained about the same as at the last review. The Monitoring Team recommends that Brenham SSLC develop a plan to address the quality components that are monitored in this outcome and outcome 3 above (i.e., overall, indicators 8 through 29). The indicators in outcome 4 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	163	145	155	242	59			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
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.	17% 1/6	1/1	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.	NA	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:
19. Five of six ISPs (Individual #145, Individual #177, Individual #155, Individual #242, Individual #59) included a description of the individual's preference for where to live and how that was determined. The IDT was not able to reliably describe the preferences for Individual #163 due to his lack of exposure to and awareness of community living options.

20, 25, 27. These indicators were not scored because none of these individuals had annual ISP meeting during this onsite visit and no others were observed by the Monitoring Team.

21. One of six ISPs (Individual #177) fully included the opinions and recommendation of the IDT's staff members. Findings included:
- Assessments often provided a statement of the opinion and recommendation of the respective team member. That being said, some important assessments were not available at the time of the ISP to provide the required opinions and recommendations. This was true for all individuals, except Individual #177.
- ISPs did not yet consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For example, the ISP did not document the independent recommendations from the following:
  - For Individual #155, the ISP did not document either a behavior or psychiatry opinion, but behavioral/psychiatric needs were identified as the primary barrier.
  - The ISP for Individual #59 did not include an independent statement from the Speech/Language Pathologist or behavioral health staff.

22. Five of six ISPs (Individual #145, Individual #155, Individual #163, Individual #242, Individual #59) included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. For Individual #177, the IDT did not make a complete statement, but stated it was deferring to LAR.

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. Examples included:
- For Individual #155, the ISP did not include any discussion of alternative living options, required supports, or documentation of any living options awareness. Instead, the narrative stated only that his LARs seem to be aware of alternative living options.
- For Individual #242, the IDT identified that she had a failed placement in 2012 and didn't adjust well to change. The team did not discuss the previous transition process and how it may have been adapted to meet her needs for a slower process.
- For Individual #59, the OT/PT assessment provided an excellent discussion about community living supports he might need. This was positive, but the IDT did not document any discussion of this information. The IDT also did not address how his documented positive reaction to 2014 group home tour should be factored in to this examination.

24. Two of six ISPs (Individual #145, Individual #242) met criterion and identified a thorough and comprehensive list of obstacles to referral in a manner that would allow for the development of relevant and measurable goals to address the obstacle. Examples of those that did not meet criterion included:

- For Individual #177, the IDT did not make a clear statement regarding the barriers. The narrative indicated only that they were deferring to the LAR, but team members individually had cited behavioral and psychiatric instability.
- The IDT for Individual #155 cited LAR choice and psychiatric instability as barriers, but did not include individual awareness.
- Individual #59's IDT identified medical needs and individual choice as barriers. The ISP stated he had been exposed to community options, but was not interested. However, there was no evidence that this was a correct statement because the IDT had not provided him with community exposure sufficient to meet his learning needs. His last documented tour of community living options was in 2014.

26. None of six individuals who were not referred had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. Findings included:

- IDTs did not specify learning or awareness outcomes or plan to collect data to evaluate awareness for any of the individuals for whom this was a barrier.
- For three individuals (Individual #145, Individual #155, Individual #242), the IDTs identified behavioral and psychiatric needs as the barrier, but did not state specific behavioral and psychiatric goals the individual would need to achieve to make community living feasible. For example:
  - For Individual #145, the IDT determined she should continue to reside at Brenham SSLC because she has had an unsuccessful community placement and was not behaviorally or psychiatrically stable. The sole related action plan was for her target behaviors to continue to be tracked and be decreased significantly within the next year. The action plans did not set any targets or expectations for progress which would trigger the IDT to come back together to discuss the feasibility of community referral or even taking group home tours.

28. None of six ISPs had individualized and measurable plans for education. IDTs typically limited action plans for community awareness to provider fairs and receiving annual living options information through the CLOIP process, but did not include any learning objectives or related data collection. None of these six individuals had any action plans for touring community living options.

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

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: It was good to see that all individuals attended their own ISP meetings (at least for a part of it). Implementation remained a problem and appropriate and full attendance and participation also needed improvement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	163	145	155	242	59			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										

32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

32. ISPs were not fully implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

33. Six of six individuals participated in their ISP meetings.

34. Two of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples included:

- The IDT for Individual #145 did not include the PCP or psychiatry representation, but she had significant health and psychiatric needs. Similarly, the nutritionist did not participate in the ISP annual meeting, even though Individual #145 was morbidly obese.
- The SLP did not attend the annual ISP meeting for Individual #177, who had communication needs that impacted her developmental, educational and behavioral needs.
- Behavioral health staff did not participate in Individual #59's annual ISP meeting, even though he had a behavior support plan and behavioral needs related to serious injuries.

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

Summary: Brenham SSLC did not determine what assessments were needed and did not arrange for needed assessments for most individuals. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals:								
			177	163	145	155	242	59			
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.	20% 1/5	N/A	0/1	0/1	1/1	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 one of five individuals (Individual #155). For example:

- The IDT for Individual #163 did not request an SLP assessment or update, but simply stated it was not due until 2022. He had significant needs in this area.
- For Individual #242, the IDT Did not request an OT/PT assessment, even though her risk for fractures had been elevated to high and she had a PNMP for bathing strategies. The IDT also did not request an SLP assessment, even though a need for a choice board had been identified as barrier to her proposed relationships goal.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. None of six ISPs met criterion. For example, five individuals did not have a timely psychiatric assessment or update (Individual #145, Individual #177, Individual #155, Individual #163, Individual #242.)

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

Summary: Lack of timely implementation continued to be a problem and competed with individuals making progress (and receiving supports) as well as with the Center's ability to meet the requirements of this (and many other) set of indicators. The comments below, however, prove some positive observations by the Monitoring Team. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	163	145	155	242	59			
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: Despite some improvement in implementation of some action plans, this remained an area of significant concern. Delays of many months in the implementation of SAPs were not uncommon and QIDPs reported the processes for SAP development and approval had created a bottleneck that dramatically slowed implementation of those action plans. In addition, IDTs were not effectively using the three-month period between the ISP preparation meeting and the ISP meeting to complete needed actions that would lead to timely implementation.

37-38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. For all individuals, most action plans for personal goals had been infrequently implemented, if at all. This reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports. While improvement was needed, some positives were noted:

- QIDPs overall were more knowledgeable about individuals' needs than during previous visits and better prepared to discuss personal goals and action plans.
- Monthly reviews were generally completed more timely.
- ISPAs more frequently evidenced the use of some data to support decision-making.

• It was particularly positive to see that the Center had begun a methodical review of the quality of QIDP monthly reviews, with required corrective action and follow-up. This initiative held promise for additional improvement.

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.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	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.	39% 7/18	0/2	0/2	1/2	1/2	1/2	1/2	1/2	0/2	2/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #163 – falls, and skin integrity; Individual #155 – constipation/bowel obstruction, and fractures; Individual #59 – falls, and constipation/bowel obstruction; Individual #570 – seizures, and skin integrity; Individual #350 – fractures, and cardiac disease; Individual #125 – constipation/bowel obstruction, and choking; Individual #437 – fractures, and skin integrity; Individual #242 – weight, and urinary tract infections (UTIs); and Individual #148 – fractures, 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 #570 – skin integrity, and Individual #148 – fractures. 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, and/or did not include the necessary information in the change of status IRRF. The following individuals did not have changes of status in the specified risk areas: Individual #59 – constipation/bowel obstruction; Individual #570 – seizures; Individual #350 – fractures; Individual #125 – choking; Individual #437 – fractures; and Individual #148 – fractures, and constipation/bowel obstruction.											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.	
Summary: Brenham SSLC made progress in that, for most individuals, some psychiatric indicators were identified in one or more documents. For some	Individuals:

individuals, some sub-indicators met criteria. The next steps, of defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed. Additional specific comments are provided below.

Moreover, the Monitoring Team has revised the wording and sub-indicators for indicators 4, 5, and 6 in order to provide more guidance and specific feedback to the Centers. These indicators will remain in active monitoring.

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

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

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

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

The Monitoring Team looks for:

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

Brenham SSLC showed progress in this area in that most individuals had one or more indicators related to the reduction of psychiatric symptoms. The psychiatric indicators for reduction for three individuals (Individual #86, Individual #163, Individual #293) met criteria for sub-indicators a and b above in that the indicators were present and were related to the diagnosis. Two of these three (Individual #86, Individual #293), also met criteria with sub-indicator c, in that the indicators were fully defined/described using observable terminology.

Some individuals had different lists of psychiatric indicators in different documents and sometimes within the same document. In some cases, the chosen psychiatric indicators were not directly related to the diagnosis. Many indicators were not defined or described in observable terminology (e.g., elevated mood, depressive symptoms).

None of the individuals had psychiatric indicators for increase in positive/desirable actions.

<u>5. Psychiatric goals</u>:
The Monitoring Team looks for:

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

At Brenham SSLC, there were goals written in the psychiatric medication treatment plan. These were confusing because some individuals had multiple indicators that were different depending on what document was reviewed. Goals need to include the psychiatric indicator and a criterion.

The Center utilized the ADAMS for obtaining data regarding psychiatric indicators for almost all individuals and as the primary outcome for any goals that were written (e.g., for Individual #86). The ADAMS can be used as one input for the psychiatrist's decision making, but the ADAMS does not provide a direct measurement of the occurrence/nonoccurrence of the types of psychiatric indicators listed for these individuals.

The exception was for Individual #293. He had a goal for reduction of the observable psychiatric indicators.

There were no goals (and no indicators as noted above) for improvement in the psychiatric disorder.

6. Documentation:
The Monitoring Team looks for:

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

At Brenham SSLC, psychiatric indicators/goals were not incorporated into the Center's overall documentation system. That is, they were not in the IHCP and, therefore, were not part of the ISP and QIDP monthly reviews.

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

At Brenham SSLC, reliable data were not reported for psychiatric indicators (other than the ADAMS, but see comments above). Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Summary: Brenham SSLC made progress in that for most individuals some psychiatric indicators were identified in one or more documents. The next steps, ensuring consistency of the indicators between documents, defining these indicators in observable terminology, ensuring they related to the diagnosis, and then collecting data were needed. Also, putting these indicators into goals and then including them in the IHCP section of the ISP was also needed.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: One or more aspects of the CPE were missing from each individual's CPE. The percentage of individuals who had required admission-related documentation improved since the last review, as did the percentage of individuals whose psychiatric diagnoses were consistent across the Center's records. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168

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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	67% 2/3	1/1	N/A	N/A	N/A	1/1	N/A	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.	67% 6/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. None of the evaluations met all of the requirements. None of the examples included a sufficient bio-psycho-social formulation. This was the most common deficiency. One evaluation was lacking sufficient information in one element, one evaluation was lacking sufficient information in two elements, three evaluations were lacking sufficient information in three elements, one evaluation was lacking sufficient information in four elements, two evaluations were lacking sufficient information in six elements, and one evaluation was lacking sufficient information in seven elements.

15. For the three individuals admitted in the two years prior to the onsite review, all had a CPE performed within 30 days of admission. Individual #168 was admitted to the Center on 2/21/18, a Wednesday. The initial IPN from primary care was completed 2/23/18, on the second business day.

16. There were three individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #168, Individual #293, and Individual #145.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: Continued improvement was shown in annual updates being completed, having the required content, and psychiatrist attendance at annual ISP meetings. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
17	Status and treatment document was updated within past 12 months.	71% 5/7	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1

18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	14% 1/7	0/1	1/1	0/1	0/1	0/1	0/1	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.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
17. Seven individuals required annual evaluations. Five were completed. Individual #293 and Individual #163 did not have current annual evaluations.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. One of the annual evaluations, regarding Individual #86, contained all of the required elements. The remaining four evaluations were missing from one to 14 elements. One evaluation was missing one element, one evaluation was missing ten elements, one evaluation was missing 11 elements and one evaluation was missing 14 elements.

19. The Monitoring Team scored indicator 19 based upon completion of either the annual evaluation or a quarterly review within 90 days of the ISP meeting.

20. The psychiatrist attended the ISP meeting for seven of the individuals in the review group.

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

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

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.	
Summary: PSPs contained the relevant content. One, however, was more than two years old and needed to be updated. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments: 22. PSP documents regarding Individual #86 and Individual #518 were reviewed. The plan regarding Individual #518 was dated in 2016 and, thus, was out of date. The plan regarding Individual #86 allowed for the capture of bipolar mood symptoms, specifically mood fluctuations. There were plans to administer the ADAMS scale on a monthly basis or when mood instability occurred.										

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: Consent forms for each medication were present and current. This was the case for the previous reviews, too (with one exception at the last review). Therefore, indicator 28 will be moved to the category of requiring less oversight. The documentation, however, was missing complete risk-benefit discussions and references to alternate/non-pharmacological interventions. These two indicators (30, 31) will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	Comments: 28. Current medication consent forms were provided for all medications prescribed for individuals included in the review group. 30. The risk versus benefit discussion was not included in the consent forms in eight examples. The consent forms for Individual #155 included a brief risk versus benefit discussion. This was good to see. The psychiatrists indicated that they had begun to include this documentation in the consent forms.										

31. The consent forms did not include individualized alternate and non-pharmacological interventions. In some examples, it was noted that there were no alternatives. In one example, regarding Individual #86, it was noted that cognitive behavioral therapy (CBT) would be an alternative to treatment with medication, but in the same form, there was a notation that this individual would be unable to benefit from CBT.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Brenham SSLC addressed concerns raised at the last review regarding providing a PBSP for all individuals who needed one (indicator 1) and in creating goals for counseling programs (indicator 2). The goals/objectives were written in measurable terminology, an improvement from the previous two reviews when most were not written this way. The Center did not demonstrate that data collected for PBSP target and replacement behaviors were reliable. This should be a priority for the Center. Indicators 3 and 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
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	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments:											

2-4. All eight individuals had measurable goals related to their psychological/behavioral health. This included goals to reduce identified problem behaviors and increase replacement/alternative behaviors. Counseling goals were also measurable, although these needed more detail to be identified as good behavioral objectives. All goals were based upon the individuals' assessments. 5. While there was evidence of regular assessment of inter-observer agreement for five of the eight individuals (Individual #177, Individual #471, Individual #145, Individual #490, Individual #155), a system for assessing data timeliness had just recently been introduced. Reported findings did not support adequate recording of data within two hours of behavioral occurrence.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: All but one of the annual behavioral health updates were current, and about half met the content requirements. Missing from the others was information about physical health factors. Similarly, the functional assessments were current for all but one individual, and half met criteria. The others were missing various important components. Note, however, that all three indicators met criteria for two of the individuals; this was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
10	The individual has a current, and complete annual behavioral health update.	44% 4/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	0/1	1/1	1/1
12	The functional assessment is complete.	50% 4/8	1/1	N/A	0/1	0/1	1/1	1/1	0/1	1/1	0/1

Comments: 10. Four of the nine individuals (Individual #471, Individual #163, Individual #145, Individual #490) had a current and complete behavioral health assessment. Although current, the reports for Individual #177, Individual #155, and Individual #168 did not include a review of his or her physical health over the previous 12 months. Individual #86 had one report completed in June 2017. When an updated report was requested, the Center provided one updated in July 2018. Neither of these included a review of her physical health over the previous year. Lastly, Individual #293's behavioral health assessment was completed in November 2016. 11. The functional assessment was current for seven of the eight individuals who had a PBSP. The exception was Individual #293 whose assessment was completed in November 2016. 12. The functional assessment was considered completed for four of the eight individuals. These were Individual #177, Individual #145, Individual #490, and Individual #155.

For several individuals (Individual #471, Individual #163, Individual #168), no target behaviors occurred during the direct observation. There was no explanation as to why additional observations were not necessary.

Individual #168's report indicated that indirect assessments were not needed, but it was not clear how this was determined.

Finally, Individual #293's assessment was missing all indicators with the exception of identified consequences.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Brenham SSLC now made sure that PBSPs were implemented timely and after consents/approvals were obtained; this was an improvement from the past two reviews. PBSPs had also improved, such that more required components were included. Specific suggestions are provided below. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	1/1	N/A	1/1	1/1	1/1	1/1	0/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. For seven of the eight individuals who had PBSPs, there was documentation that the plan had been implemented within 14 days of all necessary consents/approvals. The Center could not locate the training rosters for Individual #293.

15. Although none of the PBSPs were considered fully complete, several indicators were met in the majority of the plans. This included the following:

- operational definitions of both target and replacement behaviors.
- antecedent and consequent strategies for weakening undesired behaviors.
- guidelines for training/reinforcing functionally equivalent replacement behaviors.
- clear interventions.

Five of the eight plans also identified more enriched reinforcement strategies, including in some cases, the use of token programs to reduce problem behavior and strengthen desired behavior. Staff are advised to closely examine the effectiveness of these token

programs, particularly because token exchange was often limited to once daily without consideration for weekends and/or that the individual could view the token chart only once per shift.

One element that was missing from all plans was the identification of sufficient opportunities for the replacement behavior to be reinforced or trained.

Individual specific comments are below.

- Individual #168's plan included a target behavior of threatening others (to file an allegation). This was defined as his making an allegation of abuse, neglect, or exploitation against a staff member. As it is his right to protect himself, this should not be identified as a problem behavior or labeled as a threat. If he makes unfounded allegations, there should be a strategy for addressing this issue in a more supportive manner.
- Individual #177 was encouraged to complete a complaint form if she wanted to protest some event/action. As she is a 10-year-old girl, this response requirement is not developmentally appropriate. She should be allowed to voice her concerns without added effort to be heard.
- There is a history of trauma or suspicion of trauma for both Individual #145 and Individual #177, respectively. As such, it would be appropriate to work with knowledgeable state staff to ensure that all PBSPs are based on a trauma-informed plan of care.

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

Summary: Since the last review, Brenham SSLC had re-established the provision of counseling/psychotherapy services onsite and/or pursued it off-site for all individuals. Thus, indicator 24 will be returned to the category of requiring less oversight. A next step is for the onsite counseling program to create progress notes that contain the required content. Thus indicator 25 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 4/4	1/1	N/A	N/A	N/A	1/1	1/1	N/A	N/A	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/3	0/1	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A

Comments:
24. At the time of the onsite visit, four of the individuals in the review group were involved in counseling. Individual #177, Individual #145, and Individual #490 were meeting with the onsite counselor. It was positive to learn that following his request for change to a male counselor, Individual #168 was meeting with a community-based counselor.

25. Only the plans and progress notes provided by the onsite counselor were reviewed. In each case, the following problems were identified:

- the objective did not indicate the conditions under which the behavior was to occur, nor the level of prompting allowed.
- there was no reference to evidence-based practices.
- although progress notes included a narrative summary of each meeting, there was not a consistent data-based review of progress.
- there were no identified procedures, including staff training, to ensure generalization of learned skills.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.												
Summary: IDTs, with input from PCPs, 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 oversight.			Individuals:									
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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 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: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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

Summary: Center staff should continue to improve the quality of the medical assessments with a particular focus on plans of care for applicable active problems. Indicators a and c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that two individuals' AMAs (i.e., Individual #125, and Individual #242) 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, complete interval histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Most, but not all included family history, and allergies or severe side effects of medications. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate, that are consistent with current standards of care/clinical guidelines.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #163 – respiratory compromise, and infections; Individual #155 – constipation/bowel obstruction, and cardiac disease; Individual #59 – gastrointestinal (GI) problems, and falls; Individual #570 – osteoporosis, and skin integrity; Individual #350 – falls, and cardiac disease; Individual #125 – cardiac disease, and constipation/bowel obstruction; Individual #437 – GI problems, and osteoporosis; Individual #242 – falls, and urinary tract infections (UTIs); and Individual #148 – skin integrity, and cardiac disease].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
	current standards of practice consistent with risk-benefit considerations.										
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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 #163 – respiratory compromise, and infections; Individual #155 – constipation/bowel obstruction, and cardiac disease; Individual #59 – GI problems, and falls; Individual #570 – osteoporosis, and skin integrity; Individual #350 – falls, and cardiac disease; Individual #125 – cardiac disease, and constipation/bowel obstruction; Individual #437 – GI problems, and osteoporosis; Individual #242 – falls, and UTIs; and Individual #148 – skin integrity, and cardiac disease). None of the IHCPs reviewed set forth comprehensive medical plans consistent with current medical guidelines/standards of practice to address the individuals' chronic and/or at-risk conditions.

b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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 two previous reviews and this one, individuals reviewed received comprehensive dental summaries (Round 11 – 89%, Round 12 – 100%, and Round 13 – 100%), Indicator c will move to the category requiring less oversight. Unless clinical justification is provided, annual dental exams need to include an updated periodontal chart. Indicator b will remain in active oversight.

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they moved to the category requiring less oversight.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	56%	0/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1

		5/9									
c.	Individual receives a comprehensive dental summary.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: b. It was positive that for five of the nine individuals reviewed, the dental exams included all of the required components. It was also good to see that all of the remaining dental exams reviewed included the following:

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

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- Periodontal charting, which is required as part of the "annual comprehensive dental exam." Further, in follow-up to discussion during the onsite review, an annual periodontal evaluation for adults is consistent with the recommendation of the American Academy of Periodontists (i.e., https://www.perio.org/consumer/perio-evaluation.htm).

c. It was very good to see that all of the dental summaries reviewed included the following:

- Effectiveness of pre-treatment sedation;
- Recommendation of need for desensitization or another plan;
- A description of the treatment provided (i.e., treatment completed);
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Treatment plan, including the recall frequency;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Good progress was noted with regard to the completion of annual and quarterly nursing assessments, including physical assessments. However, continued focus is needed to ensure nurses complete quality nursing assessments for the annual ISPs that identify and analyze relevant clinical data and use this information to offer relevant recommendations to IDTs. In addition, when individuals experience changes of status, nurses need to complete and document assessments in accordance with current standards of practice. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	88% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	N/A
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.	9% 1/11	0/2	0/2	1/1	0/1	0/1	0/1	0/1	0/2	N/A

Comments: a. With the exception of Individual #125's annual and quarterly nursing assessments, good progress was noted with regard to the completion of these assessments. Nurses included more clinical data in the assessments. However, as discussed below, more analysis of this information was needed.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #163 – falls, and skin integrity; Individual #155 – constipation/bowel obstruction, and fractures; Individual #59 – falls, and constipation/bowel obstruction; Individual #570 – seizures, and skin integrity; Individual #350 – fractures, and cardiac disease; Individual #125 –

constipation/bowel obstruction, and choking; Individual #437 – fractures, and skin integrity; Individual #242 – weight, and UTIs; and Individual #148 – fractures, and constipation/bowel obstruction).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, for a few of the risk areas reviewed, nurses included status updates, including relevant clinical data (i.e., Individual #570 – skin integrity, Individual #350 – fractures, and Individual #437 – fractures, and skin integrity). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

- For Individual #163, the nursing IPN, dated 6/7/18 at 10:35 p.m., did not provide details regarding the fall, including how it occurred. The IPN indicated that the individual "was witnessed sliding off the side of the bed," but did not indicate what he was trying to do, and/or if he hit his head or any other body part when he landed on the floor. This was especially concerning, because on 2/11/18, he was found on the floor beside his bed and he had sustained a laceration to the right eyebrow. Without these details, an assessment and analysis of this incident was not possible.
- Upon Individual #163's return the from hospital, an IPN, dated 5/22/18 at 6:11 p.m., did not include a comprehensive description of skin issues. He had a left lateral thigh skin tear, but the nurse provided no description of the area, if it was draining, the odor, or the length and depth. In addition, the note referenced bilateral 1 centimeter (cm) circular stage II pressure injuries, but the nurse did not indicate the locations, a description of the areas, if drainage was present, the depth, or odor. Also, the IPN noted edema to the individual's hands and feet, but did not include measurements for future comparison.
- An IPN, dated 5/12/18, noted Individual #155 had scratched his eyelid and was in bed panting. The IPN then indicated: "No distress." The nurse conducted no further assessment at that time. Later that day, he was sent to the ED and admitted for a bowel obstruction.
- An IPN, dated 4/3/18, indicated that Individual #155 complained of pain to his right ankle. The nurse provided no description of the foot/ankle, pedal pulse, circulation check, temperature of the skin, comparison to the left foot, the individual's ability to bear weight, pain scale, gait, or mention of any current injury or fall.
- An IPN, dated 1/29/18 at 2:15 p.m., indicated staff reported an abrasion to Individual #570's right buttock. Although the note indicated that the nurse notified the PCP, there was no indication that the nurse assessed the individual for pain or informed the direct support professionals to keep the individual off the affected area, and to keep the area clean and dry until the PCP saw him, and ordered treatments.
- An IPN, dated 1/4/18 at 8:10 p.m., noted that during bathing, when staff attempted to get Individual #350 up from the shower seat, she hollered in pain and pointed to her left ankle. When staff removed her stocking and brace, her leg was purple/blue/red with swelling to the left ankle and the entire foot. The nurse's assessment did not contain the temperature of the skin, if there were any open areas, range of motion, ability to bear weight, pedal pulses, or recent history of falls/injuries.
- For Individual #125, no assessment or justification was found in the IPNs for the Bisacodyl suppository given on 5/16/18, nor was there a description of the results.

- A nursing IPN, dated 2/5/18, noted that Individual #437's face was red and slightly warm to the touch. However, the nurse did not conduct and/or document an assessment of pain, if the individual's skin was smooth or had bumps, how long it had been red, and if there were red areas on other parts of the body.
- Between May 2017 and May 2018, Individual #242's weight dropped from 113.6 pounds to 89 pounds. No nursing assessments were found to address her continual and unplanned weight loss.
- For Individual #242, a nursing IPN, dated 4/19/18, noted: "initial dose Macrobid 100mg [milligrams] given PO [by mouth]." No documentation was found indicating that it was for a UTI. Further, the nurse did not complete and/or document an assessment.

On a positive note:

- A nursing IPN, dated 2/11/18 at 4:04 p.m., noted direct support staff found Individual #59 crawling out of his room. The nurse completed and documented an assessment that was consistent with applicable nursing guidelines.

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

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

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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 IHCP that included preventative measures was for Individual #242 – UTIs. The IHCP did not include any ongoing nursing assessments addressing vital signs, output, symptoms of UTIs, or pain while urinating. It did include an action step to offer

Individual #242 eight ounces of fluids with each medication pass. However, it did not require nurses to document intake to provide a mechanism for measuring achievement of the stated goal: will drink at least 48 ounces of fluid daily. Unfortunately, there was no documentation found that nursing staff had offered extra fluids during medication passes.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. If the Center sustains its performance in this area, after the next review, the related indicator might move to less oversight. Since the last review, the scores during this review generally showed improvement with regard to the timely referral of individuals to the PNMT. The Center should focus on sustaining its progress in this area, as well as ensuring the PNMT completes reviews for individuals that meet criteria for PNMT review. The quality of the PNMT comprehensive assessments also needs improvement. At this time, all of these indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	71% 5/7	1/1	1/1	N/A	0/1	1/1	N/A	1/1	1/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	57% 4/7	1/1	1/1		0/1	1/1		0/1	1/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	75% 3/4	1/1	0/1		N/A	1/1		N/A	1/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	43% 3/7	1/1	0/1		0/1	1/1		0/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 2/2	1/1	N/A		N/A	1/1		N/A	N/A	N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7	0/1	0/1		0/1	0/1		0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem;	0% 0/4	N/A	0/1		0/1	N/A		0/1	N/A	0/1

	• 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.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1		N/A	0/1		N/A	0/1	N/A

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

- On 6/15/18, Individual #163 was diagnosed with possible aspiration pneumonia. His IDT referred him to the PNMT timely, and the PNMT completed a timely review, and assessment.
- On 4/10/18, Individual #155 broke his ankle, and his IDT referred him to the PNMT. The PNMT conducted a review, but did not conduct an assessment. Given the change in mobility that the broken ankle caused and the individual's risk related to bowel obstruction, an assessment was warranted to assess the impact of the fracture on other related systems, and develop steps to mitigate the increased risk. On 5/12/18, Individual #155 was hospitalized for abdominal pain, a perforated bowel, and sepsis. At the time of the Monitoring Team's onsite review, he remained in an LTAC, after having undergone a colectomy with a colostomy with complications. The review the PNMT conducted of the fracture was incomplete. For example, the PNMT did not address the impact of the discrepancy in his leg lengths, or the impact of his behaviors (e.g., his stability when mimicking challenging behaviors).
- Individual #59's PNMT assessment was over a year old, so it was not scored.
- On 2/16/18, Individual #570 met criteria for PNMT referral due to a Stage 3 wound. A PNMT note was provided stating that a referral was not recommended, but the PNMT should have made/accepted a referral, and conducted a review. A Stage 3 pressure ulcer is a threshold that requires referral and a review, at a minimum.
- On 7/28/17, Individual #350 experienced a fracture of her left lateral malleolus (i.e., ankle). Two days later, the PNMT initiated an assessment, which was completed timely. The quality of the assessment is discussed below.
- On 1/11/18, Individual #437's IDT referred her to the PNMT due to weight gain, but the PNMT did not conduct a review. The PNMT only completed notes stating that although the individual met criteria for two consecutive months (i.e., January and February per PNMT notes on 1/30/18, and 2/28/18), the IDT was handling it. The PNMT should have completed a review.
- The PNMT saw Individual #242 for both falls and weight loss. The referral occurred on 5/8/18, with a review completed on 5/15/18, which was within five days. The PNMT recommended a full assessment, which was initiated on 5/15/18, and completed on 6/11/18.
- On 7/25/17, the PNMT referral noted a weight change for Individual #148, but the PNMT only provided notes on 8/1/17 and 8/22/17. The initial note stated that they thought the scale was incorrect and that they would follow the individual the next month. On 8/22/17, the PNMT note stated that calories had been reduced and there was no longer a need for PNMT involvement. The note did not meet the standards associated with a review. In addition, on 4/9/18, Individual #148 returned from the community with a deep pressure injury on his heel. His IDT did not refer him to the PNMT, and the PNMT did not

make a self-referral. (Documentation related to the stage of the pressure injury provided varying information. The Tier I documents indicated it was a "Stage 5," but this is not part of the standard staging of pressure ulcers.)

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments (i.e., generally, only the PNMT RN's signature included a date).

e. It was positive that as needed, a RN Post Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results.

h. As noted above, one individual who should have had a comprehensive PNMT assessment did not (i.e., Individual #155). The following summarizes some of the concerns noted with the three assessments that the PNMT completed:

- Individual #163's assessment lacked a thorough investigation of a number of areas, including but not limited to swallowing, and head-of-bed elevation (HOBE). The information often reflected past observations, as opposed to new assessments. For example, the PNMT assessment reviewed the speech language pathologist's (SLP's) observation of the individual during mealtimes prior to the pneumonia, but not after the event. The PNMT RN noted that Individual #163 was leaning to the right, but the PNMT assessment did not further explore this issue. The individual was at risk due to GERD, but the PNMT assessment did not explore this diagnosis as potentially relevant to the issue. Similarly, the PNMT did not discuss the impact of excessive salivation or poor oral hygiene on the risk of aspiration. Overall, the PNMT did not conduct sufficient assessments and/or analysis of data to identify the etiology/root cause of the aspiration pneumonia.
- On a positive note, Individual #350's PNMT assessment identified the presenting problem; included an assessment of current physical status; discussed pertinent diagnoses, medical history, and current health status; discussed medications that might be pertinent to the problem, and discussed the relevance to PNM supports and services; and provided evidence of observation of the individual's supports at her program areas. However, it did not discuss the potential impact of the cast on skin integrity, offer recommendations for measurable goals/objectives, or further assess the cause of the fracture, other than stepping on/off a curb.
- For Individual #242, the PNMT did a nice job of reviewing medications and identifying potential medication-related problems. While the PNMT did a good assessment with regard to the issue of falls, lacking was investigation into the issue of weight loss. Outside of discussing caloric intake and providing an oral motor summary, there was little information. No MBSS was considered to examine the pharyngeal phase of swallow. A statement was made that during the bedside swallow study, no issues were noted. However, a bedside swallow study does not adequately assess pharyngeal functioning, including issues that could impact intake without the individual showing overt signs. Also, issues with the oral phase, such as poor lingual coordination and holding food, could be signs of fatigue that could also impact intake, and, therefore, impact weight. The PNMT also made a statement that her oral intake improved, but did not include data to support this statement. The PNMT's recommendation for a goal related to falls did not match the IHCP, and the PNMT did not recommend one regarding the need for weight gain.

  In disputing these findings, in its comments on the draft report, the State stated: "As reported in the PNMT assessment, an analysis of findings from the 2017 Dysphagia Assessment, prior diagnostic testing (MBS 2012), consultation with the treating OT, and clinical assessment from PNMT SLP, #242 [sic] did not present with a change in status of swallowing skills (i.e. no new

	clinical observations such as odynophagia or indicators such as declines in pulmonary health) which would indicate an acute decline in the pharyngeal phase of the swallow. Data provided on meal intake indicated that #242 [sic] had no meal refusals in the last six months. Additionally, the data revealed that #242 [sic] was consuming the majority (75% or >) of meals with breakfast at 86% and lunch and dinner and 93% of the time. In regards to the statement that oral holding or poor lingual coordination are indicators of fatigue, the current dysphagia literature does not support this observation (Solomon, 2004 & 2006, Burkhead, Sapienza, & Rosenbeck 2007, Kays, 2010, Ravenhorst-Bell 2012). Additionally, objective measurements of fatigue cannot be identified through VFSS [videofluoroscopic study]. While the clinical/bedside examination and objective instrumental testing yield useful information for the assessment and management of dysphagia, each has its disadvantages. Therefore, the treating SLP must establish what assessments are required for a particular patient and critically appraise the evidence bases for each. For #242 [sic], much of the evidence pointed to iatrogenic cause for the weight loss (i.e. increase/change in psychiatric medication) and within that framework, an instrumental assessment of swallowing function was not warranted at that time." In response, Individual #242 did present with a change in status that was potentially linked to swallowing issues. Specifically, between January 2018 and May 2018, she experienced an eight-pound unplanned weight loss. The State expressed that "much" (i.e., but not all) evidence pointed to changes in psychiatric medication as the cause of the weight loss. This theory of the cause should have led the PNMT to investigate the issue of lethargy and fatigue, as discussed in the Monitoring Team's findings. The citations the State provided were not to specific articles. However, to clarify the statement, the fatigue the Monitoring Team referenced is not myofascial fatigue, which many articles discuss, but rather fatigue on the body. In other words, if a person is fatigued to the point that it impacts their level of alertness or focus, such fatigue might also impact the person's ability to adequately process food in the oral and pharyngeal phases. The Monitoring Team agrees that a VFSS is not an objective measurement of fatigue, but an assessor is able to see the impact of multiple swallows and whether or not the safety of the swallow decreases with subsequent bites. In addition, since the individual was going through medication changes, the impact on swallowing might be to a degree that an assessor could not identify them through a bedside examination.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. Although three PNMPs met criteria, most PNMPs still had missing information, or out-of-date information. With minimal effort and attention to detail, though, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148

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.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	1/1	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.	17% 3/18	0/2	0/2	1/2	0/2	1/2	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.	6% 1/16	0/2	0/2	1/2	0/2	0/1	0/2	0/1	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: aspiration, and falls for Individual #163; choking, and falls for Individual #155; falls, and aspiration for Individual #59; aspiration, and skin integrity for Individual #570; aspiration, and falls for Individual #350; aspiration, and choking for Individual #125; GI problems, and weight for Individual #437; falls, and weight for Individual #242; and skin integrity, and weight for Individual #148.

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. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs for Individual #155, Individual #570, and Individual #437 included all of the necessary components to meet the individuals' needs. The following summarizes the findings with regard to the PNMPs reviewed:

- All of the PNMPs, as applicable to the individuals' needs included:
  - Positioning instructions;
  - Transfer instructions;
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Handling precautions or moving instructions;
  - Mealtime instructions;
  - Medication administration instructions; and

- Oral hygiene instructions.
- Most, but not all of the PNMPs reviewed, as applicable to the individuals:
  - Were reviewed and/or updated within the last 12 months. Based on review of other documents, Individual #59's PNMP should have been updated to reflect his high-risk status for aspiration;
  - Included descriptions of adaptive equipment. Individual #163's OT/PT assessment identified a padded headboard, but the PNMP did not;
  - Included mobility instructions. Individual #242's PNMP indicated she was ambulatory, but left out important information about the level of independence; and
  - Included complete communication strategies (i.e., Individual #242's PNMP only discussed receptive language).
- The components of the PNMPs on which the Center should focus on making improvements include:
  - Four PNMPs reviewed omitted risks, had not been updated to reflect current risks, or only referred to "general triggers;" and
  - Five PNMPs were missing pictures (i.e., one or more picture was missing, for example, bed positioning with the individual in the bed).

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

e. The IHCPs reviewed that identified the necessary clinical indicators were those for falls for Individual #59, falls for Individual #350, and weight for Individual #437.

f. The IHCP that identified triggers and actions to take should they occur was for falls for Individual #59.

g. The IHCPs reviewed did not include PNMP monitoring, and/or define the frequency of monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Given that over the last two review periods and during this review, the IDTs of individuals reviewed with enteral nutrition included clinical justification for the continued medical necessity, and discussed the least restrictive method of enteral nutrition in the individuals' ISPs/IRRFs (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator a will move to the category requiring less oversight. The remaining indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical	100% 3/3	N/A	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A

	necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.										
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.	N/A			N/A	N/A			N/A		
Comments: a. and b. For the individuals reviewed with enteral nutrition, IDTs had provided clinical justification for the continued medical necessity, and discussed the least restrictive method of enteral nutrition in their ISPs/IRRFs.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Given that for three reviews, OTs/PTs completed timely assessments for newly admitted individuals (Round 10 – 100%, Round 11 – N/A, Round 12 – 100%, and Round 13 - 100%), Indicator a.i and a.ii will move to the category requiring less oversight. The Center's performance with regard to the timeliness of OT/PT assessments for other individuals, as well as the provision of OT/PT assessments in accordance with the individuals' needs has remained the same, and requires improvement. The quality of OT/PT assessments continues to be an area on which Center staff should focus. The remaining indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	67% 6/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1

b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	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% 0/6	0/1	0/1	0/1	N/A	N/A	0/1	0/1	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	N/A	0/1	0/1	N/A	N/A	0/1	N/A

Comments: a. and b. The following concerns were noted:

- On 4/3/18, Individual #163's IDT requested a consultation to trial feeding him from the left to help him maintain a centered positioning in his chair. The Center did not submit evidence to show that the OT/PT completed this consultation. His ISP, dated 4/19/18, described a decreased ability to self-feed, but the ISP did not include an action plan for the OT to assess him further or address this decline. His IDT also requested a consultation to assess his fine motor skills and ability to participate with SAPs, but based on the documentation submitted, the OT had not completed it.
- On 4/3/18, in response to increased redness and swelling on the tips of Individual #125's first, second, and third toes, a note stated that Habilitation Therapy staff would follow up. However, the Center submitted no evidence that this occurred.
- Based on documentation provided, the OT/PT completed Individual #242's last assessment in 2015. She had OT/PT-related supports, so at least an update was warranted

d. The Monitoring Team reviewed the quality of comprehensive OT/PT assessments for six individuals. The following summarizes 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 only assessment that met this criterion was for Individual #59. For the remaining individuals, the assessors did not discuss whether or not medication side effects were present and/or potentially impacting an OT/PT problem(s);
- 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): Most of the assessments met this criterion. However, for Individual #155, the assessment was unclear regarding the use of a weighted blanket. Some documents (e.g., the PBSP) stated that he uses a weighted blanket, but the other documents stated that he just uses his comforter. This should be clarified and incorporated into his PNMP, so that the PNMP and PBSP are consistent;
- 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: Two of the assessments reviewed did not provide a comparative analysis, and/or omitted important information (e.g., Individual #148's assessment made no mention of his ability to walk in the recent past);
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings, and/or other data to support conclusions that "supports are effective." Assessments included such statements despite data showing poor outcomes for individuals (e.g., multiple falls for Individual #163, and Individual #155). In its comments on the draft report, the State disputed this finding for Individual #155. The State cited numerous documents and indicated that: "…it is documented that #155's falls were due to his challenging behaviors and not due to physical issues. PT cannot provide supports to prevent these falls…" While it is true that the falls were related to the individual's challenging behaviors, the assessor had not looked at the individual's stride or balance when he ran, which was the behavior in which he was engaged when most of the falls occurred. A PT's assessment of this particular area might help to identify other supports that would potentially assist Individual #155. However, without a consult or assessment focusing on this issue, the question remained unanswered;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: A number of assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, 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; and
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living.

e. As discussed above, Individual #242 should have had at least an update completed, but did not. The following summarizes some examples of concerns noted with regard to the required components of the two OT/PT updates reviewed:

- 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: Individual 350's update did not include relevant information;

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For Individual #350, the assessors did not discuss whether or not medication side effects were present and/or potentially impacting OT/PT functioning;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day: Both assessments included vague information regarding the individuals' OT/PT-related functioning (e.g., specifics regarding activities of daily living were missing);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Individual #350's assessment met criterion, because it sited data from nine monitoring reports to support statements regarding effectiveness of supports. Individual #570's assessment stated supports were effective, but offered no data to support such a conclusion;
- 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: As discussed above, data is needed in order to provide clinical justification for decisions; 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: Without complete assessments, it was unclear whether or not the assessors identified a full set of recommendations to address individuals' needs.

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

- 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;
- 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); and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

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: Work is needed to ensure that ISP include thorough descriptions of individuals' OT/PT functioning. Although ISPs/ISPAs generally included interventions/programs recommended in assessments, as discussed above, assessments did not consistently address unmet OT/PT needs. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight.								
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 10/10	1/1	1/1	1/1	1/1	2/2	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	1/1	N/A	N/A	2/2	N/A	N/A	N/A	N/A
Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Given that over the last two review periods and during this review, newly admitted individuals reviewed had timely communication assessments (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator a.i and a.ii will move to the category requiring less oversight. In a number of instances, SLPs had not provided individuals with the correct type of assessment (i.e., screening versus comprehensive versus update). In addition, significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	44% 4/9	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1

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% 0/2	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A

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

- In April 2017, the Speech Language Pathologist (SLP) completed Individual #163's last screening. It noted deficits, but the SLP provided no rationale as to why he would not have benefitted from a more thorough assessment to potentially identify methods to enhance his communication abilities.

- It was unclear when Individual #155 last had a comprehensive assessment. The Center submitted a screening. However, an ISPA, dated 12/27/17, mentioned the use of a choice board, but no evidence was submitted to show that the SLP assessed him or why he needed a choice board, when, according to his Communication assessment, he was able to utilize conversational speech. Based on interview, the BCBA recommended a choice board. The assessment process should have been done in collaboration with the SLP.
- For Individual #59, and Individual #570 the last comprehensive assessments were completed in 2014, and clinically sufficient rationales were not provided for not completing comprehensive assessments in 2017.
- For Individual #350 and Individual #125, their updates did not provide information regarding when the last comprehensive assessments occurred. In addition, Document Request #78 asks for: "Most recent Communication assessment, and all updates since that assessment." For these individuals, the Center did not submit the underlying communication assessments. As a result, the Monitoring Team was unable to determine whether an update or comprehensive assessment was warranted.
- For Individual #437, the SLP did not complete an update. In 2016, a screening was provided. However, Individual #437 had a communication-related goal/objective that focused on her activating a switch to begin to learn cause and effect. Therefore, an annual update was warranted.
- In 2015, the SLP completed Individual #242's last comprehensive assessment. This assessment did not provide a rationale for not developing a program to address her several communication strengths and needs. As a result, she did not have an initial quality assessment, and the need for communication programming or supports could not be ruled out. She should at least have had an update, and likely requires a new comprehensive assessment.

c. The following provide some examples of problems noted with regard to the screenings reviewed:

- Individual #163's screening only reflected a review of the assessment in 2014, rather than a clear review of current status. In addition, the methods the SLP used for determining the individual's current status were not clearly indicated. The screening lacked a review of AAC.
- Individual #155's screening lacked review of his cognitive abilities. Due to his high functioning receptively and expressively, this should have been an area screened.

d. As discussed above, the following individuals should have had comprehensive assessments, but did not: Individual #163, Individual #155, Individual #59, Individual #570, Individual #350, and Individual #125. The following describes some of the concerns with the assessment reviewed for Individual #148:

- The individual's preferences and strengths are used in the development of communication supports and services: The assessment did not include a section on preferences and strengths;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: The assessment did not discuss the expansion or development of skills;
- The effectiveness of current supports, including monitoring findings: The results of monitoring/observations over the previous year were not cited. The assessor concluded that supports were effective, but provided no data to support this conclusion;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: The assessment stated that AAC was not appropriate, but did not provide sufficient justification. Given that his level

of expressive language is not highly functional, and AAC could potentially provide assistance, further assessment appeared warranted;

- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: Evidence to show compliance with this sub-indicator was not present; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: Given that the assessment was incomplete, it was unclear whether or not it included a full set of recommendations to address the individual's needs.

On a positive note, the assessment provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- A comparative analysis of current communication function with previous assessments;

e. As discussed above, Individual #437, and Individual #242 should have had updates, but did not.

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

Summary: It was positive that the ISPs reviewed provided complete functional descriptions of the individuals' communication skills. If the Center sustains this performance, Indicator a might move to the category of less oversight after the next review. It was positive that individuals' ISPs included strategies, interventions, and programs recommended in the assessments. As discussed above, though, assessments did not consistently identify and/or address unmet communication needs. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
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.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	100% 9/9	1/1	1/1	1/1	1/1	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.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
	Comments: a. It was positive that the ISPs reviewed provided complete functional descriptions of the individuals' communication skills. b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap. c. It was positive that individuals' ISPs included strategies, interventions, and programs recommended in the assessments. As discussed above, though, assessments did not consistently identify and/or address unmet communication needs. d. Individual #570 appeared to have made improvement with his goal/objective, and the SLP correspondingly updated the goal/objective to increase the level of difficulty. However, when the SLP modified the goal, no ISPA was found showing the IDT 's involvement in the decision-making.										

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: All individuals had SAPs and all were written in measurable terms. Thus, indicators 1 and 2 will be moved to the category of requiring less oversight. Although the total number of SAPs across the individuals in the review group was the same as at the last review, this time, there was only one individual who had only one SAP. Performance on the other three indicators remained about the same as at the previous two reviews. Note, however, that all SAPs met criteria for all five indicators for one individual. With additional attention, Brenham SSLC should be able to meet criteria for all SAPs for all individuals in the near future. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
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	2/2	2/2	3/3	2/2	2/2	3/3	3/3	1/1	3/3
3	The individual's SAPs were based on assessment results.	62% 13/21	2/2	2/2	2/3	2/2	0/2	0/3	3/3	1/1	1/3
4	SAPs are practical, functional, and meaningful.	48% 10/21	2/2	2/2	1/3	1/2	0/2	0/3	2/3	2/1	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	24% 5/21	2/2	0/2	1/3	0/2	1/2	1/3	0/3	0/1	0/3

Comments:
1-2. All of the individuals had skill acquisition plans (SAPs). Three SAPs were reviewed for Individual #471, Individual #490, Individual #293, and Individual #168. Four individuals had two SAPs for review (Individual #177, Individual #86, Individual #163, Individual #145), while Individual #155 had one active SAP. Of the 21 SAPs reviewed, all were measurable.

3. Thirteen of the 21 SAPs were based upon assessments. The exceptions were SAPs that addressed skills identified as mastered in the Functional Skills Assessment (FSA). These included Individual #471 paying a cashier, Individual #145 budgeting (she was reported to have good money and math skills), all of Individual #490's SAPs, and Individual #168 completing an application (he could write). When the program developer assessed Individual #168's addition and subtraction skills, it was noted that he performed quite well. Individual #145 had a SAP to e-mail her mother, but this section of the FSA was incomplete.

4. Ten of the 21 SAPS were considered practical, functional, and/or meaningful. Exceptions included SAPs that addressed skills assessed as already mastered. Other SAPs that did not meet this indicator were the following: Individual #471 was supposed to learn to recognize her name, but as written, she was simply repeating the letter(s) presented by staff; Individual #163 was learning to complete a four piece puzzle, and while this was reported to be a preference, it was not developing a meaningful skill; Individual #145 was learning to e-mail her mother, a meaningful skill, but one that she had acquired; and Individual #293 had a SAP to learn to tie his shoes, but he had no shoes with laces.

5. Of the 21 SAPs, there was evidence that six had been monitored for data reliability. However, five of these were credited as it was clear that IOA on Individual #163's puzzle SAP had been assessed during a role-play situation. Staff are advised to clearly note whether the assessment was completed through interview, role-play, or observation.

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: For two individuals, all three indicators met criteria indicating that Brenham SSLC has the capacity to do so. With attention, these indicators should be able to be at 100% performance. They play an important role in setting the stage for the selection and development of SAPs. The indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
10. Eight of the nine individuals had a current FSA, PSI, and vocational/day program assessment. The exception was Individual #490 who's FSA was an older format dated 2016.

The vocational assessments that were provided did not present a complete profile of the individual's work skills.

11. Based upon the documentation provided, it was evident that seven of the nine individuals' assessments were available to their IDTs at least 10 days prior to the ISP meeting. The exceptions were Individual #490 and Individual #168.

12. The assessments completed for Individual #177 and Individual #86 included recommendations for skill acquisition. For all others, SAP recommendations were not included in either their vocational assessment or day program assessment. While functional skills assessments usually included SAP recommendations, these were occasionally limited in number and scope. Individual #490's FSA did not include recommendations, and one to two recommendations were included in the FSA for Individual #163, Individual #145, Individual #293, and Individual #155. Between four and 10 SAP recommendations were provided for Individual #177, Individual #86, Individual #471, and Individual #168.

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, 17 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, behavioral health, and dental will move to the category of less oversight, which places the entirety of Outcome #7 for dental in 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.

Goals/Objectives and Review of Progress

In psychiatry, without measurable goals for either reduction or increase, progress could not be determined. There were delays in the completion of the psychotropic side effect assessments and in the prescriber review of the assessments. There was a need for improvement with regard to the justification of the medication regimens meeting criteria for polypharmacy.

In behavioral health, monthly progress notes were completed for three-quarters of the individuals, though when done, they contained the required content. Follow-up to peer review recommendations was not evident, and peer reviews were not occurring at the required frequency.

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

Acute Illnesses/Occurrences

Regarding when there are frequent crisis intervention restraints, the Center should focus upon indicators 20 to 23, which are about the content of the reviews that are to occur following more than three restraints in any rolling 30-day period. The content should show discussion and actions to be taken (or rationale why no action is needed). PBSPs and CIPs, however, were in place for each individual.

In psychiatry, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action.

Based on the Center's response to the Monitoring Team's document request for acute care plans, 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. The Monitoring Team recognizes that Center staff were working with State Office to correct this issue.

For acute medical issues addressed at the Center, improvement was noted in comparison with previous reviews with regard to PCPs' assessments, but a number of concerns were noted with regard to subsequent follow-up. Likewise, the Medical Department should focus on completing and documenting follow-up when individuals return from hospitalizations.

On a positive note, for the two individuals reviewed for which dental emergencies occurred, the Dental Department provided emergency dental care in a timely manner. Over three reviews, the Center had done consistently well with the three indicators related to emergency dental care, so this entire outcome will move to the category requiring less oversight.

<u>Implementation of Plans</u>
There has been considerable turnover in the psychiatric staffing at the Center, though this seemed likely to be improving going forward. The psychiatry department was well aware of past and recent problems in conducting timely quarterly psychiatry reviews and clinics. They were working towards completing these reviews. Some attention will be required to ensure that the documentation shows the full required content. The psychiatric clinics that the Monitoring Team observed were well conducted and met criteria.

In behavioral health, without reliable data, the Monitoring Team could not make a valid determination of progress. Based upon the Center's own data, when there was no progress being made, actions were suggested for some, but not all, of the individuals. Actions, however, were implemented when suggested.

Training of a higher percentage (e.g., all) of staff on individuals' PBSPs was needed. PBSP summaries for float/substitute staff now existed for all individuals. All PBSPs met criteria for credentials of staff writing the plans. Data collection systems were adequate for most individuals' target behaviors and for all individuals' 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 a lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

For a number of individuals' chronic or at-risk conditions, PCPs working with IDTs had not conducted medical assessment, tests, and evaluations consistent with current standards of care, and had not identified the necessary treatment(s), interventions, and strategies, as appropriate. In some cases, this placed individuals at significant risk.

Moreover, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Overall, improvement was noted with regard to the Medical Department's handling of non-Facility consultations. However, the timeliness of review was sometimes still an issue. In addition, since as far back as December 2014, the ophthalmologist had recommended cataract surgery for one of the individuals reviewed, but it did not occur, and surgery was no longer possible. The individual was now effectively blind in the left eye.

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.

When individuals reviewed needed suction tooth brushing, their ISPs/IHCPs included measurable strategies, but staff did not fully implement the strategies, and often, QIDPs did not summarize data in a way that allowed IDTs to take necessary action. In addition, ISPs/IHCPs need to define the frequency of monitoring of suction tooth brushing.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (45% of 47 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, including Habilitation Therapies as well as Residential and Day Program/Vocational staff, should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. Based on the Monitoring Team's observations, a particular focus should be placed on the implementation of Dining Plans.

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 will remain in active monitoring. The Center should focus upon indicators 20-23, which are about the content of the reviews that are to occur following more than three restraints in any rolling 30-day period. The content should show discussion and actions to be taken (or rationale why no actions needed). PBSPs and CIPs were in place as required and with sustained high	Individuals:

#	Indicator	Overall Score	177	490	155	168					
performance, these two indicators might be moved to the category of requiring less oversight after the next review.											
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.	75% 3/4	1/1	0/1	1/1	1/1					
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	75% 3/4	1/1	0/1	1/1	1/1					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	25% 1/4	0/1	0/1	0/1	1/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/4	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?	25% 1/4	0/1	0/1	1/1	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.	0% 0/4	0/1	0/1	0/1	0/1					
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 4/4	1/1	1/1	1/1	1/1					
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 4/4	1/1	1/1	1/1	1/1					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	25%	0/1	1/1	0/1	0/1					

		1/4									
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.	75% 3/4	1/1	1/1	1/1	0/1					
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.	75% 3/4	1/1	0/1	1/1	1/1					

Comments:

18-19. These indicators applied to four individuals in the review group (Individual #177, Individual #490, Individual #155, Individual #168) because they had experienced more than three crisis intervention restraints in a rolling 30-day period. There was evidence that the IDT for everyone, but Individual #490, had met a sufficient number of times within the required timeframe to discuss the restraints.

20-23. Although Individual #177's IDT met, they did not discuss potential variables contributing to the use of restraint. The extent to which the IDTs for Individual #155 and Individual #168 discussed these variables differed quite a bit. Therefore, individual specific feedback is provided below.

- Individual #155: In the meeting held in early April 2018, the team did review results of an adaptive behavior assessment completed in 2016. This did not provide a comprehensive review of his current adaptive skills. This was in spite of his mobility being restricted, including no access to the bathroom, due to a recent injury. While the team recognized the potential impact of medical and psychiatric conditions, the sole action plan was to have an emergency consult with his psychiatrist. Although the team acknowledged that his move to a different home in June 2017 may have contributed to the increase in behaviors leading to restraints, there were no actions identified to address this. He was also no longer attending school, but this matter was not discussed or addressed. Environmental variables, including two discovered injuries, were reviewed, but again, no action was taken other than a review of videotapes.
- Individual #168: His IDT did review his adaptive skills, and biological, medical, and psychosocial issues. Although it was determined that these did not contribute to the use of restraint, it was positive to learn that a male counselor was being sought following his request. When environmental issues were reviewed, the IDT indicated that two different restraints had occurred when he could not go to school due to staffing shortages, or that he experienced problems when substitute staff were present. Neither of these issues were addressed. A review of antecedent conditions noted that one restraint occurred when he was not allowed to listen to music on a peer's phone. Appropriately, the IDT agreed to purchase a portable radio for him to use.

24-25. All four individuals had PBSPs and CIPs.

26. Review of the individuals' PBSPs can be found elsewhere in this report (Psychology/Behavioral Health, Outcome 4, Indicator 15).

27. The CIP for Individual #490 was considered complete. For all other individuals, their CIP did not identify the specific type of restraint that could be applied. Individual #490's CIP provided a very clear description of the approved modified restraint that could be used during a crisis. Individual #177's CIP did not identify the maximum duration allowed for an individual restraint. While the author

of the CIP was indicated for Individual #177, Individual #490, and Individual #168, it was unclear who had written the plan for Individual #155. Lastly, staff are advised to sign the CIP. 28. Evidence provided by the Center indicated that the PBSPs for Individual #177, Individual #490, and Individual #155 were implemented with at least 80% integrity. For each of these individuals, integrity was assessed at least once per month. Although the minutes from Individual #168's ISPA meeting indicated that staff were implementing his plan with good integrity, there was no documentation provided to support this. 29. There was evidence that the IDT for Individual #177, Individual #155, and Individual #168 had reviewed their PBSPs. It was noted that Individual #177 had a new plan presented to the BTC in March 2018. What was not clear was whether her interim PBSP was in place up to this time. This would be concerning because she was admitted in September 2017. Individual #155's PBSP was also revised in March 2018.

Psychiatry

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

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: As Brenham SSLC creates indicators and goals for reduction and for improvement of individuals' psychiatric disorders, data can be collected, and progress determined. Even so, when individuals were clearly experiencing problems with their psychiatric condition, psychiatrists (and IDTs) took action. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
8	The individual is making progress and/or maintaining stability.	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

Comments:

8-9. Without measurable goals for either reduction or increase, progress could not be determined. The exception was for Individual #293, who had an indicator and a goal for reduction (but not for increase). However, without data, progress could not be determined for him either.

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 (e.g., medication adjustments, changes in the living environment, and alterations to non-pharmacological interventions) were developed and implemented.

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

Summary: Scores were lower than at the last review. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	86	471	163	145	490	293	155	168
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	56% 5/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	1/8 13%	0/1	N/A	0/1	0/1	1/1	0/1	0/1	0/1	0/1

Comments:

23. The psychiatric documentation generally referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in five examples.

There were some inconsistencies, as the functional assessment did not review the role of the psychiatric disorder on the presentation of behaviors in the case of Individual #145. The diagnoses noted for Individual #168 and Individual #155 in the functional assessment were inconsistent with those reported in the psychiatric documentation. For Individual #293, the behavioral health assessment was outdated as it was performed in 2016.

24. There was documentation regarding the psychiatrist's participation in the development of the PBSP for Individual #145. There was no documentation of psychiatric participation for the remaining seven individuals who had a PBSP. Previously, the psychiatrists attended Behavioral Therapy Committee (BTC) and collaborated during this meeting with regard to behavioral supports. As the psychiatry staff were aware that they were behind with regard to quarterly evaluations and documentation, they made the decision to focus their efforts on becoming current and as such were not attending BTC at the current time.

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: These indicators did not apply to any individuals in the review. Indicators 25 and 27 will remain in active monitoring for review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 25. Even though no individuals in the review group required psychiatry and neurology collaboration, the Monitoring Team attended the onsite neurology clinic. The psychiatrists were present for the review of their patients. They were able to ask questions of the neurologist and he was very accommodating with regard to collaborative treatment.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Although low performance occurred for completion of timely quarterly reviews and clinics, the Center psychiatry department was well aware of this and was working towards getting these reviews completed. Some attention will be required to ensure that the documentation shows the full required content. The psychiatric clinics that were observed by the Monitoring Team were well conducted and met criteria. With sustained high performance, this indicator (35) might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
33	Quarterly reviews were completed quarterly.	38%	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	N/A

		3/8									
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	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

33. There were delays in the completion of quarterly reviews. There was turnover in psychiatric treatment providers and some reliance of locum tenens physicians, which contributed to this issue. The Center psychiatric staff were aware of the delinquencies and were focusing their resources on timely completion of the evaluations.

One topic, discussed during the monitoring visit, was that the Center psychiatric staff were continuing to perform four quarterly evaluations in addition to one annual evaluation. They could reduce their burden by performing three quarterly evaluations and one annual evaluation. In addition, the Center now had 1.5 FTE employed psychiatric staff plus 1.0 FTE locum tenens. With the increased number of full time staff, they hoped to improve the timeliness of the quarterly evaluations.

34. The Monitoring Team looks for nine components of the quarterly review. None of the examples included all the necessary components. The evaluations were missing from one to seven of the required elements.

35. During the monitoring visit, psychiatry clinics were observed for 11 individuals, two of these individuals were included in the review group. All of the psychiatry clinics observed were good in that there was a good amount of input and discussion between the team members. Both doctors made attempts to establish rapport with the individuals. It was evident that they had reviewed documents in advance, and they asked specific questions of staff who were in attendance.

In one clinic observation, nursing and the QIDP provided written information for the psychiatrist to utilize during the clinical encounter. This was good to see. Behavioral health staff provided data to the psychiatrists, but the focus was on behavioral challenges, not specific identified symptoms or psychiatric indicators. As discussed above, there is a need for improvement in the consistency of diagnoses across documents, the consistent identification of indicators, the operational definition of indicators and the provision of data regarding said indicators for use in medication decision making by psychiatry.

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

Summary: This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	86	471	163	145	490	293	155	168
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1

Comments:

36. There were delays in both the completion of the assessment and the prescriber review of the assessments. Per a discussion with the psychiatrists during the monitoring visit, some of the delays in prescriber reviews were due to staff turnover and technological difficulties. Both of these issues have reportedly been addressed.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: Given sustained high performance, indicator 38 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
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. There was documentation of emergency/interim clinics regarding all of the individuals in the review group. The documentation from these emergency/interim clinics was generally brief, but included the appropriate information.											

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. See comment below regarding Individual #155, his hospitalization, and psychotropic medication changes.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
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	1/1	0/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments:											

40-41. There was cause for concern regarding Individual #155. At the time of the monitoring visit he was admitted to a hospital due to medical issues. While there, his psychotropic medication regimen was adjusted and the dosages of medication were increased. Due to the possible medication burden, the Monitoring Team recommended a consultation with the current treatment provider. 42. Individual #293 is prescribed psychotropic medication, but his behavioral treatment program is outdated.

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: Attention needs to be paid to the justifications for polypharmacy regimens. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	40% 2/5	1/1	N/A	1/1	N/A	0/1	N/A	N/A	0/1	0/1
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 five individuals. Polypharmacy justification was appropriately documented in two examples. There was a need for improvement with regard to the justification of the medication regimens meeting criteria for polypharmacy. 46. The polypharmacy meeting was well run. The psychiatrists did a good job of challenging each other and there was no apparent defensiveness. All of this was an improvement from the previous review. There were, however, problems with the polypharmacy data. The psychiatry staff were aware of this and are going to fix the data presentation.											

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, the Monitoring Team could not make a valid determination of progress. Therefore, indicator 6 was scored 0 for all individuals. Based upon the Center's own data, however, when an individual met his or her goal a new/revised goal was not developed. When there was no progress being made, actions were suggested for some, but not all, of the individuals. Actions, however,	Individuals:

were implemented when suggested. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
6	The individual is making expected progress	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/2	N/A	N/A	N/A	0/1	0/1	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.	40% 2/5	0/1	N/A	N/A	N/A	N/A	1/1	0/1	1/1	0/1
9	Activity and/or revisions to treatment were implemented.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A

Comments:
6. Although graphs included in the progress notes for Individual #471, Individual #163, Individual #145, and Individual #490 suggested progress in some areas, this indicator was rated as zero for all individuals due to problems with data reliability (see indicator 5).

7. Individual #163 had met his goals, as had Individual #145 with her replacement behavior, but there was no evidence of new or updated goals having been developed. While reported data suggest that Individual #471 met her goals for physical aggression, destruction, and intrusiveness in June 2018, it was not yet possible to determine whether new goals would be developed.

8-9. There was evidence of corrective actions taken for two of the five individuals for whom data suggested were not making progress. The PBSP had been revised or updated for Individual #490 and Individual #155.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Attention needs to be paid to the training of a higher percentage (e.g., all) staff on individuals' PBSPs. PBSP summaries for float/substitute staff now existed for all individuals. Thus, indicator 17 will be returned to the category of requiring less oversight. In addition, all PBSPs met criteria for credentials of staff writing the plans. This has been the case now for three of the four most recent reviews (with some exceptions in January 2017). Thus, indicator 18 will be moved to the category of requiring less oversight. Indicator 16 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
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.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

16. A comparison was made between a list of assigned staff and training rosters for seven of the eight individuals who had a PBSP. This comparison indicated that in no case had 80% or more of the staff been trained on the individual's PBSP. Documentation revealed that training had been provided to the following percentages of assigned staff: Individual #177 – 63%; Individual #471 – 19%; Individual #163 – 0%; Individual #145 – 65%; Individual #490 – 22%; Individual #155 – 55%; and Individual #168 – 70%. No training rosters were available for Individual #293.

17. Facility staff had developed a PBSP summary or instructions for substitute staff for all eight individuals. These varied in length from two pages to eight pages. Because the purpose is to provide a quick reference for staff who are not familiar with the individual, staff are advised to keep these brief while highlighting key aspects of the plan.

18. All of the functional assessments and PBSPs were written by a BCBA, or a staff member who was enrolled in or had completed coursework. All had also been reviewed by the Behavior Therapy Committee, members of which are BCBAs. Staff are advised to sign all assessments and behavior support plans.

The behavioral health services department was fully staffed with multiple BCBAs and with other staff who were engaged in pursuing certification.

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

Summary: Performance remained about the same as at the last review. Monthly progress notes were completed for three-quarters of the individuals, though when done, they contained the required content. Follow-up to peer review recommendations was not evident, and peer reviews were not occurring at the required frequency. The indicators of this outcome will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
19	The individual's progress note comments on the progress of the individual.	75% 6/8	1/1	N/A	0/1	1/1	1/1	1/1	0/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0%	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/8									
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3	N/A	1/1	0/1	N/A	1/1	N/A	N/A	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% 0/3	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	0/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. Monthly progress notes were provided for six of the eight individuals. Comments were provided regarding the individual's progress. The exceptions were Individual #471 and Individual #293. Individual #471 did not have progress notes from February 2018 through April 2018. The Center wrote that these had been "…postponed for three months to catch up on behavior plans." Individual #293 did not have any monthly progress notes since May 2017. The Center wrote that this was "…due to staff shortage." A progress note was provided for May 2017 through May 2018.

As discussed with the director of behavioral health services, staff are advised to ensure that the individual's name is included in the heading of the document. Staff are also advised to keep target behavior labels consistent throughout the report. For both Individual #490 and Individual #168, one target behavior was unauthorized departure that was later referenced as problematic departure.

20. Although graphs were included in all progress notes, none of these were considered useful for making data-based decisions. For the majority of individuals, this was due to the lack of phase change lines depicting significant events such as medication changes, introduction of a new or revised PBSP, or change in residence. Although phase change lines were included in the graphs for Individual #177, the graphs were so small that they were difficult to understand.

21. While onsite, observations were conducted at two psychiatric clinics. While data were presented for several months for both Individual #86 (she had a psychiatric support plan) and Individual #471, July 2018 data were presented for Individual #86 only. Individual #145's data were presented at the Internal Peer Review Committee meeting held the week of the visit.

22. There was evidence that three of the eight individuals had been reviewed by either the Internal or External Peer Review Committee.

- Recommendations for Individual #490 included collecting data on her loss of balance and having her lay down for an hour after lunch to recharge. There was no evidence that these recommendations had been addressed.
- For Individual #155, recommendations included updating his behavioral health assessment, conducting increased observations particularly during his refusal times, recruiting input from school staff, and adding reinforcement for participating in activities. Only the first of these recommendations was addressed, albeit five months later.
- While several recommendations were provided for Individual #168, it appeared that the majority were embedded in the documents that had been provided for review. These were not available to the Monitoring Team. However, recommendations

provided in the committee meeting minutes included elaborating on his token economy and adding information on delusional statements to his behavioral health assessment. These changes were not evident.

23. While the Center held a total of eight external peer review meetings between January 2018 and June 2018, the internal peer review committee did not meet three times monthly as expected. This review occurred once per month between January 2018 and March 2018, and twice monthly between April 2018 and June 2018.

Outcome 8 – Data are collected correctly and reliably.

Summary: There was improvement since the last review in that the Center has established measures and ways to assess those measures of data collection system quality (indicators 28 and 29). Those goals were not yet achieved (indicator 30). Data collection systems were adequate for most individuals' target behaviors and for all individuals' replacement behaviors. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	86	471	163	145	490	293	155	168
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	75% 6/8	0/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26. The data collection system as described in the PBSPs for six individuals adequately measured his or her target behaviors. For Individual #145, Individual #490, Individual #293, and Individual #155, staff were expected to record both frequency and duration measures. (Progress notes, however, only reported on frequency measures for all individuals, but Individual #490. Her progress notes also reported duration measures for two of her seven targeted behaviors.) For Individual #163 and Individual #168, frequency measures were used.

Problems were found in the plans for Individual #177 and Individual #471. Data collection instructions included a statement advising staff to provide an explanation under one behavior if multiple behaviors occurred within the same situation. This was not reflected when data were presented and could have resulted in under-reporting of some target behaviors.

27. The data systems used to measure replacement behaviors in the PBSPs for all eight individuals were determined to be adequate.

28-29. The expectation was for assessment of IOA and treatment integrity to occur at a minimum of once each month. As noted elsewhere, a system for assessing data timeliness had just recently been introduced. Levels are established at 80% or better for all three measures.

30. For none of the eight individuals was there evidence of regular assessment of data timeliness or acceptable levels of the same. For five individuals, there was evidence that acceptable levels of IOA and treatment integrity had been assessed consistently (i.e., at least monthly for six consecutive months). These were Individual #177, Individual #471, Individual #145, Individual #490, and Individual #155. It was positive to learn that multiple observations occurred in several months for both Individual #145 and Individual #490.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #163 – respiratory compromise, and infections; Individual #155 – constipation/bowel obstruction, and cardiac disease; Individual #59 – GI problems, and falls; Individual #570 – osteoporosis, and skin integrity; Individual #350 – falls, and cardiac disease; Individual #125 – cardiac disease, and constipation/bowel obstruction; Individual #437 – GI problems, and osteoporosis; Individual #242 – falls, and UTIs; and Individual #148 – skin integrity, and cardiac disease).

The goal/objective that was clinically relevant was for Individual #242's UTI risk (i.e., receipt of good personal hygiene for an individual with UTIs caused by E coli). However, the IDT did not include information concerning how to record/measure good personal hygiene and/or her participation in this process.

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

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 4/4	1/1	N/A	1/1	1/1	N/A	1/1	N/A	N/A	N/A
	iii. Breast cancer screening	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A
	iv. Vision screen	89% 8/9	1/1	0/1	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% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	50%	N/A	N/A	N/A	N/A	N/A	N/A	1/1	0/1	N/A

		1/2									
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	44% 4/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1

Comments: a. Overall, the individuals reviewed generally received timely preventive care, which was good to see. The following problems were noted:

- For Individual #155, it appeared only one dose of varicella vaccine was administered (i.e., on 8/11/11), or if this was a titer, the AMA did not document the results. An ophthalmology exam was overdue (i.e., the last one occurred on 4/25/17).
- On 1/21/15, Individual #242 had a gynecological exam, which resulted in a recommendation for follow-up in three years. Her PCP had not written an order for it until the week of the Monitoring Team's onsite visit (i.e., order written 7/12/18 for a well woman exam under TIVA).

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: This indicator will continue in active oversight.

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
			Individuals:								
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Individual #59's AMA indicated that the reason for his out-of-hospital DNR Order, dated 10/10/12, was "degenerative neurologic disorder is untreatable and incurable." A DNR progress note, dated 5/9/18, indicated that the IDT discussed continuing the DNR during the ISP meeting. The documentation submitted did not identify a condition that justified the DNR Order consistent with State Office policy. The IDT needs to determine criteria for when he would be expected to have a life expectancy for six months or less. His chromosomal abnormality is a lifelong condition, and by itself does not justify his being classified as being in the terminal phase.

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

Summary	
Summary: For acute medical issues addressed at the Center, improvement was noted in comparison with previous reviews with regard to PCPs' assessments, but a number of concerns were noted with regard to subsequent follow-up. Likewise, the	Individuals:

Medical Department should focus on completing and documenting follow-up when individuals return from hospitalizations. All of the remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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.	94% 16/17	2/2	2/2	2/2	2/2	2/2	2/2	1/1	2/2	1/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	56% 5/9	0/1	0/2	1/1	1/2	N/A	1/1	N/A	1/1	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> 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.	75% 9/12	2/2	2/2	1/2	N/A	1/1	1/1	1/2	1/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	75% 3/4	N/A	0/1	N/A		N/A	1/1	1/1	1/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance with this indicator, it 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.	75% 9/12	2/2	1/2	2/2		1/1	0/1	2/2	1/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 3/3	1/1	N/A	1/1		N/A	N/A	1/1	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	0% 0/3	0/1	N/A	0/1		N/A	N/A	0/1	N/A	
Comments: a. For the nine individuals reviewed, the Monitoring Team reviewed 17 acute illnesses addressed at the Center, including: Individual #163 (conjunctivitis on 1/16/18, and gait assessment/eye redness on 2/9/18), Individual #155 (right foot abrasion and pain											

on 4/3/18, and left ankle fracture on 4/10/18), Individual #59 (right eye laceration follow-up on 2/12/18, and productive cough on 4/4/18), Individual #570 (cough on 12/11/17, and buttock abrasion on 1/29/18), Individual #350 (cough with congestion on 1/8/18, and fall with laceration on 4/4/18), Individual #125 (contusion to wrists on 2/12/18, and refusing to walk on 4/4/18), Individual #437 (contact dermatitis on 2/5/18), Individual #242 (dermatitis on 6/5/18, and gait abnormality and mental status change on 5/14/18), and Individual #148 (left heel wound on 4/23/18, and constipation on 4/20/18).

It was positive that PCPs generally assessed the acute issues the Monitoring Team reviewed according to accepted clinical practice: The exception was for Individual #148 (constipation on 4/20/18), for which the source of the information was not documented.

b. For five of the nine acute issues reviewed, 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. However, the following provides a summary of concerns noted:

- On 2/9/18, the PCP saw Individual #163 after staff reported he was "slumping over to the right while in the wheelchair and during dining." The PCP documented that he was "at his usual baseline knocked knees gait," and noted muscle wasting in the should girdle and in the bilateral upper extremities, which might be due to disuse or a possible chronic right rotator cuff tear and joint arthritis. The plan was to request formal PT/OT to improve muscle condition, gait training, and core strength, and also consider magnetic resonance imaging (MRI) of the right shoulder if it did not respond to the OT/PT interventions. On 3/20/18, Individual #163 had an MRI of the brain, C spine, and right shoulder. The Center did not submit a PCP IPN related to the results of this MRI. Subsequent PCP IPNs addressed follow-up with Habilitation Therapy Services about Individual #163's wheelchair (3/26/18), follow-up related to weakness of the distal arms and legs (3/26/18), and neurosurgery clinic follow-up (5/15/18).
- On 4/3/18, Individual #155's PCP assessed him for right foot pain and an abrasion. It was unclear how the injury occurred, but the PCP documented swelling and discoloration of the ankle joint anterior and laterally with tenderness to palpitation. The PCP ordered imaging off campus, as well as Tylenol, and rest, ice, compression, and elevation (RICE). According to a nursing note, dated 4/4/18, the x-rays of the ankle as well as facial x-rays were negative. However, no PCP IPN was submitted to address the results of the ankle x-ray, nor was any information included in the PCP IPNs regarding the reason for the facial x-rays or the results.
- According to an IPN on 4/10/18 at 10:44 a.m., the PCP saw Individual #155 for left lateral ankle swelling, and bruising under the lateral fibular malleolus with point tenderness. The PCP ordered imaging off campus, as well as Tylenol, RICE, and weight-bearing as tolerated. According to an IPN on 4/10/18 at 4:41 p.m., the PCP reviewed the use of a wheelchair until the individual saw orthopedics, the use of ice packs, and administration of Tylenol. According to a nursing IPN, dated 4/11/18 at 2:14 p.m., as a result of follow-up with the orthopedist, Individual #155 had a temporary formed splint with an ace wrap to secure the splint. He was not to bear weight, and was to use the wheelchair. No PCP documentation regarding the orthopedist's findings and recommendations was found. On 4/11/18, the IDT held an ISPA meeting, and made numerous recommendations. Based on the ISPA documentation, the PCP did not attend this meeting. The next PCP documentation, dated 4/18/18, discussed post-orthopedic follow-up.
- On 1/29/18, Individual #570's PCP documented an assessment of an abrasion on his buttock. The PCP prescribed calazime as treatment. No further PCP IPNs were found to address further assessments or healing of the three pressure ulcers that developed and finally healed in May 2018.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #163 (ED visit for laceration to eyebrow on 2/11/18, and hospitalization for pneumonia on 5/16/18), Individual #155 (ED visit for fall with laceration on 12/20/17, and hospitalization for abdominal pain on 5/12/18), Individual #59 (ED visit for laceration on 1/5/18, and hospitalization for emesis, fever, sepsis, lactic acidosis, acute cystitis, and acute kidney injury on 2/4/18), Individual #350 (ED visit for left ankle pain on 1/4/18), Individual #125 (ED visit for fractured finger on 4/10/18), Individual #437 (hospitalization for respiratory distress on 12/18/17, and hospitalization for tachypnea and tachycardia on 5/2/18), and Individual #242 (ED visit for right shoulder swelling on 4/5/18, and ED visit for UTI on 2/19/18) .

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

- It was positive to see that the following individuals displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #163's eyebrow laceration on 2/11/18, Individual #59's laceration on 1/5/18, and Individual #350's left ankle pain on 1/4/18.
- After hours on 5/16/18, Emergency Medical Services (EMS) staff transferred Individual #163 to the hospital, where he was diagnosed with pneumonia. On 5/22/18, the IDT met and discussed the need for an increased level of supervision due to a peripherally inserted central catheter (PICC) line, the need for nursing staff to provide 24-hour care, and his move to a new home. He had a skin tear (i.e., Stage 2 pressure ulcer) to his left thigh, so the IDT discussed his positioning, as well as PT services three to five times a week for four weeks. On 5/23/18, the PCP wrote a detailed note that covered all the important clinical areas. However, during the initial 48-hour post-hospital period, this was the only PCP note related to follow-up for this hospitalization.
- A nursing IPN, dated 2/4/18 at 5:15 p.m., noted Individual #59 had one episode of emesis. An addendum at 8:06 p.m., documented an additional two episodes of emesis, along with a fever. Based on the nurse's note, the nurse contacted the PCP, and EMS transferred the individual to the ED. The PCP did not complete an IPN discussing the events leading to the hospitalization. On 2/8/18, the PCP completed a post-hospitalization note. The PCP noted the need to check a basic metabolic panel (BMP) in the morning, provided orders, and indicated follow-up would occur during sick-call "as needed." The PCP did not complete additional follow-up the next day. On 2/24/18, Individual #59 was readmitted for presumed sepsis and a UTI, but his urine culture was negative, and he was discharged.
- For Individual #437's hospitalization for respiratory distress on 12/18/17, the documents submitted did not include a PCP IPN within one day for this after-hours hospitalization. Upon the individual's return on 1/10/18, the PCP wrote an IPN, dated 1/11/18, that indicated the individual had a non-aspiration pneumonia that started as a viral infection, and resulted in a secondary multi-drug resistant (MDR) pneumonia. The PCP noted labs were pending. However, the PCP did not complete a follow-up IPN within 48 hours of the individual's return from the hospital.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: Overall, improvement was noted with regard to the Medical Department's handling of non-Facility consultations. However, the timeliness of review was sometimes still an issue. In addition, although not reflected in these scores, since as far back as December 2014, the ophthalmologist had recommended	Individuals:

cataract surgery for one of the individuals reviewed, but it did not occur, and surgery was no longer possible. The individual was now effectively blind in the left eye. These indicators will remain in active oversight.

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 14/14	2/2	2/2	2/2	2/2	N/A	2/2	2/2	N/A	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	71% 10/14	1/2	2/2	1/2	2/2		1/2	2/2		1/2
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.	100% 14/14	2/2	2/2	2/2	2/2		2/2	2/2		2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	93% 13/14	2/2	1/2	2/2	2/2		2/2	2/2		2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A	1/1	N/A	N/A		N/A	N/A		N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #163 for orthopedics on 4/9/18, and gastroenterology on 3/7/18; Individual #155 for cardiology on 2/21/18, and orthopedics on 4/11/18; Individual #59 for ophthalmology on 4/4/18, and ophthalmology on 1/22/18; Individual #570 for podiatry on 2/8/18, and podiatry on 5/31/18; Individual #125 for orthopedics on 5/8/18, and ophthalmology on 2/15/18; Individual #437 for podiatry on 2/8/18, and neurology on 2/14/18; and Individual #148 for neurology on 6/13/18, and podiatry on 6/13/18.

a. It was positive that for the consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations, and provided rationales for disagreements.

b. The reviews that did not occur timely included: Individual #163 for orthopedics on 4/9/18; Individual #59 for ophthalmology on 4/4/18; Individual #125 for orthopedics on 5/8/18; and Individual #148 for neurology on 6/13/18.

c. It was positive that for the consultations reviewed, PCP IPNs included all of the components State Office policy requires.

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 exception of the following: Individual #155 for orthopedics on 4/11/18 (i.e., no order was found for “strict elevation” of left lower extremity).

However, of significant concern, Individual #59's ophthalmology consultation, dated 1/22/18, indicated: "Despite our efforts to perform cataract extraction on the left eye since 12/2014, nothing has been done to allow this to happen. I will abandon our efforts. Follow up in 1 year." On 4/4/18, the individual was referred to another ophthalmologist and the consultation report indicated that "at this point too high risk for surgery complications of lens removal." It is unknown whether in 2014, the consultant would have been able to perform surgery to the left eye, but the delay was problematic. As a result, Individual #59 was effectively blind in the left eye. Plans were underway to remove a cataract from his right eye.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were not completed, and the PCPs had not identified the necessary treatment(s), interventions, and strategies, as appropriate. In some cases, this placed individuals at significant risk. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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.	50% 9/18	0/2	1/2	0/2	0/2	2/2	2/2	1/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #163 – respiratory compromise, and infections; Individual #155 – constipation/bowel obstruction, and cardiac disease; Individual #59 – GI problems, and falls; Individual #570 – osteoporosis, and skin integrity; Individual #350 – falls, and cardiac disease; Individual #125 – cardiac disease, and constipation/bowel obstruction; Individual #437 – GI problems, and osteoporosis; Individual #242 – falls, and UTIs; and Individual #148 – skin integrity, and cardiac disease).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #155 – cardiac disease; Individual #350 – falls, and cardiac disease; Individual #125 – cardiac disease, and constipation/bowel obstruction; Individual #437 – GI problems; Individual #242 – falls, and UTIs; and Individual #148 – skin integrity. The following provide examples of concerns noted:

- At the time of the onsite review, Individual #163 was in a long-term acute care center (LTAC). By way of recent history, on 11/4/17, he was hospitalized for community acquired pneumonia. A viral etiology was suspected, although a viral panel study was negative. Antibiotic therapy was discontinued during the hospitalization, but resumed at the time of discharge. On 12/4/17, this left lower lobe pneumonia was considered resolved radiographically. His chest x-ray indicated that he had low lung volumes. In December 2017 and January 2018, the PNMT conducted monitoring and concluded that no change was needed to the plan of care (concerns related to the quality of the PNMT's involvement are discussed elsewhere in this report). More recently, on 5/16/18, he was hospitalized for health care associated pneumonia/possible atelectasis. He had positive blood cultures for E coli. He received outpatient intravenous (IV) antibiotics to complete his treatment. During that

hospitalization, he also was considered to have urosepsis. On 6/13/18, he subsequently underwent a modified barium swallow study (MBSS), and aspirated during that procedure. On 6/15/18, he was then hospitalized for an E coli sepsis and UTI, as well as possible aspiration pneumonia, and ultimately transferred to the LTAC, where he continued to reside in early July 2018.

Individual #163 had a long history of dysphagia. On 2/11/11, an MBSS showed aspiration of thin liquid. Nectar-thick liquids and pureed-texture diet were recommended. In October 2011, he was hospitalized for a complicated left lower lobe pneumonia, with development of an abscess and residual fibrosis of his left lung base. On 7/3/13, an MBSS indicated moderate oral phase deficits and severe pharyngeal and esophageal phase deficits. At that time, the evaluator indicated the need to decide "whether or not the patient should continue to eat by mouth. If continue [sic] to eat by mouth, then continue with current pureed diet and nectar thickened liquids, strategies to decrease bolus size and pace of eating and drinking…." The pace became controlled as he lost his ability to self-feed due to his neurodegenerative process (likely related to the cervical stenosis). Even with this history, the etiology of the dysphagia had not been identified. However, it might have been from several contributing factors, and the more recent hospitalizations for sepsis, UTI, and aspiration indicated the need for further evaluation. For example, there was no information concerning the presence or not of delayed gastric emptying nor any review of the severity of gastroesophageal reflux disease (GERD), which might be contributing to aspiration. He also had a history of severe gastritis and small hiatal hernia, confirmed by an esophagogastroduodenoscopy (EGD) of 7/15/14, treated with a proton pump inhibitor, more recently changed in April 2017 to an H2 receptor blocker, with no reports of emesis or regurgitation. His recent increase in psychotropic medication needed to be reviewed as a contributing factor (a time line of increases in medication overlaid with the occurrence of pneumonia might be helpful). A review of his nutritional status also was indicated. Whether his severe cervical stenosis and neurodegenerative process was decreasing his pulmonary function and increasing his vulnerability to pulmonary infection was not discussed (i.e., challenge for positioning, strength of cough and ability to expel mucus, lung volume). With involvement at the level of C4 C5, innervation to the diaphragm with effect on respiratory excursion could be problematic. Documentation indicated that a recent orthopedic spine specialist consultation was completed, and he was not considered a candidate for surgery. With the increased frequency of severe pneumonia, further discussion with his guardians in relation to the need for enteral feeding was needed, because the risk of additional aspirations continued. Such discussion should include descriptions of efforts to identify the etiology of the dysphagia, and any potentials for the remediation of it.

- Individual #163 had a history of recurrent conjunctivitis and sclera injection of his right eye. The etiology was unclear, but according to the AMA, might have been due to contamination from rubbing his eyes, or due to an irritant, allergy, or dry eyes. He was prescribed an ocular lubricant and antihistamine eye drops. Recently, on 3/26/18, he developed a bacterial conjunctivitis in his right eye. When this occurred, he already was taking a cephalosporin for a cellulitis of his leg. The antibiotic was changed to a sulfa medication, and Rocephin was given as a one-time dose, along with a fluoroquinolone eye drop. Tylenol and Motrin were administered for discomfort. The culture from the right eye corneal exudate grew two organisms: serratia and pseudomonas, and was sensitive to fluoroquinolones. The sulfa medication was stopped and the appropriate antibiotic class was started. He had an urgent consultation with the ophthalmologist, who diagnosed a right eye corneal ulcer/hypopyon. A retinal specialist then saw him, and endophthalmitis was ruled out. Additional antibiotic drops were prescribed. The PCP followed this issue through to resolution. The evaluation, treatment, and consultation was an appropriately aggressive approach to a potentially serious infection. According to the retinal specialist, the individual had a

prior remote retinal detachment, and the posterior chamber of the right eye had been filled with silicone oil, which was protective against the spread of infection. However, given the history of repeated conjunctivitis, the IDT, including the PCP, did not hold a meeting(s) to discuss steps to prevent future infections. No information was submitted showing that the PCP requested the involvement of the infection control nurse in guiding the IDT to develop and implement steps to assure Individual #163's hands were clean, or Behavioral Health Services to assist the IDT in identifying steps to prevent him from rubbing his eyes, which could lead to further infection. Steps already taken were not discussed in an ISPA. The ophthalmologist indicated the need to ensure dirty water did not contact the eye, but there was no information as to how staff were trained during the acute phase of his illness, as well as on an ongoing basis. Although the PCP was timely in evaluating and treating the acute problem, an interdisciplinary process with leadership from the PCP will be necessary to assure this will not recur.

- Individual #155 had a long history of constipation. In November 2017, serial abdominal x-rays (KUBs) were completed to follow the resolution of a marked amount of retained stool throughout his colon. With treatment, as of 11/20/17, this began to slowly decrease. On 12/4/17, he was found to have soft stools on himself twice. A nursing IPN indicated that on 12/6/17, his bowel movement (BM) record was reviewed, and he was having a BM every day or every other day. He had been incontinent seven times during the week reviewed. Because of the soft stools found on him, his Miralax was discontinued and Senna plus was decreased. Thereafter, he appeared to improve. On 12/20/17, a KUB indicated no acute findings. On 12/23/17, he had bowel incontinence. A 12/27/17 nursing review of the weekly BM record indicated he was passing stool every two to three days. It was noted that he was independent and self-toileted, making accurate records of his BMs a challenge. An IPN, dated 1/3/18, indicated that the BM log was reviewed for the week, and his last recorded BM was on 12/27/17. He did not have one-to-one staffing, and continued to have freedom of movement. The staff were reminded to record BMs in CareTracker, and if staff saw him going into the bathroom, then they were instructed to enter that area as well to observe for results. On 1/5/18, nursing staff completed a rectal exam and no stool was found, and the nurse referenced an unremarkable abdominal exam. A PCP IPN, dated 1/5/18, reviewed his BM history and KUB findings from November through December and incorporated the nursing review findings. This PCP IPN also indicated that his father indicated that Individual #155 had a prior history of bowel obstruction in the remote past from constipation. The PCP placed an order that he was to be encouraged to take eight to 16 ounces of fluids by mouth (PO) with each medication pass three times a day, as tolerated. Eight ounces of prune juice was added with breakfast, and his Senna plus dosage was increased. Staff were again reminded to record BM documentation. After early January 2018, the documentation submitted included no further KUBs or IPNs concerning his constipation. On 1/17/18 and 1/24/18, nursing IPNs indicated BMs were recorded, but that this might not be accurate information, because recording challenges continued. It was also documented that he had no straining or other signs of constipation.

  There were no specific comments about his BMs in the next several weeks to months, until his admission to the hospital for a perforated bowel. In the submitted IPNs, nursing staff had not documented any further seven-day BM reviews, nor were KUBs documented, or comments about constipation from the PCP. In the meantime, he was placed on Latuda, and his Depakote was increased. The many IPN entries focused on his behavioral challenges, with several injuries to himself as well as peer-to-peer aggression. In April 2018, he sustained a fracture of his ankle, and a cast was applied. He was considered less mobile with no weight-bearing initially. Although his psychotropic medications might have contributed to constipation, the reduced mobility due to his ankle fracture was a new potentiating factor. On 5/12/18, he then developed acute abdominal pain and was

transferred to the hospital where he was found to have a perforated bowel. Comments from the hospital record indicated that he had a "large redundant colon packed with stool on CT abdomen." The surgeon "suspects the perforation is due to bowel habits, history of constipation, and megacolon." The operative note stated the "entire colon was markedly dilated, redundant, and stool filled." He required a left hemi colectomy with end colostomy, and his post-hospital course subsequently had complications. At the time of the Monitoring Team's onsite review in July 2018, he remained in an LTAC.

There appeared to be a good attempt to track his bowel movements through December 2017, but then the focus on this was dropped. Historically, he had bowel obstructions from constipation. He continued to have risk factors for constipation, worsened by his reduced mobility from the fracture. From a review of submitted documentation, the Center did not appear to sustain an active surveillance of his bowel movements to prevent constipation and aggravation of his reduced colonic motility. The Bowel and Bladder Chart Detail Report from 3/1/18 to 5/12/18 recorded the BMs per total shifts during that period. There were only 11 shifts with BMs recorded, and 187 shifts without BMs recorded. The Center had not identified a method to track his BMs given his level of independence.

- Individual #59 had a history of severe oropharyngeal dysphagia. On 8/17/10, an enteral feeding tube was placed. On 2/7/11, he underwent an EGD to monitor for Barrett's esophagus. On 8/21/12, he underwent an EGD for anemia, and esophagitis at the EG junction was found. Testing indicated no H pylori. On 9/23/13, he underwent a laparoscopic fundoplication for intractable GERD, as a contributing cause for several aspiration pneumonias. On 7/21/15, he underwent an EGD for weight loss, and the Barrett's mucosa was biopsied, but no malignancy was found. He continued to have pneumonias/lung infiltrates since that time (i.e., 12/27/16, 2/18/17, and 5/3/17). The AMA reported he was prescribed Prolia, which is associated with an increase in infections, but further discussion with the current PCP indicated this was not accurate, and he was not prescribed Prolia.

  On 1/29/18, a computed tomography (CT) of the chest was completed to better define his persistent abnormal radiographic findings. He was found to have low lung volumes, and bilateral atelectasis as well as scarring of his left lower lobe. A small hiatal hernia was also noted. In recent months, he had occasional emesis (i.e., 2/4/18, 4/23/18, and 6/11/18). On 2/26/18, 4/4/18 and 6/11/18, he was noted to have cough. He currently was enterally fed with intermittent bolus feedings. Given his history of intractable GERD, along with the development of a hiatal hernia, and recent emesis, no information was found to indicate that the status of his fundoplication had been reviewed to determine if it was intact or unwrapped. Recurrent coughing and emesis indicate the need for review. Also, there was no information concerning whether a gastric emptying study had been considered and/or completed, which might also complicate his pulmonary status, and lead to emesis/severe reflux. Further evaluation might lead to changes in treatment and formula feeding rates, but the current status of the fundoplication and gastric motility was unknown. The determination of the effectiveness of his current treatment remained unknown.

- Individual #59 had 1p36 deletion syndrome. As part of this syndrome, he had a severely altered gait and perception of body position. Additionally, he had generalized spasticity. His complex behaviors remained an additional challenge and led to falls (e.g., 4/20/17). He experienced injuries from his falls and self-positioning/mobility. On 1/5/18, he sustained a laceration above his left eyebrow. On 2/11/18, he was found to have a small cut over his right eyebrow when he crawled out of his room.

On 5/6/18, he sustained a head injury from falling, with a cut to the back of his head and an abrasion to his left shoulder. On 5/23/18, he sustained a cut to his right forehead.

One of the factors that an IDT should routinely review should an individual experience falls and injuries due to altered body positions is visual perception. During Individual #59 ophthalmologic exams, he was found to have a mature cataract on the left eye with blindness secondary to the cataract and a dense cataract on the right eye. Since 2014, the consultant recommended cataract removal in his left eye. However, his recent annual exam included a note stating: "nothing has been done to allow this to happen. I will abandon our efforts." The individual recently was assigned a new PCP, who investigated the history and found that the individual had a brief illness at the time of the initial referral for cataract removal in 2014, but that it was then not followed through to completion. A referral process was then started to complete this procedure, but a second opinion indicated that as of 4/4/18, cataract removal from the left eye placed the individual at risk for complications including dislocation of the lens, and was no longer recommended. A subsequent scan of the left eye was ordered to rule out retinal disease. Cataract surgery was scheduled for the right eye. It was not clear at what point the cataract in the left eye became too risky to remove, but the delay in evaluation of several years was problematic in determining the next step. The individual is now blind in the left eye. Removal of the cataract in the right eye might assist with improved awareness of his surroundings and potentially reduction of trauma from falls.

During discussion with the Medical Director, a consultation tracking data sheet currently in use was reviewed. This process was implemented this year, and would not have captured the January 2018 ophthalmology visit. It appeared that the data sheet tracking system should identify at a glance any outstanding missed follow-up needed for consultations. However, there was no review of past consultation orders/follow-ups to ensure these also were captured. It was fortunate, Individual #59's newly-assigned PCP identified the lack of follow-up with his ophthalmological needs and followed up with the recommendation, but the delay of four years indicated a systems problem.

In addition, since 10/10/12, Individual #59 had a DNR order in place, with current renewal of that status on 5/9/18. The reason documented was his degenerative neurologic disease. However, if the falls and injuries have been due to reversible causes (i.e., correctable vision loss) and not his neurological degenerative process, then this is an added concern that the individual is not receiving appropriately aggressive treatment, but instead receives a more conservative treatment approach, with assumptions his falls and other injuries are not preventable. The IDT should review all risk areas, including other causes of his falls and injuries. That he has been DNR since 2012 suggests that he is not imminently terminal and his IDT needs to review his code status to ensure it is consistent with State Office guidelines.

- Individual #570 currently was treated for osteoporosis. Since 9/9/16, his PCP prescribed Prolia, as well as calcium and Vitamin D. He had a history of spastic quadriplegia. Due to his body habitus, DEXA scans of his hips were a challenge. In 2012, his T-score of the lumbar spine was 0.1, and on 11/3/14, it was -0.3. On 1/3/14, his left hip T-score was obtained and was read as -2.7 to -3.6. The AMA, dated 7/17/17, under the summary section, stated: "The DEXA results will be received or the test will be completed if indicated, it may have been done 11/16 and the results have been misplaced." Subsequently, a PCP lab/radiology results review note, dated 2/13/18, copied the DEXA report. The DEXA scan, from 11/7/16, included a lumbar spine T-score of 0.2. No hip score was obtained. The PCP, however, did not comment on the results or provide a comparison

with prior DEXA scans or prior x-rays, some of which revealed osteoporosis (e.g., on 2/6/07, right foot). The QDRR, dated 5/11/18, included the statement: "a change to Reclast was recommended on the 2/12/18 QDRR – PCP noted last DEXA not in EPIC, review at later date." On 5/14/18, the PCP agreed with the QDRR recommendation. An order was placed for the administration of Reclast between 9/10/18 and 9/14/18, as an order "for consult for IV therapy off campus." A screenshot from 5/30/18 showed Prolia was still ordered and part of the medication drug regimen. Following the 7/17/17 AMA, the submitted PCP documentation did not provide the rationale and plan for changing Prolia to Reclast. Overall, the record was confusing, as there was a delay in the finding and review of the prior DEXA, no comments from the PCP concerning how to interpret the T-scores for this individual (lumbar versus hip scores), and there was no an order submitted to confirm the discontinuation of Prolia when Reclast was ordered. It appeared that the Prolia was due to be given March 2018. However, the delay in obtaining the DEXA report did not allow the PCP to make a final decision until after another Prolia dosage was given.

- Similarly, Individual #437 had a long history of osteoporosis. She was at risk for this disease process due to her spastic quadriplegic cerebral palsy and multiple seizure medications. In 2008, 2011, 2014, 2016, and 2018, DEXA scans were completed serially. On 8/8/17, her Vitamin D level was 31. She was treated for hypothyroidism, and on 8/8/17, her thyroid stimulating hormone (TSH) was in the normal range. She was prescribed calcium, Vitamin D, and Prolia for her osteoporosis. The Center submitted a "pharmacy progress note," which indicated the PCP should "reevaluate the need for continued Prolia therapy." On 1/8/18, the PCP signed the note electronically. The QDRR, dated 1/16/18, indicated this individual had received Prolia injections since 11/4/11, and again recommended re-evaluation of the continued need for this medication due to her recent history of septic shock and health care associated pneumonia with both rhinovirus and human meta-pneumovirus infection. The QDRR indicated Prolia "may lower the ability to fight infection…" The PCP's response was to repeat the DEXA and review the results. On 3/23/18, the DEXA scan was completed, but it was not until 5/9/18 that the PCP received the results. There was a loss in her lumbar spine bone mineral density of 4.2% compared to the prior DEXA. The left hip lost 5.1%, and the right hip gained 8.8%. In the note reviewing the DEXA scan, dated 5/9/18, the PCP provided no comment about the future use of Prolia, and there was no indication the Prolia had been discontinued after the QDRR until her final hospitalization. It could not be determined if the PCP would have discontinued the medication due to her hospitalization on 4/23/18, and subsequent death due to multiple-drug-resistant bacterial pneumonia. It was difficult to interpret the submitted documentation to determine when her last Prolia injection had been given, as the PCP did not reference Prolia. However, no order was submitted for the alternative medication recommended in the QDRR; Reclast. The submitted PCP entries did not provide information as to the reason for the delay in receiving the DEXA report, and the review, based on the pharmacy recommendation to change to Reclast, was not discussed in any submitted PCP note. The documentation did not provide the PCP's evaluation (risks/benefits) necessary to determine the appropriateness of ongoing administration of Prolia after recovering from a severe respiratory infection.

  The Center appeared to have a systems problem in obtaining these DEXA scan reports in a timely manner, and ensuring the PCPs received and reviewed them.

- Individual #570 had a history of skin integrity concerns. He had a custom-molded seating system, which was created for his wheelchair on 1/4/18. On 1/10/18, 1/12/18, 1/24/18, 1/29/18, and 2/1/18, adjustments were made to the wheelchair. On 1/29/18, he developed a dime-sized abrasion to his right hip. On 2/7/18, a dime-sized purple bruise was noted just below the

abrasion on his right hip. Further adjustments were made to the seating system. Despite pressure mapping and multiple adjustments, his skin issues continued to worsen. He had a ROHO cushion on his chair as well. On 2/13/18, when the scab came off his wound, it was determined he had a Stage 3 pressure ulcer over his right greater trochanter. A wound care nurse was then consulted and tracked the ulcer until it resolved, using the EZ graphs wound assessment worksheet template. A nursing IPN, dated 2/21/18, indicated improvement to the pressure ulcer. On 3/14/18, he then attended a rodeo and was allowed to stay in his chair for 12 hours. By 3/14/18, further deep tissue injury was suspected. He had three wounds on his buttock and hip area. On 3/16/18, Habilitation Therapy staff removed his current seat cushions and fabricated a new one utilizing a pressure relieving cushion. Further wheelchair modifications were made. Serial nursing notes, thereafter, indicated complete healing of these three pressure ulcers by 5/24/18. Despite the need to ensure good nutritional status, there was no additional nutrition assessment, other than the annual assessment, dated 7/27/17. During the time period between 1/29/18 and 5/24/18, no PCP IPNs addressed the development and treatment of the three decubiti. Additionally, a quarterly medical review would have captured any progress or complications related to decubitus care, but a quarterly medical review was not written. The PCP remains the clinical/medical team leader who should review all aspects of care relevant to skin integrity (e.g., nutrition, positioning, prevention, continence care, etc.) to ensure care consistent with current standards. However, the PCP did not provide and/or document ongoing oversight, evaluation, and treatment.

- Individual #148's AMA listed a hypertension diagnosis. The plan of care indicated he met diagnostic criteria for hypertension, and potential etiologies were reviewed. Reportedly, his blood pressure was controlled since his readmission. The AMA noted that he had no signs of end organ damage, such as left ventricular hypertrophy or chronic kidney disease. It listed his current medication at the time of the AMA as Lisinopril, and discussed dietary interventions. However, his treatment was difficult to track, because his AMA did not list Lisinopril in the medication section, only in the Plan of Care. As this document is sent with him to the ED and consultations, it is imperative that this information be accurate. The QDRR did not mention Lisinopril, and a copy of orders indicated that it was started on 5/2/18, and stopped on 5/3/18. No PCP IPN discussed a change of medication on this date. The nutrition consult listed hypertension as a diagnosis, and stated he was receiving Lisinopril. Due to these discrepancies in the documentation, this diagnosis and treatment needs further evaluation.

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 was found to show implementation of those few action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. It is important to note that the score of 100% is a false positive due to the failure of IDTs, with input from PCPs, to include medical action plans/steps in IHCPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148

a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 4/4	N/A	N/A	N/A	2/2	N/A	N/A	1/1	1/1	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those very few action steps assigned to the PCPs that were identified for the individuals reviewed generally 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 eight of the nine 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	163	155	59	570	350	125	437	242	148
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
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	1/1
Comments: a. and b. Based on the IRRF entries, for Individual #155, the Dental Department appeared to be on the right track in identifying his somewhat frequent refusals to participate in tooth brushing as an underlying cause of his dental risk, and the Dental Department made suggestions to find motivating factors that might increase his participation in tooth brushing (e.g., favorite song, completing the activity in his bedroom). However, based on the narrative in the IRRF, it appeared the IDT continued an existing tooth brushing SAP without discussing the Dental Department's recommendations related to modifying it to incorporate the individual's specific preferences. Various documents submitted included different goals/objectives related to dental (i.e., IRRF, IHCP, ISP, and SAP).											

On a positive note, for Individual #148, the IDT developed a goal/objective to increase the percentage of opportunities that he tolerated tooth brushing for two minutes from 24 out of 30 opportunities (80%) to 55 out of 60 opportunities per month (i.e., the team calculated 55/60 as 85%, but the correct calculation is 92%). Based on documentation submitted, this was a clinically relevant goal/objective, because it addressed the etiology or underlying cause of his dental risk (i.e., if he increased the number of times that he allowed staff to brush his teeth for two minutes, it likely would improve his oral hygiene).

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

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The exception was for Individual #148 for whom the QIDP included specific data and analyses of the data in the monthly reviews. The data reported showed Individual #148 made progress on his dental goal/objective.

As discussed above, Individual #148 had a clinically relevant, measurable goal/objective, and made progress on his goal/objective, which was great to see. He was part of the core group, so a full review was conducted for him. For the remaining eight 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: N/A			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	Not rated (N/R)									
Comments: c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed and/or implemented a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.	
Summary: N/A	Individuals:

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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 these indicators, they moved to the category requiring less oversight.									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.										
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.										
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.										
e.	If the individual has need for restorative work, it is completed in a timely manner.										
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.										
	Comments: a. through f. None.										

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

Summary: Given that over the two recent review periods for which these indicators were applicable, individuals with dental emergencies had dental services within 24 hours (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), had needed treatment (Round 11 – 100%, Round 12 – N/A, and Round 13 – N/A), and had pain management, as needed (Round 11 – 100%, Round 12 – N/A, and Round 13 – N/A), Indicators a, b, and c will move to the category requiring less oversight.

Individuals:

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A	N/A	N/A							
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A	N/A	N/A							

Comments: a. through c. For the two individuals reviewed for which dental emergencies occurred, the Dental Department provided emergency dental care in a timely manner.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight. However, if the Center sustains its performance with regard to the inclusion of measurable suction tooth brushing strategies in ISPs/IHCPs, then after the next review, Indicator a might move to the category of less oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4	1/1	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4	0/1		0/1	0/1			0/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4	0/1		0/1	0/1			0/1		
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	25% 1/4	0/1		0/1	1/1			0/1		

Comments: a. It was good to see that for the four applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs.

b. Based on documentation submitted, for each of the individuals, lapses occurred in the provision of suction tooth brushing. Reasons were not provided for the days/times that staff did not provide individuals with the required tooth brushing support.

c. Although it appeared that Dental Department staff conducted some monitoring of staff's implementation of suction tooth brushing for quality, as well as safety, ISP action plans did not define the frequency expected to meet the individuals' needs. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient.

Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." However, at the time of the last review, the Monitoring Team might have incorrectly scored this indicator (i.e., the Center scored 100% during Round 12). Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. Often, QIDP reports did not include specific data, but rather statements, such as "no corrective action needed," or "suction tooth brushing 3x daily. Duration varies." More specific suction tooth brushing data is needed to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset should provide

data on the number of such events during which the individual completed two minutes of suction tooth brushing (e.g., of the 60 completed sessions, 12 sessions completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department provided recommendations regarding dentures, including clinical justification for not recommending them.											

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 the Center's response to the Monitoring Team's document request for acute care plans, 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. The Monitoring Team recognizes that Center staff were working with State Office to correct this issue, and that during the next review, the Center will provide acute care plans for review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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 the Center's response to the Monitoring Team's document request for acute care plans, 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 has 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. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should continue to 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 clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 163	155	59	570	350	125	437	242	148
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	22% 4/18	1/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2	1/2
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 #163 – falls, and skin integrity; Individual #155 – constipation/bowel obstruction, and fractures; Individual #59 – falls, and constipation/bowel obstruction; Individual #570 – seizures, and skin integrity; Individual #350 – fractures, and cardiac disease; Individual #125 – constipation/bowel obstruction, and choking; Individual #437 – fractures, and skin integrity; Individual #242 – weight, and UTIs; and Individual #148 – fractures, and constipation/bowel obstruction). The goal/objective that was clinically relevant was for Individual #242's UTI risk (i.e., receipt of good personal hygiene for an individual with UTIs caused by E coli). However, the IDT did not include information concerning how to record/measure good personal hygiene and/or her participation in this process. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #163 – skin integrity, Individual #59 – constipation/bowel obstruction, Individual #350 – cardiac disease (i.e., related to blood pressure), and Individual #148 – constipation/bowel obstruction. 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 generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/11	0/2	0/1	0/1	0/1	0/2	0/1	0/1	0/2	N/A
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Although the number of falls Individual #163 experienced had decreased from the previous ISP year, the nursing annual assessment indicated that he was now using a wheelchair for mobility, which accounted for the decrease in the number of falls. However, on 2/11/18, he sustained a laceration to his right eyebrow from a fall. According to the ISPA, dated 2/12/18, the IDT recommended the following:
    - Mat beside his bed;
    - Allow him to stay up if he comes out of his room at night;
    - Change of room;
    - Put bed against wall due to right-sided weakness; and
    - Magnetic resonance imaging (MRI) to determine cause of right-sided weakness.

  The next ISPA, dated 3/5/18, noted the PNMT was discharging him with regard to his pneumonia, and he was to have an MRI scheduled. However, it did not indicate any status regarding the recommendations related to his falls from the February 2018 ISPA. The IDT did not meet again until 5/7/18, at which time they met to discuss Individual #163 leaning to the right and not assisting staff with transfers. He had not done this previously and staff noted he will "drop his weight." The ISPA briefly noted that the results of the MRI required a neurosurgery referral, but did not provide any details. The ISPAs reviewed indicated that Individual #163 continued to have a decline in his health status. However, the IDT did not document the outcome or status of the previous recommendations, or explain why his right-sided weakness and leaning was becoming more problematic. The IDT did not put a system in place to monitor his right-sided weakness, its progression, and/or how it affected his functioning and balance. Although the ISPA, dated 5/22/18, indicated that: "the IDT believes [he] would benefit from closer monitoring by nursing," there was no indication that nurses implemented additional nursing assessments and interventions. In addition, there was no indication from the ISPAs provided that the IDT assessed other factors that could affect his falls, such as dehydration and having a fever (i.e., diagnoses after a fall on 5/30/17, when he was sent to the ED after falling out of his chair and sustaining a head injury), end stage glaucoma to the right eye, a right eye corneal ulcer in March 2018 and infection, right shoulder pain, anemia, edema to the lower extremities, severe degenerative changes to the cervical spine found on MRI on 3/20/18, and/or pain (all of these potential factors were noted in the AMA, dated April 2018). The IDT failed to timely address Individual #163's falls and status changes that could impact his risk for falls, and to implement and monitor proactive interventions to prevent further falls. The Center's data indicated that on 6/7/18 and 6/9/18, he had at least two additional falls.
- Based on the documentation the Center submitted, the IDT did not hold ISPA meetings to address and track Individual #163's skin issues that were noted in the ISPA, dated 5/23/18, and were as follows:

- Skin tear on outer left thigh;
- Stage II pressure injury to sacral area; and
- Two large red areas to bilateral buttocks.

However, the AMA indicated that on 8/11/17, he had abrasions to his right upper elbow possibly from his wheelchair, and on 11/10/17, he had abrasions to his 3rd and 4th toes on his right foot demonstrating that his skin was being compromised. The AMA also noted that in March 2018, he experienced edema to his lower extremities with "multiple skin abrasions with corresponding wounds" with a worsening wound on his left anterior thigh, resulting from rubbing against a table at the Education and Training building (E&T) and new abrasions to the right elbow region, possibly from the arms on the current wheelchair. An antibiotic was started for "concern of development of RLE [right lower extremity] cellulitis in settling of multiple skin abrasions." In April 2018, the AMA indicated that new nightly wound care was ordered for these multiple skin wounds. There was no indication that the IDT met to address these skin issues and implement interventions and assessments to track the progress of his skin issues and to prevent further skin problems.

- Based on a review of the ISPAs, IPNs, the AMA, the nursing annual assessment, and two quarterly nursing assessments provided, the IDT had not implemented systematic monitoring to address Individual #155's constipation. The AMA, dated 2/13/18, noted that his bowel movements were documented in CareTracker, when possible. However, since he self-toileted, "this is not a very reliable way to monitor for regularity." In addition, the nursing annual assessment noted that the documentation addressing his bowel movements was not reliable. The ISPAs indicated that in October and November 2017, he was having significant incidents of bowel incontinence, which was abnormal. There was no indication that the IDT assessed and evaluated this issue. In addition, the documentation indicated that Individual #155 had frequent meal refusals, which the IDT also did not sufficiently assess.

The IHCP and IPNs indicated that staff were to offer him extra fluids. However, his daily fluid intake was not accurately tracked and the Center could not provide documentation from nursing indicating that extra fluids were given during medication administration. The documentation did not show that nurses conducted regular bowel assessments, and in April 2018, when his mobility was significantly compromised after the fracture of his left ankle, the IDT did not recognize the need to implement and track proactive interventions to address his increased risk for constipation. Even when KUBs were ordered to rule out constipation, the IDT did not increase the risk level for constipation from medium to high. There was no indication that the IDT identified the use of a number of psychotropic medications prescribed and frequently changed as a significant factor related to his risk of constipation as noted in the AMA.

The IDT failed to document and regularly review and analyze constipation/obstruction history, KUB results, meal refusals, fluid intake, medications and medication changes, bowel patterns and data, behaviors, and changes in mobility to attempt to prevent constipation/bowel obstruction. On 5/12/18, he developed acute abdominal pain and was transferred to the hospital where he was found to have a perforated bowel. Comments from the hospital record indicated that he had a "large redundant colon packed with stool on CT abdomen." The surgeon "suspects the perforation is due to bowel habits, history of constipation, and megacolon." The operative note stated the "entire colon was markedly dilated, redundant, and stool filled." He required a left hemi colectomy with end colostomy, and his post-hospital course subsequently had complications. At the time of the Monitoring Team's onsite review in July 2018, he remained in an LTAC.

- Although the IDT met to discuss Individual #59's falls, the documentation in the ISPAs did not reflect any analysis regarding why he was attempting to get out of bed during the night, which resulted in a fall. Such analysis was needed to assist the IDT in developing and implementing strategies to prevent further falls.
- The documentation addressing Individual #570's's skin issues was difficult to follow and inconsistent. For example, a number of the IPNs indicated that he had two areas of skin breakdown (Stage 3), while other IPNs and the ISPAs, dated 2/22/18 and 3/19/18, indicated he had one skin wound. In addition, the nurses' assessments in the IPNs did not include the same assessment criteria so that comparisons could be made regarding progress or lack of progress related to healing. The nursing interventions included in the ISPA, dated 2/22/18, did not include comprehensive skin assessments in alignment with the Center's guidelines, and were not consistently implemented and documented. The Center did not provide documentation indicating when positioning was changed during the day. In addition, no documentation was presented to show that the IDT met to review the appropriateness of an activity that entailed Individual #570 remaining in the same position in his wheelchair for at least 12 hours. Unfortunately, after participating in a 12-hour outing, he developed a "new tissues injury." In addition, the IDT should have met more frequently to monitor the status of such a significant change in status for this individual.
- An ISPA, dated 12/1/17, indicated that Individual #350's IDT made revisions to her PNMP regarding her ambulation. However, it did not provide any information regarding what event(s) precipitated the need for reassessment. (The Monitoring Team assumed that it was her left ankle fracture from September 2017). Although it was very positive that the IDT worked to keep her ambulatory, the IDT did not put a system in place to regularly monitor her ambulation status, especially since she had a history and recent history of fractures and had osteoarthritis to both knees (per the AMA, dated 1/19/18). Thus far, nursing mobility assessments and interventions had been a reaction to acute issues: falls and fracture of her left ankle in September 2017. From review of the documents provided, the IDT had not implemented any proactive nursing measures, such as monitoring her gait regularly for changes that should be addressed and assessed before an acute incident occurs. Such measures should be aimed at timely identification or prevention of further mobility issues. Consequently, Individual #350 potentially will experience additional acute issues, since no monitoring system has been implemented to promptly identify subtle changes in her mobility status. Also, the AMA and IRRF noted that she had not cooperated with obtaining a Dexa scan. However, her past history of falls and fractures placed her at risk. According to the Center's response to the TX-BR-1807-IV.1-20 request, on 3/1/18 and 5/9/18, she was a victim of peer-to-peer aggression. Given her risk related to fractures, her IDT should review and address these incidents.
- Individual #350's IRRF noted that the IDT increased her cardiac disease risk rating to medium during the previous year due to the diagnoses of hypertension and dependent edema, which required medications for her blood pressure and compression stockings for her edema. However, the IDT did not put a system in place to regularly monitor the edema and skin on her lower extremities. Thus, the IDT did not have a way to track progress or regression for this risk area. Of major concern, according to the AMA, dated 1/19/18, on 1/5/18, the individual went to the ED for left ankle edema that was "due to compression stockings not properly worn and not taken off at night." Compression stockings are designed to apply a graduated amount of pressure to the legs to optimize the return blood flow through the veins to the heart and lungs for re-oxygenation. Aside from improving the blood flow, they prevent blood from pooling in the legs and lower the risk of deep vein thrombosis (DVT). If not applied correctly, they can cause skin breakdown and ulcers, create a tourniquet effect, which slows the blood flow or can increase the risks of developing blood clots. There was no indication that the IDT reviewed and addressed this serious issue and included interventions in the IHCP to ensure Individual #350's compression stockings were applied as ordered. In addition, the IHCP did not include an assessment of her blood pressures even though the goal specifically noted target value parameters.

- Individual #125's AMA reflected a diagnosis of chronic constipation, and indicated that he had a history of significant issues with constipation. For example, the AMA indicated that on 7/20/17, a KUB was ordered for agitation and restlessness. The results demonstrated that there was a large amount of stool throughout the colon. The AMA noted that on 7/21/17, nursing was to review bowel log daily, and Mag Citrate was given for hard stools on 7/24/17. However, based on the review of more recent records, the IDT was not implementing proactive interventions to address this risk. On 5/16/18, he received a pro re nata (PRN or "as needed") suppository for constipation, but nursing staff provided poor documentation in the IPNs regarding when he had his last bowel movement, and what effects the PRN medication had. In addition, the IHCP noted that he was to have 48 ounces of fluids daily. However, the IPNs and the most current quarterly nursing assessment included no documentation that this happened. He was prescribed two laxatives and could have PRN suppositories. There was no indication that the IDT reviewed and analyzed the cause(s) of Individual #125's constipation, or if he was receiving the required amount of fluids daily. Also, the IDT has not ensured that the individual was receiving regular nursing assessments for constipation.
- Between May 2017 and May 2018, Individual #242's weight dropped from 113.6 pounds to 89 pounds, which appeared to be unplanned. Her IHCP did not address weight loss, and the IDT did not hold an ISPA meeting to address it and/or revise the IHCP.

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

Summary: For this review and the last one, the Center did well with the indicators related to: 1) nurses administering medications according to the nine rights; and 2) nurses following individuals' PNMPs 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: 163	155	59	570	350	125	437	242	148
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R	N/A	N/A					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% 6/6			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% 0/3	0/1	N/A	0/1	N/A	N/A	N/A	0/1	N/A	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.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 6/6			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.	83% 5/6			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 six individuals, including Individual #59, Individual #570, Individual #350, Individual #125, Individual #242, and Individual #148.

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:

- Even after Individual #163 had episodes of pneumonia/aspiration pneumonia, his IDT did not include respiratory assessments in his IHCP.
- Individual #59 and Individual #437 were at high risk for aspiration, but their IHCPs did not include respiratory assessments.

f. It was positive that medication nurses used the individuals' PNMPs and checked the position of the individuals prior to medication administration.

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 #570's eye, which contaminated the dropper and then contaminated his other eye when the drops were administered. Of note, the nurse administered the eye drops while the individual was sitting up in his wheelchair with his head and neck tilted forward due to his posture. With the right eye, the drops fell on the individual's cheek, and did not make it into his eye.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see continued improvement with regard to individuals being referred to the PNMT, when needed. Overall, though, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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% 0/8	0/1	0/1	0/1	0/1	0/1	0/2	0/1	N/A	N/A

	ii. Individual has a measurable goal/objective, including timeframes for completion;	13% 1/8	0/1	1/1	0/1	0/1	0/1	0/2	0/1		
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	13% 1/8	0/1	1/1	0/1	0/1	0/1	0/2	0/1		
	iv. Individual has made progress on his/her goal/objective; and	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/2	0/1		
	v. 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	0/2	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;	80% 8/10	1/1	1/1	1/1	0/1	1/1	N/A	1/1	2/2	1/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/10	0/1	0/1	0/1	0/1	0/1		0/1	0/2	0/2
	iii. Individual has a measurable goal/objective, including timeframes for completion;	20% 2/10	0/1	0/1	0/1	0/1	0/1		1/1	0/2	1/2
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	20% 2/10	0/1	0/1	0/1	0/1	0/1		1/1	0/2	1/2
	v. Individual has made progress on his/her goal/objective; and	0% 0/10	0/1	0/1	0/1	0/1	0/1		0/1	0/2	0/2
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1		0/1	0/2	0/2

Comments: The Monitoring Team reviewed eight goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: falls for Individual #163; choking for Individual #155; falls for Individual #59; aspiration for Individual #570; aspiration for Individual #350; aspiration, and choking for Individual #125; and GI problems for Individual #437.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. 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: choking for Individual #155.

b.i. The Monitoring Team reviewed 10 areas of need for eight individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: aspiration for Individual #163; falls for Individual #155; aspiration for Individual #59; skin

integrity for Individual #570; falls for Individual #350; weight for Individual #437; falls, and weight for Individual #242; and skin integrity, and weight for Individual #148.

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

- On 2/16/18, Individual #570 met criteria for PNMT referral due to a Stage 3 wound. A PNMT note was provided stating that a referral was not recommended, but the PNMT should have made/accepted a referral, and conducted a review. A Stage 3 pressure ulcer is a threshold that requires referral and a review, at a minimum.
- On 4/9/18, Individual #148 returned from the community with a deep pressure injury on his heel. His IDT did not refer him to the PNMT, and the PNMT did not make a self-referral. (Documentation related to the stage of the pressure injury provided varying information. The Tier I documents indicated it was a "Stage 5," but this is not part of the standard staging of pressure ulcers.)

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. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: weight for Individual #437, and skin integrity for Individual #148.

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 generally were not available to IDTs. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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.	39% 7/18	0/2	0/2	2/2	2/2	2/2	0/2	1/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	40% 4/10	1/1	1/2	N/A	0/1	1/1	N/A	0/1	1/2	0/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	75% 3/4	1/1	0/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were for falls, and aspiration for Individual #59; aspiration, and skin integrity for Individual #570; aspiration, and falls for Individual #350; and weight for Individual #437.

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

- Individual #570 had a history of skin integrity concerns. He had a custom-molded seating system, which was created for his wheelchair on 1/4/18. On 1/10/18, 1/12/18, 1/24/18, 1/29/18, and 2/1/18, adjustments were made to the wheelchair. On 1/29/18, he developed a dime-sized abrasion to his right hip. On 2/7/18, a dime-sized purple bruise was noted just below the abrasion on his right hip. The IDT clinicians made further adjustments to the seating system. Despite pressure mapping and multiple adjustments, his skin issues continued to worsen. He had a ROHO cushion on his chair as well. On 2/13/18, when the scab came off his wound, it was determined he had a Stage 3 pressure ulcer over his right greater trochanter. As discussed above, on 2/16/18, Individual #570 met criteria for PNMT referral due to a Stage 3 wound. A note was provided stating that a referral was not recommended, but the PNMT should have made/accepted a referral, and conducted a review. A Stage 3 pressure ulcer is a threshold that requires referral and a review, at a minimum.

  The IDT then consulted a wound care nurse, who tracked the ulcer until it resolved, using the EZ graphs wound assessment worksheet template. A nursing IPN, dated 2/21/18, indicated improvement to the pressure ulcer. On 3/14/18, he then attended a rodeo and was allowed to stay in his chair for 12 hours. By 3/14/18, further deep tissue injury was suspected. He had three wounds on his buttock and hip area. On 3/16/18, Habilitation Therapy staff removed his current seat cushions and fabricated a new one utilizing a pressure relieving cushion. Further wheelchair modifications were made. Serial nursing notes, thereafter, indicated complete healing of these three pressure ulcers by 5/24/18. Despite the need to ensure good nutritional status, there was no additional nutrition assessment, other than the annual assessment, dated 7/27/17. During the time period between 1/29/18 and 5/24/18, no PCP IPNs addressed the development and treatment of the three decubiti.
- Although Individual #437's IDT made a referral in January 2018 to the PNMT, the PNMT pushed the referral back to the IDT without addressing the potential global impacts of the weight gain, such as potential wheelchair fit issues. No ISPA was found to show that the IDT met to discuss her weight issues.
- Individual #242 experienced unplanned weight loss (i.e., between May 2017 and May 2018, her weight dropped from 113.6 pounds to 89 pounds), but her IDT had not developed an IHCP related to weight.
- Individual #148 had a with a deep pressure injury on his heel. His IDT did not refer him to the PNMT, and the PNMT did not make a self-referral. (Documentation related to the stage of the pressure injury provided varying information. The Tier I documents indicated it was a "Stage 5," but this is not part of the standard staging of pressure ulcers.)
- Individual #148's IDT did not develop an IHCP related to weight, despite a history of weight gain prior to his transition to the community, and again upon his readmission.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.

Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies as well as Residential and Day Program/Vocational staff, should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. Based on the Monitoring Team's observations, a particular focus should be placed on the implementation of Dining Plans.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	55% 26/47	
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.	75% 3/4	
Comments: a. The Monitoring Team conducted 47 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 21 out of 28 observations (75%). Staff followed individuals' dining plans during five out of 18 mealtime observations (28%). Staff completed transfers correctly during zero out of one observations (0%).			

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	163	155	59	570	350	125	437	242	148
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A			N/A	N/A			N/A		
Comments: a. This indicator was not applicable to the three individuals reviewed with enteral nutrition.											

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: Half of the individuals reviewed did not have clinically relevant goals/objectives, and more than half did not have measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 4/8	1/1	N/A	1/1	0/1	2/2	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	25% 2/8	0/1		0/1	0/1	2/2	0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8	0/1		0/1	0/1	0/2	0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1		0/1	0/1	0/2	0/1		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1		0/1	0/1	0/2	0/1		0/1	0/1

Comments: a. and b. Individual #155 (i.e., due to level of independence) and Individual #437 (i.e., due to limitations in ability to participate in a meaningful goal) did not require OT/PT goals/objectives. Both were part of the core group, so full reviews were conducted for them.

The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #350 (i.e., walking with a rolling walker, and demonstrating left knee/hip flexion in swing phase in order to clear left foot).

Although the following goals/objectives were clinically relevant, because they were not measurable, the related data could not be used to measure the individual's progress or lack thereof: Individual #163's goal/objective to sit straight in his wheelchair without leaning to the right; and Individual #59's goal/objective to propel his wheelchair from the "dayroom" to his bedroom.

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: For approximately half of the OT/PT goals/objectives reviewed, evidence was found to show that they were implemented. It is important to note, however,	Individuals:

that a number of individuals who should have had measurable OT/PT plans or strategies did not. These indicators will continue in active oversight.

#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	50% 2/4	0/1	N/A	0/1	N/A	2/2	N/A	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 2/2	N/A	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A

Comments: a. Evidence was found in integrated ISP reviews that supports were implemented for half of the OT/PT goals/objectives reviewed. In other cases, the goal/objective was never implemented, or the QIDP monthly reviews and PT notes did not include specific data.

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

Summary: Some issues continued to exist with regard to the proper fit of adaptive equipment. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]

Individuals:

#	Indicator	Overall Score	59	34	148	250	90	18	323	44	322
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	83% 30/36	1/1	0/2	2/3	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		347	446	84	331	343	392	453	539	26

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	2/2	2/2	1/1	2/2	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		554	81	54	287	92	527	472	582	470
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	1/1	2/2	1/1	2/2	0/1	1/1	1/1
		Individuals:									
#	Indicator		350								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: c. Based on observation of Individual #34, Individual #18, and Individual #81 in their wheelchairs, they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or the staff not positioning individuals correctly, or other factors.

In addition:

- Staff were unable to locate Individual #34's hand mitts.
- Staff were unable to locate Individual #148's arm-elbow brace.
- Individual #472's socks were not positioned correctly in her ankle foot orthosis (AFO), resulting in direct contact between the AFO and skin, which increased the risk of skin breakdown.

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, one indicator related to skill acquisition/engagement 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.

Brenham SSLC ISPs now had some goals that were individualized and measurable. This was good to see, however, without data, progress cannot be determined. Similarly, many SAPs were not implemented in a timely manner (i.e., not until months after the ISP meeting), which contributed to a lack of progress.

Although none of the SAPs contained all of the necessary components, most of the SAPs included more than two-thirds of the components. Critical missing components were specific instructions for staff and responses/consequences for correct performance. Monthly reviews and graphic presentations of SAPs, were not, but should be, occurring regularly for all individuals.

Engagement observed by the Monitoring Team was scored higher than at any of the previous reviews. Engagement was not regularly measured by the Center and the Center's own engagement goals were not met.

For the applicable individual reviewed, the IDT did not have a way to measure a clinically relevant outcome(s) related to dental refusals.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Brenham SSLC now had some goals that were individualized (indicator 1) and measurable (indicator 2). This was good to see, however, without data (indicator 3), progress cannot be determined.			Individuals:								
#	Indicator	Overall Score	177	163	145	155	242	59			

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 and implementing actions plans that clearly support the achievement of those personal goals, and thus, the Center can achieve compliance with this outcome and its indicators.

4-7. A personal goal that meets criterion for Indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For these six individuals, there was no basis for assessing progress as the IDTs failed to develop any personal goals that were also measurable and had reliable and valid data. The Monitoring Team continued to find the lack consistent implementation to be significant concern.

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

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	163	145	155	242	59			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/4	0/1	Not onsite	0/1	Not onsite	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. The Monitoring Team's evaluation of this indicator is based on observations, interviews, and review of documentation that reflects implementation. Two individuals (Individual #155, Individual #163) were hospitalized throughout this visit, such that staff could not be observed in interactions with them. As a result, this indicator is scored based on four individuals.

Overall, none of these four ISPs had documentation that reflected consistent implementation. In addition, staff lacked knowledge of how and when to implement action plans.

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

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Performance remained low on all of these indicators, all of which will remain in active monitoring. Note that many SAPs were not implemented in a timely manner (i.e., not until months after the ISP meeting), which contributes to a lack of progress.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
6	The individual is progressing on his/her SAPS	11% 2/19	0/2	0/2	1/3	0/2	1/1	0/3	0/3	0/3	N/A
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% 0/15	0/2	0/2	0/2	0/2	N/A	0/3	0/3	0/1	N/A
9	(No longer scored)										

Comments:

6. Nineteen of the 21 SAPs were assessed for progress. The exceptions were Individual #145's budgeting SAP because there was only one data point, and Individual #168's addition/subtraction SAP because this was discontinued once staff identified that he had these skills. Of these 19 SAPs, progress was identified for Individual #471 learning to identify letters and Individual #145 learning to e-mail her mother.

7. In no case was there evidence that the individual had met his or her goal.

8. In no case was there evidence that action was taken to address the individual's lack of progress. What was particularly concerning was the length of time it often took to get a SAP written and into Caretracker to begin with. For example, both of Individual #86's SAPs were unavailable for 11 months, two of Individual #293's SAPs were unavailable for seven months, and none of Individual #168's SAPs were developed until four months following his admission.

Additionally, SAP implementation was often less than what was scheduled. In four cases (Individual #177 writing her name, Individual #471 paying a cashier and crossing the street, and Individual #145 e-mailing her mother), the number of sessions implemented across a six-month period was less than 50% of what was expected.

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 more than two-thirds of the components. Critical missing components were specific instructions for staff and responses/consequences for correct performance. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
13	The individual's SAPs are complete.	0% 0/21	0/2 15/20	0/2 17/20	0/3 20/30	0/2 14/20	0/2 17/20	0/3 22/30	0/3 22/30	0/1 7/10	0/3 22/30

Comments:

13. Although none of the SAPs were considered complete, more than 90% of them included seven of the 10 identified elements; this was good to see:

- a task analysis where appropriate.
- a behavioral objective.
- operational definitions.
- a relevant discriminative stimulus.
- an identified consequence for correct responding.
- plans for maintenance and generalization.
- documentation methodology.

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

Although plans identified praise as a known preference, staff are advised to re-consider this as an effective reinforcer, particularly when the individual is not making progress.

Elements that were missing in most of the plans included specific instructions. Many plans focused on the best way to communicate with the individual and while this is important, it does not provide guidelines to ensure consistent presentation of task materials. The goal should be for all instructors to be able to read the instructions and present the task in the same manner.

While many tasks presumably occur once daily (e.g., making a purchase, bathing, working on a budget), others are amenable to multiple trials (e.g., writing one's name, operating a CD player, completing math problems). In the latter case, the number of trials should be specified.

Lastly, consequences for incorrect responding were often quite generic. These did not provide specific strategies for staff to employ when the individual did not successfully complete the identified step.

Outcome 5- SAPs are implemented with integrity.												
Summary: Performance improved for both indicators, which was good to see, however, both scores still remained low. Attention to implementation of SAPs as written is important if individuals are to make progress and benefit from all of the work that goes into assessing, planning, and writing SAPs. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
14	SAPs are implemented as written.	40% 2/5	1/1	0/1	Not rated	Not rated	1/1	0/1	Not rated	Not rated	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.	24% 5/21	2/2	0/2	1/3	0/2	2/2	1/3	0/3	0/1	0/3

Comments:

14. During the onsite visit, an observation of training on one SAP was scheduled for six individuals. The exceptions included Individual #163 and Individual #155 who were in the hospital. Staff reported that Individual #471 had only one SAP that was implemented at a specific time when the Monitoring Team was not available. For all others, individual specific feedback is provided below.

- Individual #177 was observed completing her DVD SAP. This was implemented as written. Staff may want to probe the terminal objective because she was able to complete many of the steps in the chain.
- Individual #86 was observed using the automatic door opener. The staff member did not implement this as written because she repeatedly presented the discriminative stimulus or verbal prompts before increasing her level of assistance.
- Individual #145 was observed sending an e-mail to her mother. The task was implemented as written, although it was completed in the home office versus her day program site. Individual #145 was able to complete most of the steps in the SAP, therefore, staff are advised to probe the terminal objective to determine whether she had already acquired this skill.
- Individual #490 was observed reading a nutritional label. This was not implemented as written because she was not required to locate the calories on the label, but rather was asked to state the number of calories once the staff member pointed to this.
- Individual #293 could not be observed tying his shoes because he had no shoes with laces. The staff member searched the home, but all of Individual #293's shoes were slip on.
- Individual #168 was observed completing an employment application. He readily completed the form, only requiring information from staff regarding his address. As he had been living at the Center for a little less than five months, he may not have memorized this information. Although the staff member gave the correct instruction, the application itself did not match the SAP as written. The SAP outlined steps to write his name/address/birthdate, name of his school, indicate the position he's applying for, and list references. The form that was used did not require most of this information. Further, it included a space to indicate whether the person applying had an Alaskan driver's license. Staff are advised to ensure that materials used match the SAP being implemented.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually. Based upon the documentation provided, it was determined that five of the 21 SAPs had been monitored at least once over the previous six-month period. These were the following:

Individual #177 (write name and operate DVD player), Individual #471 (identify letter), Individual #145 (budget), and Individual #490 (apply lotion).

No assessment was indicated as having occurred for any of the remaining SAPs. Staff are advised to ensure that assessment is completed through observation of a training session versus role-play (e.g., Individual #163's puzzle SAP).

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

Summary: Performance was a little lower than at the last review. At this point, monthly reviews and graphic presentations should be occurring for all individuals. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168
16	There is evidence that SAPs are reviewed monthly.	24% 5/21	1/2	0/2	3/3	0/2	0/2	1/3	0/3	0/1	0/3
17	SAP outcomes are graphed.	70% 14/20	2/2	0/2	2/3	2/2	2/2	3/3	1/3	1/1	1/2

Comments:
16. There was evidence that one to three SAPs were reviewed consistently in the QIDP Monthly Report for three individuals. These were all three SAPs for Individual #471, the writing name SAP for Individual #177, and the applying lotion SAP for Individual #490.

For all other SAPs, either there was not a regular review of the SAP or there were no data reported to allow for an assessment of progress.

17. As the IDT determined to discontinue the addition/subtraction SAP for Individual #168 before it was ever implemented, 20 SAPs were assessed for this indicator. There were graphs for 14 of these SAPs. The six exceptions were both SAPs for Individual #86, Individual #471's learning to identify letters, Individual #293's SAPs to replace the shredder bag and tie his shoes, and Individual #168's SAP to learn to budget.

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

Summary: Engagement observed by the Monitoring Team was scored higher than any of the previous reviews. Engagement goals were set (this was in place for some time now, therefore, indicator 20 will be moved to the category of requiring less oversight), but engagement was not regularly measured by the Center and their goals were not met. Indicators 18, 19, and 21 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	177	86	471	163	145	490	293	155	168

18	The individual is meaningfully engaged in residential and treatment sites.	57% 4/7	1/1	0/1	1/1	Not onsite	1/1	0/1	0/1	Not onsite	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. During the onsite visit, individuals were observed in their homes, work sites, and/or day programs. Of the seven individuals met during the onsite visit, four were considered to be meaningfully engaged. This was Individual #177, Individual #471, Individual #145, and Individual #168. Although Individual #293 went to work off campus for most of the day, when he was observed in or near his home, he was often unengaged. Individual #86 and Individual #490 were often observed sitting without active engagement.

19-21. Although the Center's policy was to assess engagement each month in all residential and day/work program sites, this had not been achieved in the six months prior to the onsite visit. Similarly, engagement levels were established at 70% across all settings, but this had not been achieved.

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

Summary: Since the last review, individual goals for community activities were set, but not yet for training skills in the community. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 177	86	471	163	145	490	293	155	168
22	For the individual, goal frequencies of community recreational activities are established and achieved.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Goal frequencies for community recreational activities were established and achieved for eight of the nine individuals reviewed. The exception was Individual #168, although he was going on an outing the day he was observed completing his SAP.

23. There was no evidence of SAP training in the community for any of the nine individuals.

24. There was no evidence that the IDTs for any of the nine individuals had met to discuss barriers to community recreational activities or community-based training.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: Five of the six sub-indicators were met for the two individuals. With attention to this, indicator 25 might move to 100% performance. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	177	168							
25	The student receives educational services that are integrated with the ISP.	0% 0/2	0/1	0/1							
Comments: 25. Two of the nine individuals who were reviewed were of school-age and receiving educational services. There was evidence that both Individual #177 and Individual #168 were enrolled and attending school. For both individuals, there was public school-related information in their ISP, including action plans to support the IEP. The IEP also reflected a consideration of inclusive services and an extended school year. It was very positive to learn that Individual #177 was attending summer school, particularly because she appeared to look forward to this activity. The signature sheet for the IEP suggested that only Individual #177's QIDP had attended her IEP meeting. Lastly, there was evidence in a QIDP Monthly Report that only Individual #168's IDT included a review of his school report cards											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For the applicable individual reviewed, the IDT did not have a way to measure a clinically relevant outcome(s) related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1		0/1							
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1		0/1							

d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1		0/1							
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1		0/1							
Comments: a. through d. For Individual #155, who refused dental services, the IDT had not developed a specific, clinically relevant goal(s)/objective(s) related to his refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was positive that one individual reviewed had a clinically relevant measurable communication goal/objective, he made progress, and the SLP worked with the IDT to modify the goal/objective to continue his learning process. For a number of other individuals, though, IDTs did not have a way to measure clinically relevant communication goals/objectives. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
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	0/1	1/1	1/1	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	0/1	1/1	0/1	0/1	1/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The following individuals had clinically relevant and measurable goals/objectives: Individual #570 (related to use of a Dynavox), and Individual #437 (related to activating a switch). Although the following goal/objective was clinically relevant, because it was not measurable, the related data could not be used to measure the individual's progress or lack thereof: Individual #350 (related to selecting a meal).											

c. through e. Individual #570 appeared to have made improvement with his goal/objective, and the SLP correspondingly updated the goal/objective to increase the level of difficulty. However, no ISPA was found showing the IDT 's involvement in the decision-making when the SLP modified the goal and the QIDP did not reflect progress in the ISP monthly reviews. A full review was conducted for him. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	163	155	59	570	350	125	437	242	148
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	N/A	N/A	N/A	0/1	0/1	N/A	0/1	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included: • Although the SLP's notes indicated that the goal/objective for Individual #570 was implemented, the QIDP monthly reviews did not reflect the individual's progress. • A goal recommended as part of Individual #350's communication assessment in January 2018 was included in the ISP, dated 2/2/18. As of 5/18/18, no documentation was found to show that this service was provided. • For Individual #437, a communication SAP was developed in October 2017, but as of April 2018 (prior to her death), the SAP had not been implemented.											

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 they are readily available, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	453	539	26	428	332	97	91		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	43% 3/7	0/1	1/1	0/1	1/1	0/1	1/1	0/1		

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	33% 1/3									
Comments: a. and b. It was concerning that often individuals' AAC devices were not present or readily accessible, and/or that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. At this time, one indicator 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.

Although some progress had occurred, more work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff.

For one individual, post-move monitoring at all sites occurred timely, but for the other individual, the Post-Move Monitor did not visit the day site. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, the PMM accurately rating the presence or absence of supports, and the PMM and IDTs documenting follow-up to supports not in place.

One of the individuals experienced two psychiatric hospitalizations after twice eloping from her school setting and subsequent involvement by school security staff. Following these events, her legally authorized representative (LAR), Local Intellectual Disabilities Authority (LIDDA), and IDT agreed she should return to Brenham SSLC. The IDT discussed issues that might have contributed to the potentially disrupted community transitions (PDCTs) and identified some things that could have been done differently. This is an important part of the PDCT process, so this was a positive step. However, the IDT still failed to fully identify some additional concerns and address how these could be rectified for future transitions.

It was good to see ongoing collaboration between transition staff and LIDDA staff to address individuals' needs during and after transition from the Center. The related indicator will move to the category of less oversight. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Improvements also are needed with regard to, as needed, collaboration between Center and community clinicians, clinicians' completion of settings assessments, development and implementation of individualized transition activities, and improved documentation of the evidence to confirm the completion of pre-move supports. Significant improvement is needed with regard to the development and implementation of training supports and activities for community provider staff.

It was positive that one individual reviewed transitioned to the community within 180 days, and that for the other individual who did not, documentation showed adequate justification.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: Although some progress had occurred, more work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should continue to be a focus for Center staff. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	292	533							
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: Since the last review, seven individuals transitioned from the Center to the community. Two were included in this review (i.e., Individual #292, Individual #533). Individual #292 transitioned to a community home, and Individual #533 moved into his mother's home with Host Home services. The Monitoring Team reviewed these two transitions and discussed them in detail with the Brenham SSLC Admissions and Placement staff.

1. IDTs should describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. At the time of the last monitoring visit, the Monitoring Team noted some evidence of incremental progress, but still found supports did not consistently fulfill the requirements for compliance or provide the Post-Move Monitor (PMM) with measurable criteria or indicators that could be used to ensure supports were being provided as needed. Further, the IDTs needed to focus considerable attention on the development and implementation of pre-move training supports, which would allow the Center to objectively verify provider staff competence to implement all important health and safety supports prior to individuals' moves to the community. This remained an area of need for this monitoring visit. To move toward compliance, the IDTs needed to continue to focus on identifying the measurable criteria upon which the PMM may accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: IDTs developed 11 pre-move supports for Individual #292 and eight pre-move supports for Individual #533.
    - For Individual #292, four of 11 pre-move supports addressed the provision of furnishings and bedding. These supports met criterion for measurability.
    - For Individual #533, two of eight pre-move supports addressed the availability of equipment and materials that Brenham SSLC would provide, and each met criterion for measurability.
    - Individual #292 had a support for 24-hour supervision, but it did not describe the purpose for that supervision or her related needs (i.e. a recent and ongoing history of elopement). The support stated the required evidence was to be observation and documentation, but it did not specify what should be observed and/or documented.

- Most of the remaining pre-move supports for these two individuals were for staff training. The Monitoring Team found that neither CLDP indicated the provider staff knowledge, or competence, required to provide the needed supports. To continue to move toward compliance, the Center should continue to focus on defining specific competency criteria and ensuring the tools for measuring those competencies are thorough and appropriate to the need. Findings included:
  - For Individual #292, the pre-move training supports indicated only that BSSLC would provide training in broad categories: her positive behavior support plan (PBSP); skill acquisition programs (SAPs); preferences and strengths, daily schedule; activities of daily living skills; and, medication administration and medications. None of the supports provided any further specificity about what staff needed to know about her individualized needs, nor did they specify any competency criteria or demonstration of staff knowledge/competence.
  - For Individual #533, the supports indicated Brenham SSLC staff would provide training regarding his communication strategies; mealtime and medication administration strategies; and, strengths, preferences, likes and dislikes. These supports did not provide any measurable specificity about his individualized needs, what should be included in the training, or how the Center could confirm needed knowledge and competence on the part of provider staff. It was also concerning that the IDT did not develop supports for training provider staff who would be providing services in the host home, although the training roster did indicate some such training did occur.
  - The Monitoring Team also requested the pre-move training materials and documentation of any testing of staff knowledge/competence that might provide some level of measurability. The Center did not provide any training materials or any evidence of competency testing/demonstration; instead, it only provided training rosters. Attendance at a training would not be sufficient to demonstrate provider staff knowledge.

- Post-Move: IDTs developed 40 post-move supports for Individual #292, and 35 post-move supports for Individual #533. Some post-move supports were measurable, but this continued to be an area needing improvement. For both individuals, post-move supports for training any new staff did not meet criterion. Similar to the pre-move supports described above, these supports did not consistently describe competency criteria or describe adequate competency testing. Other examples included:
  - For Individual #292, a CLDP support indicated provider staff should monitor for challenging behaviors and psychiatric symptoms and seek the assistance of a behavioral health professional, if detected. The support only required documentation as evidence, but did not specify the specific nature of the documentation that needed to be kept or provide any guidance as to the specific challenging behaviors and/or psychiatric symptoms. It also did not require any provider staff interview to ascertain if they had knowledge of her behaviors and psychiatric symptoms. Further, the CLDP did not even require training on the latter.
  - For Individual #533, two supports related to psychiatric care did not have evidence specified. All other post move supports required documentation as evidence, but did not specify what needed to be documented. Thirteen of the 35 post-move supports also required provider staff interview but seldom provided the specific topics the PMM should cover.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order to be scored as meeting criterion. The Center identified many supports for these two individuals and it was positive IDTs had

made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below. It was positive transition staff had identified some key issues in the identification of CLDP supports and had devised some creative strategies to obtain important input from Center staff, such as a questionnaire about how staff addressed individuals' daily needs.

- Past history, and recent and current behavioral and psychiatric problems: CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. Findings included, for example:
  - For both individuals, the IDT did develop some post-move supports related to current behavioral needs. This was positive, but these supports were not consistently clear and/or comprehensive.
  - For Individual #292, supports did not address many of her behavioral needs. For example:
    - The pre- and post-move behavioral training supports did not provide any staff competency criteria, or reference staff knowledge of behavioral and psychiatric history.
    - The training supports did not include providing any in-service or information for personnel at Individual #292's new school setting. This was of significant concern. Per a 9/28/17 ISPA, just one month before transition, she had an encounter with law enforcement after she became upset at school. She began having challenging behaviors and left the classroom, ran down the hallway, and fought staff and the law enforcement officer. The officer placed her in handcuffs, because she was a threat to herself and others and transported her back to the Center. Upon returning, she continued to engage in challenging behaviors and the Center administered a chemical restraint. This should have prompted the IDT to develop supports to address how school personnel would be offered information about behavioral strategies for prevention and intervention.
    - Another post-move support stated only that the provider would use the Center's PBSP to address her challenging behaviors of verbal aggression, elopement, and physical aggression. This support was very broad and did not include any specific expectations for prevention and intervention strategies. The PBSP also contained some facility-specific requirements, such as to use Prevention and Management of Aggressive Behavior (PMAB) techniques, that would not be relevant in the community and, further, did not describe how those could be accommodated in the community.
    - The IDT did not develop a counseling support, even though Individual #292 had been receiving ongoing counseling at the Center.
  - For Individual #533, CLDP supports were limited to very broad recommendations to train the family and any new provider staff on his PBSP, to continue the current PBSP, and a recommendation to work with the provider's Board Certified Behavior Analyst (BCBA) to adjust PBSP "as needed." The support did not clarify what the expectations were for the latter support. The IDT did not make any recommendations for how provider staff would be trained or how Individual #533's mother and family could be provided with practical modifications for PBSP implementation.
- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. To meet criteria, IDTs still needed to develop clear and comprehensive supports in these areas. Findings included, for example:
  - Neither CLDP provided an individualized support regarding specific needs for supervision.
  - Neither CLDP included supports for any nursing oversight that might be needed.
  - For Individual #292:

- It was positive the IDT developed several supports related to her weight. These included regular monitoring of her weight; healthy diet guidelines with specific examples; learning to cook; 30 to 45 minutes of physical activity daily; and, access to z dietitian per her primary care practitioner's (PCP's) referral.
- The CLDP did not include training supports for her Integrated Health Care Plans (IHCPs) or nursing/health needs, with the exception of medications and medication administration. Even the latter were non-specific.
- The CLDP did not include supports related to her recent history of urinary tract infection (UTI). Per the IHCP and habilitation therapy assessment, she needed supports to improve both personal hygiene and water intake, but the IDT did not develop related supports for staff knowledge of these needs or monitoring for UTI symptoms.

o For Individual #533:
  - The IDT documented that he typically ate slowly, but would sometimes overstuff his mouth and take extra-large bites of food and large gulps of liquid. He had a physical and nutritional management plan (PNMP) for dining instructions and adaptive equipment, but the CLDP included only one related support for the use of a nosey cup. It did not address the dining instructions. Another post-move support broadly indicated any new staff would be trained on mealtime strategies, but provided no related criteria.
  - His Integrated Risk Rating Form (IRRF) indicated he was at low risk in the area of weight, but other documentation indicated he had a history of being overweight. He had also gained 14 pounds over six days while at home over Christmas, a trend which also had been seen following an extended home visit in December 2015. A post-move support called for him to be weighed monthly, but given these historical trends, the IDT should have considered a more assertive support to review weights on a more frequent basis. His supports also included a high-calorie diet, but with no suggestions for how to modify the diet if similar weight gains were noted after transition.

- What was important to the individual: The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Findings included, for example:
  - o Per her CLDP, it was most important to Individual #292 to live near her family. The CLDP provided only a broad and vague support to provide opportunities for family contact through phone calls and visits. Per her ISP, participation in sporting events was very important. A support called for the provider to "encourage" a try-out for Special Olympics, but lacked an outcome for participation or even a description of what level encouragement would be expected.
  - o For Individual #533, the CLDP stated his important outcomes were to live with his mother and to attend Brenham Production Services (BPS). It was positive the CLDP addressed the fundamental outcomes of where he would live and work.
  - o CLDPs should, but did not, include supports that formalized an 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.
    - For Individual #292, the IDT set only minimal expectations for meaningful day activities that emphasized community participation and integration.
    - Per Individual #533's ISP vision statement, the IDT believed the following outcomes to be important: to operate a CD player to be able to listen to his favorite music; to operate a television to be able to watch his favorite cartoons; and to make a minimum of $50 a month to be able to go out to eat on a weekly basis. The

CLDP did not include any supports that addressed how he wanted to spend his time or that encouraged community participation and integration.

- Need/desire for employment, and/or other meaningful day activities: Findings included, for example:
  - o Per her ISP, Individual #292 preferred the selected provider specifically because it offered opportunities to learn more, make more money, and gain job skills. The IDT did not develop any supports related to school, work, or a day program, or provide a vocational or day program assessment.
  - o Individual #533's CLDP included a support to attend BPS with a job to be determined per his preference, but the IDT did not provide any information about what his preference in this area might be. The CLDP also did not include any supports that described his preferences about activities or strategies for promoting participation in any activities.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports that included some elements of positive reinforcement and other motivating components. Neither CLDP addressed this assertively.
- Teaching, maintenance, participation, and acquisition of specific skills:
  - o For Individual #292, it was positive the CLDP contained some focus on skill acquisition. These included SAPs for tooth brushing and cooking, both appropriate given her needs and interests. At the Center, she also had SAPs for flossing, hair washing, and budgeting, all of which would have been important for community living.
  - o Individual #533's CLDP did not have any supports for teaching, maintenance, participation, and acquisition of specific skills.
- All recommendations from assessments are included, or if not, there is a rationale provided: Brenham SSLC had a process in place for documenting in the CLDP the IDT's discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional recommendations. The Monitoring Team noted this process was often used very effectively to identify and rectify issues related to clarity, measurability, and comprehensiveness. Still, for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification as described above. These included, for example, Individual #292's need for counseling.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: For one individual, post-move monitoring at all sites occurred timely, but for the other individual, the Post-Move Monitor did not visit the day site. Some of the areas in which further efforts were needed related to the PMM basing decisions about supports on reliable and valid data, the PMM accurately rating the presence or absence of supports, and the PMM and IDTs documenting follow-up to supports not in place. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	292	533							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	50% 1/2	0/1	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 scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	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. Post-move monitoring was completed at the residential and/or provider office sites at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes and were done in the proper format. However, per the PMM Checklists, for Individual #292's 45-day and 90-day visits, monitoring did not occur at the day habilitation program, even though the documentation further indicated she had begun attending. The PMM did document visiting all locations for Individual #533.

4. PMM Checklists provided some good examples of documenting valid and reliable data, but this was not yet consistent. To continue to move toward compliance, the Center should continue to focus on improving overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. Findings included, for example:

- As described above with regard to Indicator #1, the training supports for provider staff did not specify the competency criteria that the PMM needed to be able to accurately collect valid data.
- CLDPs often relied solely on documentation as the prescribed evidence to substantiate supports were being provided as needed. The IDTs should carefully consider whether additional prongs of evidence, such as interviews, and/or observations should be included to ensure valid and reliable data. In any event, IDTs still needed to develop supports that made clear what the documentation, observations, and/or interviews should cover.
- For Individual #292, the comments for her medication administration stated staff had been trained and were assisting her. The PMM Checklist indicated the PMM completed a staff interview, but the comments did not convey what staff were asked, how they replied, or whether that demonstrated competence.

- For all PMM visits, Individual #533's mother reported she was not using the nosey cup to slow his rate of fluid consumption as a CLDP support indicated; instead, she was encouraging him to slow down and using a straw. For provider staff, the PMM Checklist indicated only that they stated they had been trained and that the nosey cup was available at the day habilitation program. The PMM did not provide evidence that provider staff had knowledge of the purpose and use of the nosey cup.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent. As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written and/or a lack of reliable and valid evidence that demonstrated a support was in place as required. Examples of important supports not in place as required included the following:

- For Individual #292:
  - At the time of the seven and 45-day PMM visits, the CLDP called for the provider to submit documentation related to becoming the representative payee. The CLDP called for documentation as evidence, but the PMM relied only on staff interview saying they had done so.
  - At the time of the 45-day PMM visit, the community behavioral health provider had not yet seen her.
- For Individual #533:
  - He had not had the recommended dental follow-up through the seven-day, 45-day and 90-day PMM visits.
  - He had significant and ongoing weight gain, beginning at the time of the seven-day PMM visit, with a reported 24-pound gain from his last recorded weight at the Center. By the time of the 180-day PMM visit, he had gained almost 70 pounds. He had not had a referral to a dietitian.
  - Many of Individual #533's supports, such as being seen by the psychiatrist and the neurologist had not been met, because of increasing refusals to leave the house for appointments.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still exceptions in which the evidence provided did not clearly substantiate the finding with valid and reliable data as described above. For example, Individual #292's support for assistance with medication administration was marked as in place, but offered no evidence provider staff had knowledge of those requirements. Likewise, Individual #533's support for the use of the nosey cup was marked as in place at the time of the 45-day PMM visit, even though the evidence indicated the cup was not in use at home, and did not demonstrate it was being used as required at the day habilitation program.

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. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. This, in turn, relies on accuracy, completeness and measurability of the supports. The PMM often accurately identified when supports were not in place and took action toward resolution, but this was not yet consistent. At other times, follow-up was not documented in a timely manner. Examples included:

- At the time of the seven-day PMM visit, the community behavioral support staff had not seen Individual #292 as indicated. The PMM noted this and scored it as not in place, but did not document it as an area of concern or take any follow-up action. At the time of the 45-day PMM visit, the community behavioral support staff still had not seen Individual #292.

- At the time of the seven-day PMM visit for Individual #533, the PMM correctly noted that his supports related to weight gain and work attendance had not been met. The PMM documented emailing the provider to take follow-up actions, but did not document confirming those actions until the time of the 45-day PMM visit.

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

Outcome 3 – Supports are in place to minimize or eliminate the incidence of preventable negative events following transition into the community.												
Summary: One of the individuals experienced two psychiatric hospitalizations after twice eloping from her school setting and subsequent involvement by school security staff. Following these events, her LAR, LIDDA, and IDT agreed she should return to Brenham SSLC. The IDT discussed issues that might have contributed to the PDCTs and identified some things that could have been done differently. This is an important part of the PDCT process, so this was a positive step. However, the IDT still failed to fully identify some additional concerns and address how these could be rectified for future transitions. This indicator will continue in active oversight.			Individuals:									
#	Indicator	Overall Score	292	533								
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.	50% 1/2	0/1	1/1								

Comments: 11. Individual #533 had not had a PDCT event. Individual #292 had experienced two psychiatric hospitalizations after twice eloping from her school setting and subsequent involvement by school security staff. Following these events, her LAR, LIDDA, and IDT agreed she should return to Brenham SSLC. The Center held two PDCT meetings, as described below:

- On 12/21/18, Brenham SSLC staff discovered the first PDCT event, and on 1/5/18, held the related ISPA meeting. Per the documentation, on an undetermined date, the provider dropped Individual #292 off at school late and did not accompany her inside. She reportedly became confused and left the school. She became aggressive when school security approached her. The school contacted the provider to come get her, but her aggression escalated. Provider staff reported they did not feel safe, so Individual #292 was admitted to a psychiatric hospital for overnight observation.
- On 2/22/18, the IDT held a second PDCT ISPA. On 2/13/18, Individual #292 left her classroom at school and attempted to run into the road several times, resisted attempts at re-direction, and, at one point, obtained a weapon of some sort. As a result, school district staff restrained her and she was taken to a psychiatric hospital. Once she returned to the provider home, she

continued to run into the street and have physical altercations with others. The IDT, LAR, LIDDA and provider all concluded she should return to Center.

- The IDT discussed issues that may have contributed to the PDCTs and identified some things that could have been done differently. This is an important part of the PDCT process, so this was a positive step. The IDT still failed to fully identify some additional concerns and address how these could be rectified for future transitions. Findings included, for example:
  - On 11/28/17, the community PCP changed Individual #292's psychotropic medications. Per the ISPA, the IDT discussed whether they should have made a recommendation for no changes to this regimen for one year, instead of the existing non-specific support to "continue as prescribed."
  - The CLDP did not include any post-move support for counseling to assist Individual #292 in adjusting to the transition. It was positive that after the first PDCT occurred, the IDT recognized this as something that should have been implemented, and they made a recommendation for an appointment to be made as soon as possible. At the time of the second PDCT meeting, approximately six weeks later, she had only been to one counseling session. The IDT did not then discuss whether developing their post-move follow-up could have been more assertive, including stating clear expectations about the frequency of counseling and implementing a frequent timeline for monitoring for completion.
  - The IDT further indicated the provider could have offered a more structured environment, but did not identify that CLDP supports had not addressed how this might have occurred.
  - The IDT also did not discuss the following issues that may have contributed to the PDCT events: the non-specific and broad behavioral supports; the lack of competency criteria and competency testing related to her behavioral needs prior to the transition; the lack of rigorous testing of staff knowledge after transition; the lack of training for school staff; and/or any need for follow-up remedial training that addressed all the above concerns.

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: Given that over the last two review periods and during this review, APC and transition department staff collaborated with the LIDDA staff when necessary to meet the individuals' needs during the transition and following the transition (Round 11 – 100%, Round 12 – 100%, and Round 13 - 100%), Indicator 18 will move to the category requiring less oversight. Improvements were needed with regard to the completion/review of all relevant assessments as well as the quality of transition assessments. Improvements also are needed with regard to, as needed, collaboration between Center and community clinicians, clinicians' completion of settings assessments, development and implementation of individualized transition activities, and improved documentation of the evidence to confirm the completion of pre-move supports. Significant improvement is needed with regard to the development and implementation of training supports and activities for community provider staff. Currently, the remaining indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	292	533							
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.	50% 1/2	0/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments: 12. Assessments did not consistently meet criterion for this indicator. This remained an area of need. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated within 45 Days of transition: Most assessments provided for review met criterion for timeliness. Assessments that did not meet criterion included:
  - The CLDP for Individual #292 included a review of the most recent Quarterly Drug Regimen Review (QDRR). The IDT did not document a similar review for Individual #533, and the QDRR provided took place eight days after the CLDP was held.

- The CLDP for Individual #292 included a detailed review of the IRRF, which was positive. The IDT for Individual #533 also included a brief statement that the IRRF had been reviewed with no changes. The Center should provide a copy of the updated IRRF to the provider as a part of the assessment packet, as it provides a great deal of important health information.
    - The Center did not provide a vocational or day assessment for Individual #292. She was still attending school, but was almost 17 years old at the time of transition, an age at which the IDT and school should have been engaged in school-to-work transition planning. In addition, the IDT was aware she would be attending a day program when not in school and should have provided an assessment of her needs in that regard.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Many discipline assessments provided a summary of relevant facts in the available assessments, but the missing vocational assessment for Individual #292 negatively impacted this finding. Both individuals also had assessments that included some out-of-date information.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Currently, assessments did not consistently meet criterion in this area. For example:
    - For Individual #292, the behavioral health specialist (BHS) did not provide a specific recommendation for continuation of counseling, even though the assessment narrative noted she should continue counseling that targeted healthy relationships and coping skills.
    - For Individual #533, the speech/language pathologist's (SLP) assessment provided no specific communication recommendations, although the narrative indicated staff should continue to model the use of signs throughout the day whenever possible to label objects/items, to indicate specific activities, and when providing verbal instructions. Further, the narrative stated that staff should encourage Individual #533 to imitate the signs and that staff could model the use of picture communication boards.

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 the CLDP 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: For both individuals, the Center maintained detailed Transition Logs. These were helpful in understanding how the Centers transition processes ensured necessary participation. Section IV of the CLDP document, entitled Community Living, also provided details of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. As it related to whether the CLDP was reviewed with Individual #292 to facilitate her decision-making about supports and services, the Monitoring Team did have a concern, however. Per the ISP and 14-Day ISPA, her preference was to live independently in an apartment. The IDT indicated she understood this could be a long-term goal and was excited to move into a group home as a step toward her ultimate goal. The documentation did not evidence the IDT provided her with a clear understanding how/if her CLDP laid out a path toward her stated goal of living independently.

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: Per training rosters, the Center did engage provider staff in training community provider staff, as well as Individual #533's family members. This training did not meet criterion for these two CLDPs, as described below and with regard to Indicator #1 above. Findings included, for example:

- The CLDP training supports were broad and vague. The IDTs did not identify the content of required training.
- The IDTs did not identify the expected provider staff knowledge or competencies that needed to be demonstrated.
- The Center did not provide any documentation or materials for review that demonstrated the content of the training provided.
- The Center did not provide any evidence that confirmed provider staff had the knowledge and competencies to address the individuals' health and safety needs or otherwise ensure supports were implemented as required.

15. When necessary, Center 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 to whether any collaboration was needed, and if any was completed, summarize findings and outcomes. Both CLDPs included a section to address this indicator, but neither provided a specific description of the IDT's consideration, instead stating only this was not applicable for Individual #292, and indicating "none" for Individual #533. The IDT should provide a descriptive statement of the considerations for making these determinations.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Neither CLDP met criterion. For Individual #292, the CLDP provided a broad statement that the Transition Specialist, QIDP, and Home Manager met with the provider home manager to ensure her needs would be met, but did not reference any consideration of the need for a settings assessment. For Individual #533, this section in the CLDP simply stated "none" and provided no description of the IDT's consideration.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that occurred and their results. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs. Neither CLDP provided a specific description of these considerations.

18. The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to or on the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but neither of these two PMSRs accomplished this. Examples of concerns from this review included:

- For both individuals, the PMM documented receiving the signed training rosters after the completion of the training, but these were insufficient as evidence that provider staff were competent.

- The PMM did not make any comments or provide any clear evidence that pre-move supports were in place. The PMSRs consisted only of checked boxes.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: For this review, and the last two, it was positive that individuals often transitioned to the community within 180 days, and that when they did not, documentation showed adequate justification. Given the importance of this indicator, it will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	292	533								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1								

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

- Individual #292 was referred on 7/28/16, and transitioned on 11/9/17. This exceeded 180 days, but the Transition Log documented adequate ongoing activity by transition staff and the IDT to locate an appropriate setting.
- At the request of his LAR, Individual #533 was referred on 7/25/17, and transitioned on 12/4/17. This was 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